Board of Directors
Public Meeting Agenda

Meeting to be held at 10.00 am on Thursday 09 September 2021
remotely via Teams in line with social distancing

Item No.	Timing	Title	Purpose	Page No.	Lead
Introduction and Administration					
1	10.00	Apologies	Receive	Verbal	Chair
2		Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda	Noting	Verbal	Chair
3		Minutes of the meeting held in Public on 08 July 2021	Approve	Pg. 4	Chair
4		Matters Arising	Receive	Verbal	Chair
Chair and Chief Executive Strategic Updates					
5	10.05	Chair's Report	Receive and Discuss	Verbal	Chair
6	10.10	Chief Executive's Report	Receive and Discuss	Verbal	Chief Executive
Quality					
7	10.20	Patient Story	Receive and Discuss	Presentation	Director of Patient Care and Chief Nurse
8	10.35	Nursing Staff Update	Receive and Discuss	Pg. 25	Director of Patient Care and Chief Nurse
Workforce					
9	10.45	Workforce Report Month 04	Receive and Discuss	Pg. 33	Director of Workforce
Performance and Finance					
10	10.50	Performance Report Month 04	Receive and Discuss	Pg. 38	Director of Operations
11	10.55	Finance Report Month 04	Receive and Discuss	Pg. 50	Deputy Director of Finance

Investment					
12	11.05	Milton Keynes Radiotherapy	Receive and Discuss	Pg. 67	Chief Executive
13	11.15	Cardiology Cath Lab Upgrade	Receive and Discuss	Pg. 72	Director of Operations
Assurance and Statutory Items					
14	11.25	Significant Risk Register	For Information	Pg. 74	Director of Corporate Affairs
15	11.30	Board Assurance Framework	Receive and Discuss	Pg. 84	Director of Corporate Affairs
16	11.35	Trust Board of Director – Terms of Reference	For Approval	Pg. 137	Director of Corporate Affairs
17	11.40	(Summary Report) Audit Committee – a. 19 July 2021	For Information	Pg. 143	Chair of Committee
18		(Summary Reports) Finance and Investment Committee – a. 28 June 2021 b. 03 August 2021	For Information	Pg. 144 Pg. 145	Chair of Committee
19		(Summary Report) Charitable Funds Committee – a. 15 July 2021	For Information	Pg. 146	Chair of Committee
20		(Summary Report) Workforce and Development Assurance Committee a. 21 July 2021	For Information	Pg. 147	Chair of Committee
Administration and Closing					
21	11.45	Questions from Members of the Public	Receive and Respond	Verbal	Chair
22		Motion to Close the Meeting	Receive	Verbal	Chair
23		Resolution to Exclude the Press and Public	Approve	Resolution to Exclude the Press and Public The Chair to request the	

				Board pass the following resolution to exclude the press and public and move into private session to consider private business: “That representatives of the press and members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted.	
11.55		Close			
Next Meeting: Thursday 04 November 2021					

Milton Keynes University Hospital NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Minutes of the Public Trust Board of Directors Meeting held on Thursday, 08 July 2021 at 10.00 hours via Teams

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

In Attendance:		
Kate Jarman	Director of Corporate Affairs	(KJ)
Jackie Collier	Director of Transformation & Partnerships	(JC)
Jill Wilkinson	Programme Director	(JW)
Victoria Burns	Lead Nurse for Dementia Care (For Item 07)	(LW)
Elizabeth Maushe	Learning Disability Nurse (For Item 07)	(EM)
Dr Janet Costa	Guardian of Safe Working Hours (For Item 15)	(JC)
Rosie Sampson	Business Manager - Medical Directors Office (For Item 15)	(RS)
Alice Fiancet	Communications Specialist	(AF)
Kwame Mensa-Bonsu	Trust Secretary (Minutes)	(KMB)

1 Welcome and Apologies

1.1 AD welcomed all present to the meeting. There were apologies from Andrew Blakeman, Senior Independent Director/Non-Executive Director; and Dr Luke James, Non-Executive Director.

2 Declarations of interest

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

3 Minutes of the meeting held on 06 May 2021

3.1 The minutes of the Public Board meeting held on 06 May 2021 were reviewed and **approved** by the Board.

4 Matters Arising

4.1 There was no Action Log.

5 Chair's Update

5.1 AD informed the Board that the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System (ICS) planned to hold a Development Day in October 2021, which should provide an opportunity for the representatives of the constituent organisations to have more extensive discussion on strategy and other important issues. AD advised that the BLMK ICS had also reviewed the recently circulated draft ICS Governance Framework and fed back the view that the ICSs should not be heavily bureaucratic but should rather preserve the ability of NHS bodies to react quickly to events such as the COVID-19 pandemic. AD noted that she and JH had scheduled a meeting in August 2021 with their counterparts at Bedfordshire Hospital to discuss the BLMK ICS and other collaborative arrangements between the two organisations.

5.2 AD advised that a Board Development Day would be held in September 2021, the purpose of which was to provide an opportunity for Trust Board members to develop their interpersonal relations and review the organisation's strategic direction. AD advised that she had attended the launch of a Trust Veterans Network, made up of retired and active members of the armed forces, and noted that the group had a lot of impressive plans for enhancing the support for their members. AD stated that she had also started visited to the Trust's Hotel Services, which had risen fully to the challenge of contributing effectively to the hospital during and after the peak of the COVID-19 pandemic.

5.3 AD informed the Board that she had arranged a visit to the Woughton Parish Council in July 2021 to review the activities of several community organisations. The East of England Regional Chairs' Network was also pushing forward on its anti-racism agenda with the expectation that the constituent organisations would respond and take the relevant actions.

5.4 AD noted that at an NHS Providers (NHSP) meeting for Chairs and Chief Executives in June 2021, the discussions had been around the need to recognise the significant changes taking place in the NHS particularly with the appointment of a new Secretary of State for Health and the expected appointment of a new Chief Executive for NHS England. There had been discussions on the steps which needed to be taken to meet the challenges of reducing waiting lists across the country, and the impact of 'long' COVID', another possible wave of COVID-19 infections and of winter illnesses on the NHS, and the digital transformation agenda.

The Board **noted** the update.

6 Chief Executive's Update

6.1 JH informed the Board that the Trust had published a very well-received yearbook in July 2021 on the NHS's 73rd birthday to commemorate the brave and excellent efforts of the Trust's staff during the COVID-19 pandemic. The Trust planned to publish a second volume of the yearbook as more areas of the hospital wanted their COVID-19 pandemic stories to be recorded and published.

6.2 JH advised that, due to a technical fault, one of the Trust's laminar flow orthopaedic theatres had been closed since June 2021. This had resulted in the loss of activity due to the postponement of surgical appointments. Steps were being taken to restore the theatre so those surgical procedures could be undertaken.

6.3 IR advised that the number of COVID-19 inpatients was increasing, noting that while most were being treated with steroids and other evidence-based treatments, only 2 of them had been admitted to the ICU. IR stated that evidence of the significant spread of COVID-19 infections in the community was reflected in the increasing number of patients who attended the hospital for other ailments but were found to be asymptomatically infected after they were routinely tested for COVID-19. IR stated that the severity of the illnesses of patients who were presenting with COVID-19 infections was significantly less than those who presented in the first and second waves but emphasised that the number of infections was increasing. IR advised that Ward 22 had been re-opened and set up as the COVID-19 ward.

6.4 JH stated that as part of a programme of work to improve patient experience across the Trust, the Early Pregnancy Assessment Unit (EPAU) had been relocated from Ward 10 to a dedicated, separate unit in

Ward 9. The new EPAU would have its own dedicated entrance and reception desk and enable the Trust to ensure that those using the facility had all the necessary privacy that they needed and that they had the best possible support.

6.5 Ward 14 had been fully refurbished and reopened and was ready for the transfer of patients and activity from Ward 1, so that could be refurbished as well. JH noted that the completion of the Pathway Unit would enable the Trust to accelerate the refurbishment work on the rest of the hospital's wards.

6.6 JH informed the Board that the Trust had in July 2021 opened a new Neonatal Transitional Care Unit with the aim of keeping new mothers and their babies together if the new-born needed additional care. A specially trained team would provide that additional care without the new mother and their baby having to be separated from each other. In June 2021, the Trust also launched a 'Hospital Navigator Scheme' to provide support for patients who had been abused domestically. The scheme was launched in conjunction with the Thames Valley Police and would be supported by a team of volunteers based in the Trust's Emergency Department (ED). The volunteers would provide comfort, advice and support to individuals who may be particularly vulnerable, and those patients who required further intervention would be directed to YMCA Milton Keynes for specialist support. JH advised that, under the auspices of the Staff Health and Wellbeing Agenda, the Trust had also launched a policy to support the provision of paid leave for members of staff who had been domestically abused.

6.7 JH stated that NHS Providers (NHSP) had commissioned the Trust to talk to the Boards of Directors of other NHS providers about the hospital's significant digital journey, and the latest to receive a virtual presentation on this was the July 2021 meeting of the Board of Airedale NHS Foundation Trust based in Keighley, West Yorkshire. JH noted that the Trust was supporting many NHS providers, and was ready to support more, on their digital journeys. JH had also conducted an interview in July 2021 with the BBC on the Trust's implementation of the Accelerator Programme.

6.8 KJ reported that from July 2021 staff were being required to order their COVID-19 lateral test kits from the UK government's central system, instead of from the Trust. KJ stated that members of staff were being encouraged to continue with the practice of testing themselves twice a week and to continue reporting their results on the Trust's website. In response to HS's query around the monitoring of staff compliance, KJ stated the Trust was able to assess from the submissions of test results the volume and regularity of self-testing which was being conducted in areas of the hospitals. IR added that, to comply with the confidentiality standards, access to the test results of individual staff members was heavily restricted. IR noted that he, NBM and a few very senior managers could only access those records on a need-to-know basis.

6.9 JH provided a presentation on the refreshed set of Trust Objectives and highlighted them as:

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

JH advised that the refreshed set of Objectives would be allocated to the Board's Committees for them to monitor and report to the Board on the progress being made against them. JH stated that the Objectives would be communicated widely through the organisation so that both the staff and patients would be aware of them. AD noted that the Board had agreed that it was right, with reference to the impact of the COVID-19 pandemic, to maintain the set of Objective but to refresh them so they became more patient-focussed.

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

7 Patient Story

7.1 VB presented the story which highlighted the work conducted by the Trust's Safeguarding Team, during the COVID-19 related restrictions to visits by relatives and friends, to provide input aimed at improving the stimulation required by patients with Dementia.

7.2 VB highlighted the input provided by the Safeguarding Team as including:

- Dementia Puzzles;
- Dementia Friendly colouring books and pencils;
- Dementia Friendly Puzzle Books (word search, crossword) and highlighters;
- Playing Cards/Dominos;
- The "What Matters to Me" 'passport' which allowed the Trust to capture important pieces of information for patients with Dementia and other patients, such as those living with Parkinson's, so caregivers would have a holistic view of them;
- Robopets to provide scientifically proven pet therapy to patients;
- A plan to create a social club and bar in Ward 18, and a market where patients could buy items in Ward 23.

7.3 VB advised that steps had been taken in June 2021 to successfully recruit a 1-year fixed term Meaningful Activity Facilitator who would work closely with frailty ward and therapy staff to plan and implement meaningful activities with the patients. The role was a pilot funded by the hospital's Charity, and its success would be assessed through measurables such as a reduction in falls, pressure damage, and violence and aggression. If the pilot role was successful, funding would be sought for a permanent Meaningful Activity Facilitator to be recruited.

7.4 HH thanked the Safeguarding Team for the steps they had taken to provide holistic treatments for the patients in their care and stated that the Charitable Funds Committee was pleased to have been of help and was ready to continue providing support. NMc stated that the Safeguarding Team's work was very inspiring, and in reference to the patient therapy treatment, noted that the use of robot kittens to provide comfort to patients was so simple but very effective. HS noted that the care provided to patients with dementia usually extended to the patients' families and added that the Team was providing a remarkable service. KJ advised that the extraordinary work of the Safeguarding Team on various very complex wards had been recognised at the Charitable Funds Committee, and the hospital Charity was looking to provide more support to progress their many initiatives and plans.

7.5 AD stated that it would be important that the support and activities to be provided by the Facilitator and the Safeguarding Team were as individualised as possible. AD noted that not all patients would have had for instance, life experiences which would include bars and markets. NBM, in response, stated that steps were being taken introduce a lot more activities to cater for a patient profile which was becoming younger. NBM advised that the male patients were also becoming more challenging to manage and stimulate, and this required the Safeguarding Team to continually seek improvements to the service provision. AD thanked VB for the presentation and for all the initiatives being undertaken to improve the service.

The Board **noted** the Patient Story.

8 Incident, Improvement and Learning Report

8.1 KJ presented a report which provided an overview of the 8 new Serious Incidents reported in June 2021, the trends and a brief summary of linked programmes of work in response to the incidents. KJ advised that the report format would change in the near future in compliance with both an updated Patient Safety framework and recommendations from the Ockendon Review on how maternity-related incidents should be reported to the Trust Board. The level of transparency required for maternity-related incidents would

be applied to incidents in all other areas to ensure there was parity and consistency in the reports to the Board.

8.2 KJ highlighted the workshops and other support work conducted in May 2021 by the Appreciative Inquiry (AI) Programme Team with 13 members of the Trust's Emergency Department (ED) staff. The themes from the AI workshops included:

- Exploring and noticing what works well and trying to understand why, so this could be replicated;
- Rethinking handovers so that they are meaningful and enhance considering other perspectives and discussion within a time limited period;
- Notching up the noticing of positive everyday practices so that these can be amplified and shared;
- Exploring the concept of patient transfer from ED to the wards using AI to focus on what matters to people, how it feels and what works well. Patient transfers to wards could be tricky especially if telephone handover prior to the transfer had not taken place.

KJ advised that following the AI workshops in the ED, the positive practices which would be amplified and replicated by others included:

- The example of a member of ED reception staff adding their name as a contact on the slip of paper providing the contact telephone number for relatives of patients during this period of COVID-19 related restrictions in the hospital;
- The example of an ED receptionist leaving their desk to speak privately with a patient, so the patient didn't have to reveal all their details in front of others;
- The example of an ED receptionist regularly handing out the Friends and Family Test forms to patients, and then going out to the waiting area in their free time to help patients complete them.

8.3 KJ noted that the investigation into nosocomial or healthcare associated COVID-19 infections had progressed and it had been established that:

- There were 92 cases of positive COVID swabs in patients who had been under the care of the Trust for over 14 days at the time of the first positive swab. As such, these cases were described as "hospital onset - definite healthcare associated COVID-19 infections". Of the 92 patients with definite healthcare associated COVID, 31 subsequently died. 20 of these patients died 'of COVID' and 11 died 'with COVID';
- A further 143 cases of positive COVID swabs in patients who had been under the care of the Trust for between 8 and 14 days at the time of the first positive swab. These cases were described as "hospital onset - probable healthcare associated COVID-19 infections".

KJ advised that the Trust had, in line with its Duty of Candour obligations, been in touch with the bereaved families and had shared the summaries of care provided to their relatives and the areas of learning. IR stated that it was a matter of profound regret that patients under the care of the Trust had been infected by COVID-19 and had subsequently passed away. IR added the Trust had learnt lessons and was determined to ensure that patients were safeguarded in the future.

8.4 The report noted that of the 1913 COVID-19 patients admitted to the Trust, 21.6% or 414 of them died, which was in line with the national mortality rate was 21.7%. IR stated that the data clearly indicated that the hospitalisation and the quality of the management of COVID-19 patients was very much in line with the national data.

The Board **noted** the Incident, Improvement and Learning Report.

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8.5 IR informed the Board that the inquest into the death of a patient, whose cause of death was identified at post-mortem as 'hypoxic encephalopathy secondary to a cardiac arrest on induction of anaesthesia', was due to be concluded on 08 July 2021.

9 Maternity Update – Ockendon Requirements

9.1 NBM presented the report and advised that the Trust had submitted all required evidence on the progress made against the recommendations contained in the Ockendon Report and was awaiting feedback from the East of England Regional Maternity Team. The feedback from the Regional Team would determine whether an action plan was needed for further improvements or not.

9.2 NBM reported on the granting of a bid for funding to the BLMK Local Maternity & Neonatal System (LMNS) to support the implementation of the recommendations of the Ockendon Review across the BLMK area. The Trust was awaiting its share of the funds, which would be utilised to support the recruitment of staff including:

- Midwives;
- A Fetal Monitoring Specialist Midwife;
- One Consultant PA to support the twice daily seven-day ward rounds;
- One Consultant PA to support the fetal monitoring lead Consultant role;
- Support for members of the MDT required to attend PROMPT training.

NBM stated that the Board would be updated when the Trust's share of the funds was agreed and how that share could impact on the recruitment plans for Maternity was assessed.

The Board **noted** the update.

10 Clinical Negligence Scheme for Trusts (CNST)

10.1 NBM presented the document which self-certified that the Trust was compliant with all elements of the CNST. This was to ensure that Trusts completed the safety actions related to the maternity incentive scheme, and where necessary, submitted an action plan for the safety actions which had not been met.

10.2 NBM advised that there had been communication that a couple of the elements related to external reviews had been revised, and that as a result, the submission date of 15 July 2021 had been extended. NBM stated that the actual revisions were yet to be forwarded and asked the approval of the completed self-certification document be delegated to HS, IR and herself. This request was made in view of the next Board meeting being scheduled for September 2021, which will be after the likely extended deadline for submission.

10.3 IR advised that there had been a request from CNST for the Trust to also commit to ensuring that at least 90% of each of the relevant Maternity staff groups would, at any one time, have undergone fetal monitoring training. IR stated that he and NBM believed this standard to be a reasonable one for the Trust to commit itself to. JH expressed the Trust's gratitude for the work undertaken by NBM, Melissa Davis, Head of Midwifery, Gynaecology & Paediatrics and the Maternity Team for completing the difficult task of collating all the evidence needed to provide evidence of compliance.

The Board **approved** the following:

- The commitment of the Trust to ensuring that at least 90% of each the relevant Maternity staff groups would, at any one time, have undergone fetal monitoring training;
- NBM, IR and HS to, on behalf of the Board, approve the revised and updated self-certification document, and to advise JH to sign it for submission.

11 Nursing Staffing Report

11.1 NBM presented the report and highlighted the following:

- 38 of 45 student nurses offered employment as band 5 nurses, after their final sign-off placements at the Trust, had accepted their offers;

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- Establishment reviews for all inpatient wards and departments had been progressed and was on schedule to be completed by September 2021;
- Steps would be taken to substantiate the Nursing Associate role and integrate it into the Trust's nursing establishment skill mix. The Nursing Associate role had been in existence in the Trust for two years;
- Due to a recent increase in the number of band 6 junior ward sisters//charge nurses on each shift, there was the need for the nursing skill mix to be reviewed.

11.2 HS asked for the Board to take note of the successful recruitment exercises during a challenging period for band 5 nurses, and for health care assistants through the 'Accelerated Healthcare Support Worker Recruitment Scheme'. HS, with reference to the success of the Workforce Matron role in supporting the recruiting of nursing staff, enquired whether there were plans to create similar roles in all divisions. NBM, in response, stated that there were no such plans as all Matrons had recruitment as part of their remits and added the Workforce Matron worked collaboratively with all the other Matrons and the Divisional Chief Nurses. NBM noted that the Workforce Matron planned to take steps to enhance the support for the retention efforts for the nursing staff.

The Board **noted** the Nurse Staffing report

12 Workforce Report Month 02

12.1 DP presented the Workforce Month 02 report and highlighted the following:

- The vacancy rate had increased slightly to 10.2% in Month 02, from 10% in Month 12;
- A small increase in the number of staff who needed to self-isolate either due to being infected with COVID-19 or having been in contact with someone who was infected;
- Staff turnover improved year-on-year by almost 2% from 9.2% to 7.4%;
- The statutory and mandatory training compliance rate was at 95% in Month 02, from 97% in Month 12, while appraisals compliance rate was at 93% in Month 02, from 95% in Month 12;
- The Trust's 'Living our Values' Programme has progressed, and 450 members of staff had attended Values into Action workshops between July and August 2021. About 150 other members of staff had been booked to attend subsequent workshops;
- An additional counsellor had been recruited to support the in-person on-site counselling sessions under the auspices of the Staff Well-Being Agenda
- The 2020 Staff Survey Action Plan had progressed, and listening events were being held in the Divisions and Clinical Service Units (CSUs) to discuss the local Staff Survey results and either develop corrective action plans or share their good practice;
- A whole-day masterclass on 'Leading Inclusively with Cultural Intelligence' had been arranged for the Trust Board meeting in December 2021;
- NMc had accepted her nomination as the Trust's Wellbeing Guardian.

12.2 DP advised that the Trust Disciplinary Policy and Procedure had been revised, in line with the 'Fair and Just Culture Principles' and published on the Trust's intranet and website as required.

12.3 JH, on behalf of the Trust Board, thanked the Mandatory Training Team, in particular and the Workforce Team as a whole for the effective steps they had undertaken to maintain the very strong mandatory training compliance and staff retention rates through the COVID-19 pandemic and beyond. HT, in agreement, noted that the Workforce metrics provided evidence of the positive actions which had been undertaken by the Workforce Team. In response to HT's query on potential concerns around recruitment activity, DP stated that there were no concerns as advertisements for roles in the Trust were each receiving a large number of applications. DP advised that this was a result of the success of the steps taken to make the Trust an attractive place for work. DP added that steps were being taken to ensure all members of staff understood that they had a voice and could contribute to the progress of the Trust.

The Board **noted** the Month 02 Workforce report.

13 Performance Report Month 02

13.1 EL presented the reported and noted that:

- Emergency Department's (ED) performance against the 4-hour waiting target was at 89.4% in Month 02 from 90.3% in Month 12. This was due to the challenge of managing above average attendances, particularly on Mondays and Tuesdays, when there are usually over 300 patients attending the ED each day;
- Staffing pressures were also beginning develop in the ED and around the hospital due to staff needing to isolate;
- Ambulance handovers which were over 30 mins increased to 11% in Month 02, from 6.2% in Month 01, due to a significant increase in the number of Type 1 attendances to the ED;
- For length of stay, the number of patients who had stayed in hospital of 21 days or more after their treatment was at 69 in Month 02, from 59 in Month 01. EL advised that this was due to the difficulties associated with the discharge of a large number of out of area patients, and the need to coordinate with out of area social care agencies.

13.2 JH stated that, though the aspiration was to achieve compliance with the national ED performance target of 95%, it ought to be noted that in the East of England region, the Trust was ranked in the top 3 for ED performance.

The Board **noted** the Month 02 Performance Report.

14 Finance Paper Month 02

14.1 TW presented the Month 02 Finance Report and noted that:

- The Trust was projecting a deficit of £1.1m for the 6 months of 2021/22 to September 2021;
- On a control total basis, the Trust reported a deficit of £106k in month 02 and £90k YTD, which was £71k favourable to the plan in-month and £291k YTD.;
- The M02 financial position included income and expenditure of £2.7M YTD associated with the Elective Recovery Fund, which was provided by the UK government to help hospitals clear the backlog of patients;
- The cash balance at the end of May 2021 was £48.5m;
- Capital spend as at the end of May 2021 was £0.7m.

The Board **noted** the Month 02 Finance report.

15 Guardian of Safe Working Hours Annual Report (2020-2021)

15.1 IR presented the report and advised that it was to demonstrate compliance with the national terms and conditions for medical staff in training for the period between April 2020 – March 2021. IR stated that the report also described the exception reporting process through which doctors in training could report on the issues they encountered during their training, such as safety concerns and excessive working hours. IR advised that exception reporting was positive and should be encouraged as it also impacted on patient safety.

15.2 JC advised that though the practice of exception reporting had been well accepted in the Trust she continued to encourage the trainers and consultants to support the trainees to submit their exception reports, and for supervisors to respond and resolve all issues in reports within the statutorily stipulated timelines. AD stated that it was very much in line with the culture of openness that was being fostered in the Trust, for staff to be able to communicate about both positive and negative issues. AD noted that patient safety was enhanced when the staff felt supported, and problems were discussed and resolved. In response to AD's query on the timeliness of the responses to issues raised in exception reports, JC stated that supervisors responded to and resolved issues within two weeks of them being raised. In response the NMc's query around the psychological impact arising from excessive working hours, JC

stated that the consultants provided extensive one to one psychological support when individual doctors in training felt overwhelmed with the intensity and hours of work.

15.3 IR stated that the governance and assurance reporting for the Safe Working functions would be:

- Monthly reports to the doctors in training and the consultants;
- Quarterly reports to the Workforce Development and Assurance Committee;
- Annual Reports to the Trust Board.

15.3 IR informed the Board that Health Education England (HEE) South-East had provided a glowing letter acknowledging the current training facilities and support for trainees in Obstetrics and Gynaecology had resolved all concerns. The Trust had, in response to concerns raised by HEE South-East, significantly improved the educational and psychological support provided to trainee doctors in Obstetrics and Gynaecology and established a vibrant Junior Doctor Forum for all trainee doctors in the Trust. HEE South-East had removed a related risk entry from their risk register, as they no longer considered the allocation of trainee doctors to Obstetrics and Gynaecology an issue and would recommend that the General Medical Council also removed a related risk entry from their risk register.

The Board **noted** the Guardian of Safe Working Hours Annual Report (2020-2021).

16 Significant Risk Register

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

17 Board Assurance Framework (BAF)

17.1 The Board **noted** the BAF.

18.1 Summary Report for the Audit Committee Meeting – 19 May 2021

18.1.1 The Board **noted** the report.

18.2 **Summary Report for the Audit Committee Meeting – 07 June 2021**

18.2.1 The Board **noted** the report.

19.1 Summary Report for the Finance and Investment Committee Meeting – 04 May 2021

19.1.1 The Board **noted** the report.

19.2 Summary Report for the Finance and Investment Committee Meeting – 01 June 2021

19.2.1 The Board **noted** the report.

20 **Questions from Members of the Public**

20.1 Ms Lucinda Mobaraki, a Public Governor, asked a question:

a. Should the objectives include a system to manage patients' expectations?

JH provided a verbal response below:

We are reframing our objectives to ensure they capture what patients can expect when they come to our hospital. I think it is right that they have high expectations of our hospital that we will do our very best to meet. I am not sure that at this stage we should be looking to manage expectations but will keep this under review as our progress against these objectives evolve.

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21 Any Other Business

21.1 The meeting closed at 11.50 am.

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TheMKWay
CARE. COMMUNICATE.
COLLABORATE. CONTRIBUTE.

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Robotic assisted surgery

A patient's story

Eleanor Shield – ANP Enhanced Recovery

Barrie Keeler – Colorectal Consultant Surgeon

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

Chief Executive: Professor Joe Harrison
Chair: Alison Davis

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Robots in Milton Keynes..

Robot at MKUH…

Versius cases at MKUH

- Colorectal – 89
- Gynaecology – 68
- General surgery – 54
- Abdominal Wall reconstruction - 1

Victoria

66 year old lady lives with her husband and has 2 young adopted children.

Referred from the Bowel Cancer Screening Programme with an adenocarcinoma in her ascending colon.

Met with Mr Keeler in outpatients & the Colorectal Cancer Nurse

Discussed surgery with the use of a robot

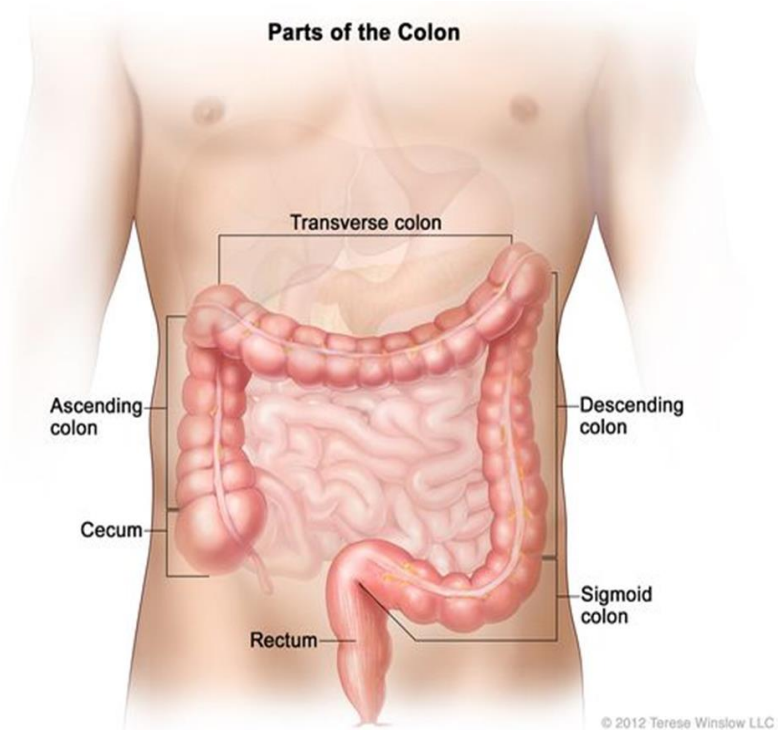
Booked for surgery under 2WW

Attended pre-assessment

Counselled by Enhanced Recovery Nurse

Robotically assisted right hemicolectomy

Followed the Enhanced Recovery Programme



How did it make you feel knowing you were having robotic surgery?

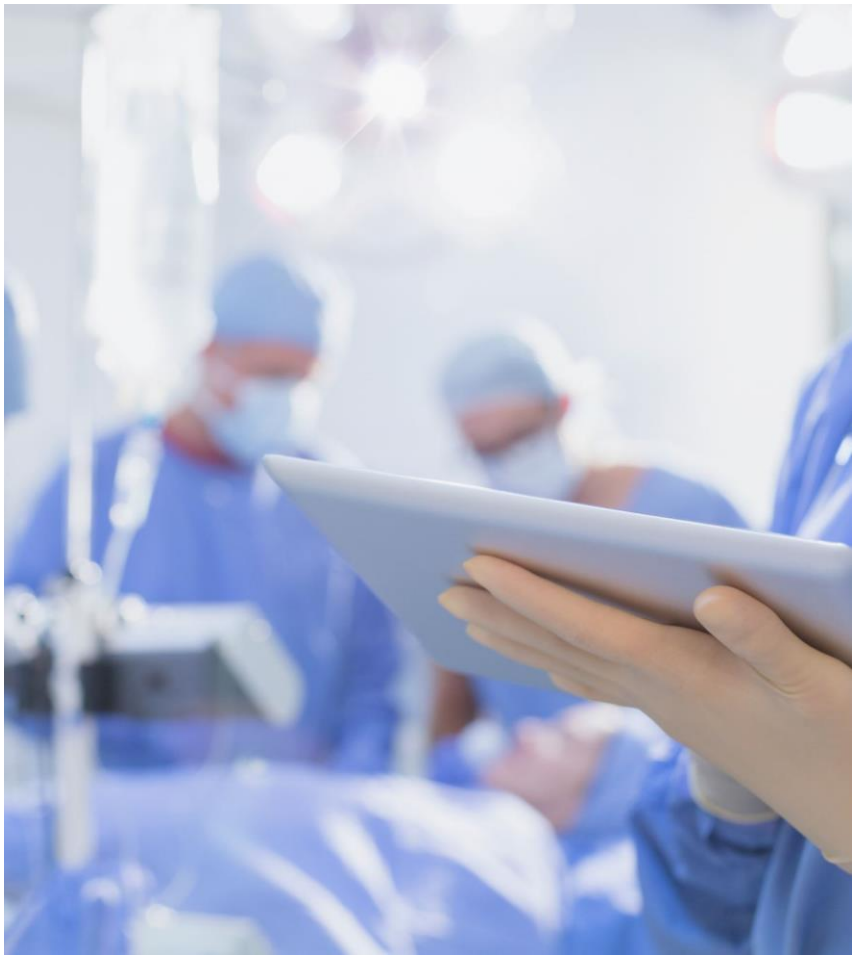
- Unaware
- Surprised
- Supported
- Well informed
- Comfortable
- Excellent communication
- I trusted Mr Keeler and all the team.

The day of surgery.

"I wanted it done as soon as possible"

"Relieved"

"Excited"



How was your recovery after your operation?

Milton Keynes University Hospital NHS Foundation Trust

"My recovery was really good"

"I was up and about the next day"

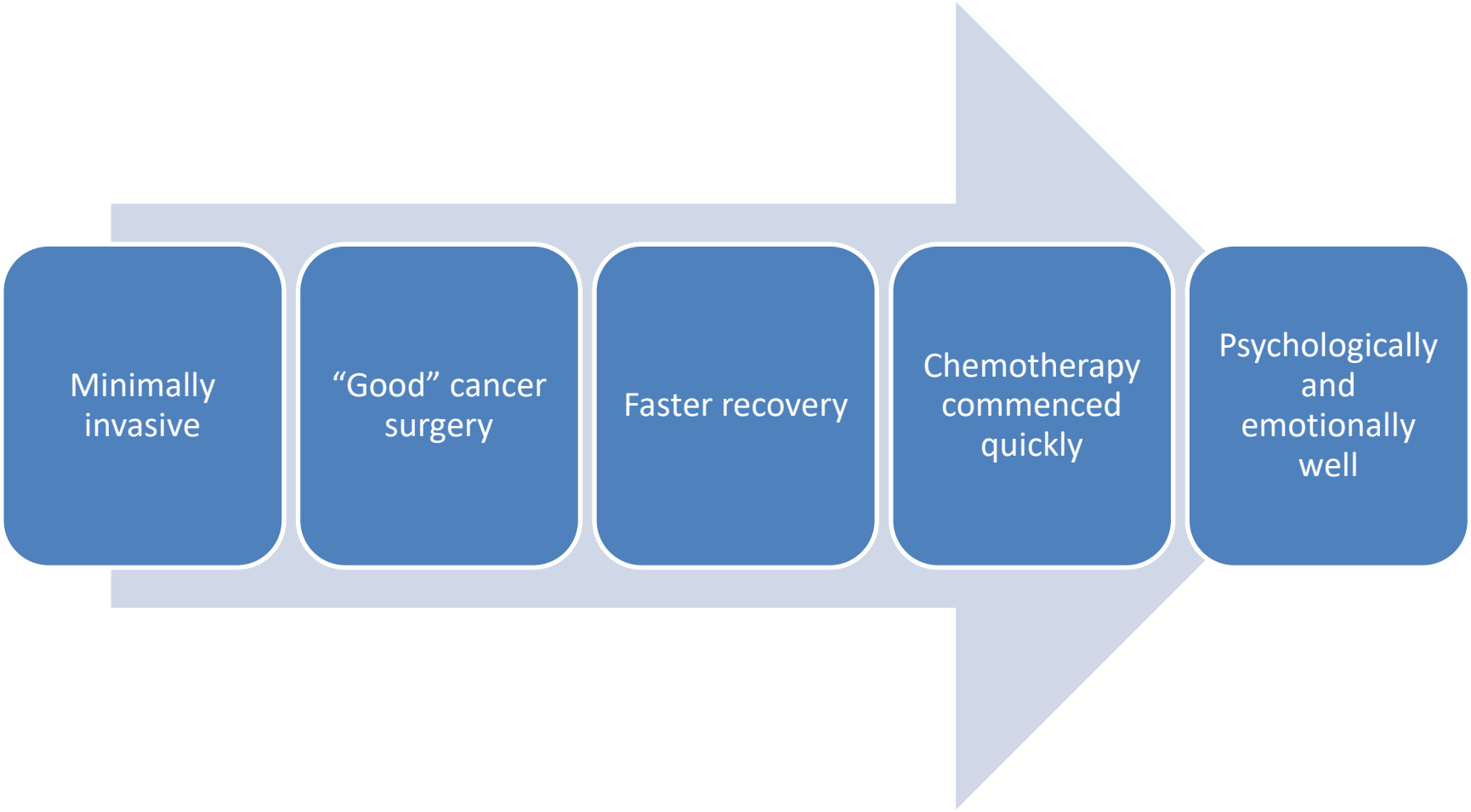
"I was offered breakfast the morning after"

" I was sick and did have an accident in my bed but the staff were really kind even though I was embarrassed"

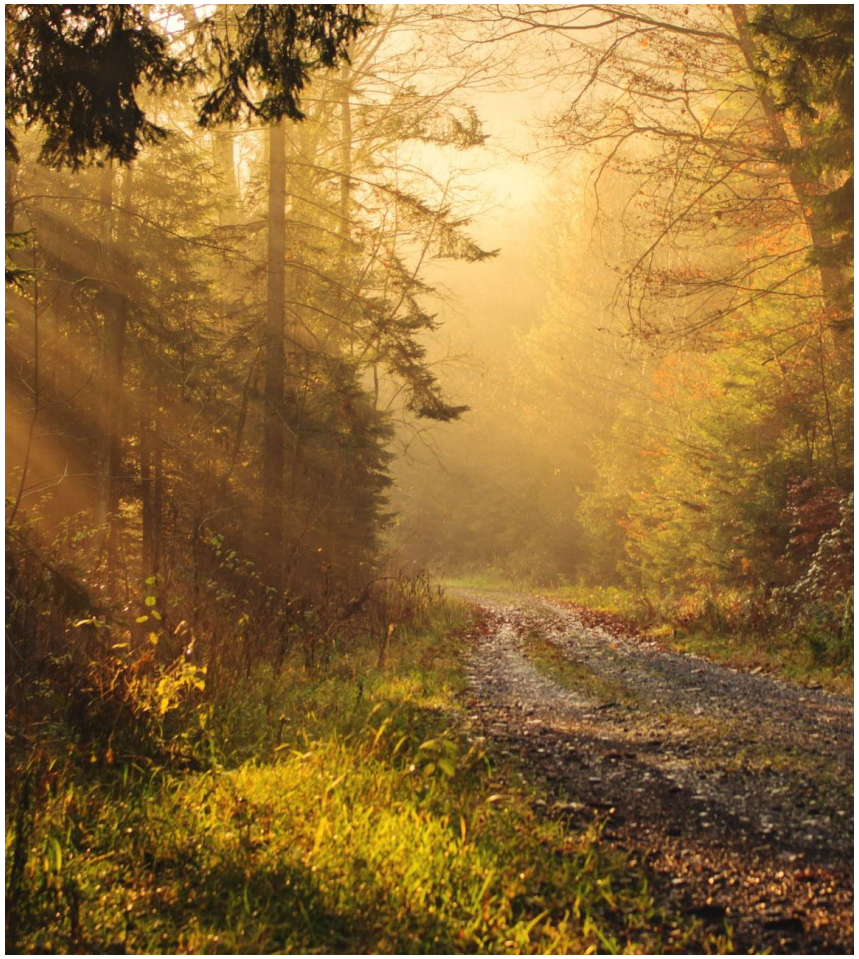
"I went home after 5 days"

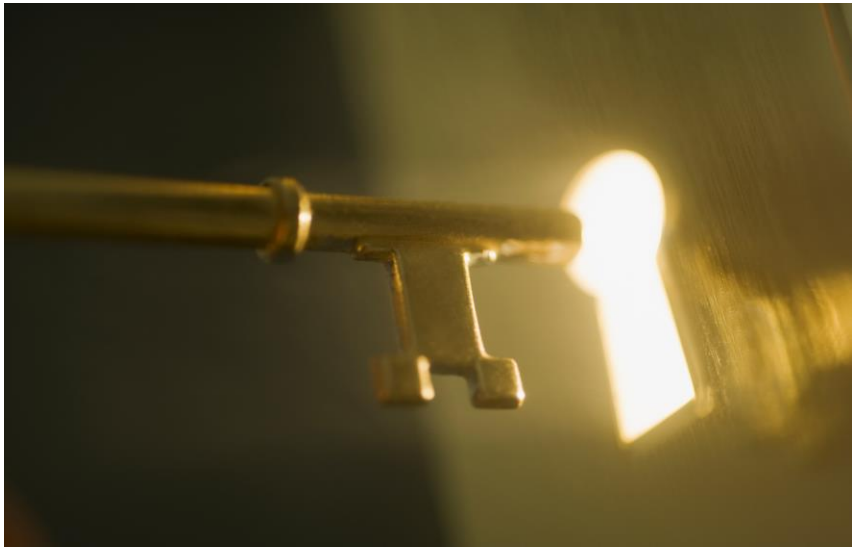
"My wounds were very small and have healed completely"

Benefits of robotic surgery for Allison



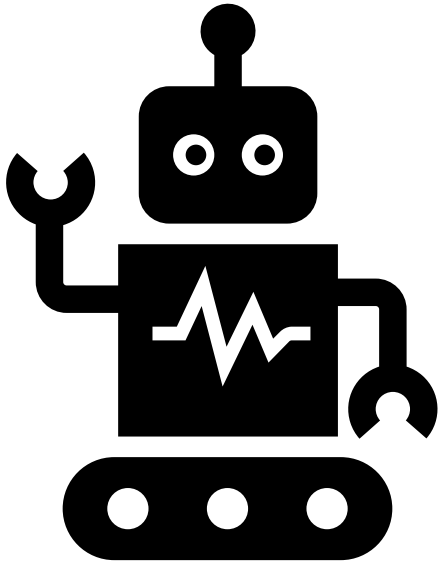
Overall thoughts





The future

- Expansion of robotic assisted surgery into other specialities.
- Promotion of robotic service to primary care and the public.
- Dedicated Intranet/ hospital internet page.
- Add patient feedback to the website.



Meeting title	Board of Directors	**Date:** September 9th 2021
Report title:	Nursing Staffing Report	**Agenda item: 8**
Lead director **Report author** **Sponsor(s)**	**Name:** Nicky Burns-Muir **Name:** Matthew Sandham Emma Thorne	**Title:** Director of Patient Care/Chief Nurse **Title:** Associate Chief Nurse Workforce Matron
FoI status:		

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

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

Report history	To every Public Board
Next steps	
Appendices	Appendices 1

Board of Directors Report on Nursing and Midwifery staffing levels
Amalgamated report for June and July 2021

1. Purpose

To provide Board with: -

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

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

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

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

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

CHPPD	Total Patient Numbers	Registered Midwives/Nurses	Care Staff	Overall
June	13038	4.3	3.0	7.4
July	13467	4.4	2.8	7.2

Month	**RN/RM Day % Fill Rate**	**HCA/MCA Day % Fill Rate**	**RN/RM Night % Fill Rate**	**HCA/MCA Night % Fill Rate**
June	75.2%	85.4%	95.5%	115.8%
July	74.8%	79.9%	94.1%	110.1%

- *June and July 2021 data are included in Appendix 1.*

Areas with notable fill rates

During the months of June and July the Trust saw a continued increase in attendance which has affected the CHPPD hours in the month of June.

3. Recruitment Overview

Are we safe ?

The Tables below are the residual numbers of vacancies.

Medicine

Band	WTE Vacancy	Percentage	Turn over percentage
Band 2	16WTE	9.5%	6.9%
Band 5&6	34.4 WTE	10%	6%

Medicine's Band 5's has slightly increased due to a small number of leavers.

Surgery

Band	WTE Vacancy	Percentage	Turn Over percentage
Band 2	17 .1WTE	6 %	6%
Band 5&6	12.43 WTE	6%	5%

Surgery has remained static.

Women's and Children

Band	WTE Vacancy	Percentage	Turn Over percentage
Band 2	1.17WTE	4%	6 %
Band 5&6	16.61WTE	7 %	2%

Women's and Children have been successful in recruiting all their students.

It is important the Trust Board are aware Maternity staffing. The below table shows the progress on recruitment.

Maternity

	Establishment	WTE Vacancy	Pre-employment	Residual Vacancies
Funded	144.86 WTE	12.8 WTE	12.8 WTE	0 WTE
Post Ockenden review funded	144.86 + 14 WTE Ockenden uplift	14 WTE	1 WTE	13 WTE

Maternity is actively recruiting to the vacancies with a bespoke recruitment plan.

4. Recruitment

The Divisions are running recruitment campaigns with a particular focus on Ward 1, 17 and Emergency Department.

The Trust is also attending Milton Keynes Job Show being held in central Milton Keynes (Middleton Hall) on Friday 17th September and Saturday 18th September. The Nursing and Midwifery team will be represented throughout the two days.

The Trust temporary workforce team have been very successful in recruiting a number of Health Care Support Workers (HSCW) to the hospital bank. The staff on the bank can then experience a number of different clinical wards while they decide what career journey they would like to take.

It has been agreed that we need to offer the bank staff the opportunity to become permanent. The bank staff have been asked to put in an expression of interest for a permanent post.

To date we have had 20 HSCW responded, and we are currently working through the requests to match them with the Trust vacancies.

5. Birthrate Plus Intrapartum Acuity tool

This differs to using Birthrate Plus for workforce planning in which the midwife records the category only once on transfer from the delivery suite.

Local Maternity and Neonatal System (LMNS) provided financial support to the Trust to purchase of the Birthrate Plus Intrapartum Acuity tool.

The Intrapartum Acuity Tool provides an objective assessment of the complexity and risk of women during intrapartum care to calculate the number of midwives required to achieve the agreed safety staffing standard of one midwife to one woman during labour and delivery. If the number of midwives available is less than the acuity calculates then the Midwife coordinators and managers can then make clinical decisions and manage resources appropriately.

The Acuity Tool only applies to the workload in the delivery suite which may also include a triage service but is not used in other wards or assessment areas even if women there are in early labour. This is because the tool has been developed and validated for delivery suite activity only.

The calculation is based on inputting data every 2 and 4 hourly intervals within the 24-hour period by the midwife coordinator who enters the number(s) of women in the various categories with the emphasis on the appropriate category in a real time assessment. The number of midwives available at the time are included plus the coordinator and the acuity immediately shows the midwives required to deliver safe care.

The Acuity Tool can be accessed remotely by managers if a situation cannot be resolved by the midwife coordinators/shift leads onsite which supports the on-call maternity staff to support and decide on the appropriate course of action for mitigation.

It has been reported nationally that using the Acuity Tool in maternity units has shown that it does provide an accurate robust tool to predict acuity and staffing levels required. As the tool becomes embedded it will allow the ability to review trends in activity to inform workforce planning and decision making. It also enables a fairer allocation of midwifery resources and improved management of non-labouring women.

Are we effective?

6. Establishment Reviews

The reviews continue to progress and this has given the opportunity to hold professional judgement conversations and consider new ways of working and review data (funded establishment, staff in post figures, vacancy information, staff turnover rates, ward skill mix, and Healthroster fill rates).

The reviews will conclude at the end of September with the proposed outcomes being presented at the next Public Trust Board on November 11th, 2021.

7. Healthroster Check and Challenge

The focus within the check and challenge meetings during June and July was on the percentage of allocated annual leave for each area. Balancing encouraging staff to take annual leave following a difficult time during the pandemic we wanted to review the wards against the agreed annual leave set within the parameters of 11% to 17 %.

At the time of roster approval and within the check and challenge meetings it was reported that all ward areas for June and July had allocated annual leave within the agreed parameters.

This data has been reviewed by the Divisional Chief Nurse (DCN) in medicine due to the staffing challenges experienced during the summer holidays. The review of the annual leave allocation again confirmed that no clinical areas had gone above the agreed parameters. The DCN is now reviewing other data such as sickness levels (including COVID isolation), bank and agency fill rates and the activity on previous years. This report will be shared with the Chief Nurse and Workforce Board with actions, recommendations and outcomes.

8. SafeCare Tool Update

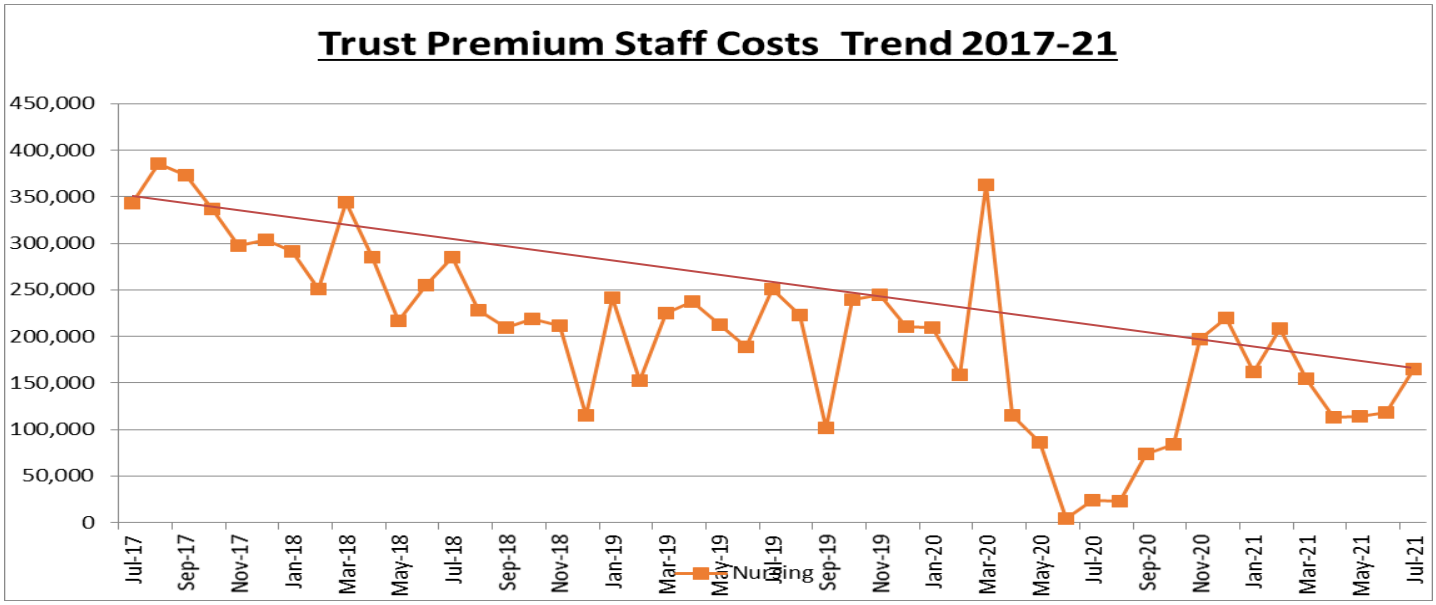
SafeCare Tool is progressing to the “Embedding “stage of the implementation plan.

A census is filled in by all adult and paediatric wards three times a day and there is currently 90% compliance. The census includes the number of staff on shift on duty and patient acuity at the time of completion. Staff with authorised access can review the data on the Hospital intranet.

The Trust uses the census data to inform safe staffing levels following a professional judgement review carried out by the matrons on a daily basis.

The SafeCare tool census data is used within the Hospital Safety Huddles at 08.30, midday, 15.00 and 22.00. This information informs the Trust of the areas that are experiencing increased acuity which then allows the senior team to review and plan mitigations.
The next steps for the SafeCare tool are to use the information to inform ward establishment reviews and future business cases. In the future this will also be linked for additional information for clinical incident reviews.

9. Agency graph



During the period of July, we saw the agency cost rise. This has been driven by staff isolating and an increase in capacity. July Agency cost is lower than 2018/2019.

We celebrate

Nursing Times Workforce Summit & Awards

Milton Keynes University Hospital has been shortlisted in the 'Team of the Year' category at the Nursing Times Workforce Summit Awards.

The entry showcased:

- The work undertaken by MKUH with our HCSW recruitment programme
- The quality bespoke induction programme offered to new recruits with our 'Fundamentals of Care' induction programme.
- The collaboration with NHSI/E & the Princes Trust
- Acknowledging the huge amount of work undertaken by teams to ensure the project success in the time frame given by NHSI.

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

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
AMU	72.6%	89.1%	95.4%	111.1%	541	6.4	2.8	9.2
ICU	83.7%	99.4%	96.9%	-	224	22.4	1.6	24.0
Ward 2	75.3%	76.5%	95.2%	101.5%	695	4.4	2.4	6.8
NNU	72.4%	80.6%	83.9%	113.3%	357	10.3	2.1	12.4
Ward 14								
Ward 10								
Ward 15	79.0%	90.4%	95.0%	148.3%	742	3.6	3.0	6.6
Ward 16	80.6%	84.0%	99.5%	108.3%	831	3.4	2.2	5.6
Ward 17	75.9%	88.1%	97.5%	118.3%	748	4.1	2.1	6.2
Ward 18	73.6%	102.8%	101.1%	150.8%	816	2.9	4.1	7.0
Ward 19	82.2%	99.2%	103.3%	145.6%	819	3.2	3.9	7.1
Ward 20	76.3%	73.9%	100.2%	107.7%	751	3.6	2.7	6.3
Ward 21	69.3%	79.9%	80.9%	111.8%	421	5.6	3.4	9.1
Ward 22	55.2%	61.1%	90.1%	85.6%	242	7.9	8.0	16.0
Ward 23	80.0%	93.2%	102.7%	123.3%	1115	3.2	3.7	6.9
Ward 24	80.0%	71.5%	90.0%	101.7%	350	5.7	3.7	9.4
Ward 3	76.3%	84.6%	100.0%	107.8%	813	2.9	3.1	6.1
Ward 5	72.1%	72.5%	103.2%	89.9%	454	7.4	1.3	8.8
Ward 7	72.4%	80.6%	100.0%	101.1%	621	3.7	3.9	7.7
Ward 8	79.7%	79.2%	101.1%	118.3%	710	3.5	2.6	6.1
Ward 9	71.8%	91.0%	84.3%	91.2%	1236	1.9	1.7	3.6
Ward 25	70.8%	99.0%	100.0%	142.3%	552	4.5	4.1	8.6

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

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
AMU	80.6%	85.7%	100.0%	112.9%	698	5.2	2.2	7.4
ICU	79.1%	84.1%	87.5%	-	209	24.9	1.5	26.4
Ward 2	111.4%	106.5%	80.2%		681	4.9	2.7	7.5
NNU	69.8%	63.5%	79.6%	38.9%	446	8.2	1.9	10.1
Ward 14	-	-	-	-	0	-	-	-
Ward 10	46.8%	71.6%	42.5%	57.9%	279	2.4	1.7	4.1
Ward 15	80.3%	85.0%	94.4%	137.1%	684	4.2	3.1	7.3
Ward 16	79.1%	87.4%	94.5%	103.2%	859	3.2	2.2	5.5
Ward 17	75.1%	77.5%	97.6%	113.7%	744	4.2	2.0	6.2
Ward 18	77.0%	78.8%	101.0%	118.2%	811	3.1	3.3	6.4
Ward 19	91.9%	87.6%	134.9%	127.6%	850	3.7	3.4	7.2
Ward 20	80.5%	77.7%	111.4%	106.5%	728	4.6	2.5	7.1
Ward 21	81.4%	70.3%	100.6%	100.9%	390	7.6	5.1	12.8
Ward 22	60.7%	61.7%	77.5%	76.8%	423	5.2	2.6	7.7
Ward 23	70.2%	79.5%	96.8%	121.5%	1084	2.2	2.5	4.7
Ward 24	61.9%	91.0%	99.4%	118.1%	426	5.8	7.5	13.3
Ward 3	80.4%	77.5%	89.2%	103.2%	720	2.8	2.0	4.8
Ward 5	72.2%	88.1%	128.3%	125.8%	539	7.1	1.6	8.7
Ward 7	75.1%	77.6%	100.0%	118.3%	665	3.7	4.0	7.6
Ward 8	73.1%	71.2%	97.8%	98.4%	626	3.8	2.6	6.5
Ward 9	50.7%	66.1%	78.3%	66.4%	1046	2.2	1.5	3.7
Ward 25	68.8%	88.5%	98.9%	122.6%	559	4.5	3.7	8.2

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: 09 September 2021**
Report Title	**Workforce Report**	**Agenda Item: 9**
Lead Director	**Name: Danielle Petch**	**Title: Director of Workforce**
Report Author	**Name: Paul Sukhu**	**Title: Deputy Director of Workforce**

Key Highlights/ Summary	This report provides a summary of workforce Key Performance Indicators for the full year ending 31 July 2021 (Month 4) and relevant Workforce and Organisational Development updates to Trust Board			
Recommendation *(Tick the relevant box(es))*	**For Information** ✓	**For Approval** ☐	**For Noting** ☐	**For Review** ☐

Strategic Objectives Links	Objective 8: Investing in our people
Board Assurance Framework (BAF)/ Risk Register Links	BAF risks 19-24

Report History	Trust Executive Group, 8 September 2021
Next Steps	JCNC, 9 September 2021
Appendices/Attachments	

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators as at 31 July 2021 (Month 4), covering the preceding 13 months.

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

Indicator	Measure	Target	07/2020	08/2020	09/2020	10/2020	11/2020	12/2020	01/2021	02/2021	03/2021	04/2021	05/2021	06/2021	07/2021
Staff in post (as at report date)	WTE		3276.7	3227.3	3243.8	3245.1	3256.5	3251.3	3250.0	3284.0	3311.6	3337.3	3304.1	3310.7	**3328.5**
	Headcount		3766	3707	3727	3728	3738	3729	3730	3765	3795	3826	3793	3797	**3810**
Establishment (as at report date - as per finance data)	WTE		3658.1	3685.4	3607.7	3633.1	3630.6	3634.2	3635.5	3635.4	3635.4	3662.8	3677.7	3681.7	**3675.1**
	%, Vacancy Rate *(for Cost Centres, excludes Reserves)*	10%	10.2%	12.6%	10.0%	10.6%	10.2%	10.5%	10.6%	9.5%	8.7%	8.9%	10.2%	10.1%	**9.4%**
Staff Costs (12 months)	%, Temp Staff Cost		12.5%	12.2%	12.1%	11.9%	11.7%	11.7%	11.6%	11.6%	11.6%	11.3%	11.3%	11.4%	**11.6%**
	%, Temp Staff Usage		12.8%	12.5%	12.2%	12.0%	11.9%	11.8%	11.8%	11.8%	11.8%	11.7%	11.8%	12.0%	**12.2%**
Absence (12 months)	%, 12 month Absence Rate	4%	4.4%	4.5%	4.5%	4.6%	4.7%	4.8%	5.0%	5.1%	4.8%	4.5%	4.4%	4.5%	**4.6%**
	- %, 12 month Absence Rate - Long Term		*2.3%*	*2.4%*	*2.4%*	*2.6%*	*2.6%*	*2.7%*	*2.7%*	*2.8%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	**2.8%**
	- %, 12 month Absence Rate - Short Term		*2.1%*	*2.1%*	*2.1%*	*2.1%*	*2.1%*	*2.2%*	*2.4%*	*2.3%*	*2.1%*	*1.8%*	*1.8%*	*1.8%*	**1.8%**
	%,In month Absence Rate - Total		3.3%	3.6%	4.0%	4.1%	5.0%	6.1%	6.7%	4.7%	3.6%	3.3%	4.2%	4.4%	**4.6%**
	- %, In month Absence Rate - Long Term		*2.2%*	*2.5%*	*2.5%*	*2.7%*	*2.6%*	*3.6%*	*2.9%*	*2.9%*	*2.4%*	*2.3%*	*2.9%*	*2.8%*	**3.3%**
	- %, In month Absence Rate - Short Term		*1.1%*	*1.1%*	*1.5%*	*1.4%*	*2.4%*	*2.5%*	*3.8%*	*1.8%*	*1.2%*	*1.0%*	*1.3%*	*1.6%*	**1.3%**
	- %, In month Absence Rate - COVID-19 Sickness Absence		0.2%	0.2%	0.2%	0.2%	1.1%	2.1%	3.3%	1.3%	0.5%	0.4%	0.4%	0.3%	**0.5%**
Starters, Leavers and T/O rate (12 months)	WTE, Starters		355.9	362.0	360.5	336.0	329.9	329.2	313.0	318.0	311.6	322.2	321.3	330.7	**331.7**
	Headcount, Starters		408	414	413	386	376	373	358	363	356	367	367	376	**377**
	WTE, Leavers		251.7	251.5	249.0	241.2	244.7	240.1	233.7	229.3	203.4	204.5	215.6	219.7	**223.0**
	Headcount, Leavers		298	298	295	286	291	286	278	273	241	244	255	259	**264**
	%, Leaver Turnover Rate	10%	8.8%	8.9%	8.8%	8.5%	8.5%	8.4%	8.2%	8.0%	7.1%	7.1%	7.4%	7.5%	**7.7%**
	%, Stability Index		86.4%	86.3%	86.8%	87.0%	86.9%	87.2%	87.1%	87.0%	87.8%	87.6%	87.5%	87.1%	**86.6%**
Statutory/Mandatory Training	%, Compliance	90%	94%	95%	95%	94%	95%	95%	95%	96%	97%	95%	95%	96%	**96%**
Appraisals	%, Compliance	90%	93%	92%	92%	93%	91%	90%	92%	93%	95%	95%	93%	92%	**89%**
Medical and Dental Appraisals	%, Compliance	90%	92%	93%	86%	88%	87%	90%	86%	79%	83%	97%	96%	91%	**93%**
Time to Hire (days)	General Recruitment	35	49	51	48	47	41	56	49	39	43	48	44	47	**48**
	Medical Recruitment (excl Deanery)	35	40	81	97	71	32	49	34	53	52	49	68	62	**68**
Employee relations	Number of open disciplinary cases		26	26	27	28	25	22	19	23	14	11	14	9	**6**

2.1. The Trust's **vacancy rate** has improved in-month to 9.4%, although still higher than the previous quarter. Nationally there is an ongoing increase in vacancy rates due to the impact of pressures of working during Covid, although the impact is felt less at the Trust due to improvements in retention and stability over the same period, in particular in the Nursing and Midwifery professions. The HRBPs continue to work with Clinical Divisions to ensure recruitment activity proceeds in line with workforce plans, as well as supporting bespoke recruitment advertising campaigns where needed.

2.2. Overall **staff absence** has remained at the levels for the same period in 2020. Covid related absence remains the same as previous months. Along with other acute sites across the region, the Trust has approved its active management of both short and long-term Covid-related absence in line with Trust Policy on non-Covid absence management.

2.3. The **stability index figure** (defined as *proportion of staff in post at end of period who were in post at beginning of period).* The stability index figure has decreased slightly in-month to 86.6%. Similarly, **staff turnover** remains well below target; down to increased support through Staff Health and Wellbeing, engagement through Teams sessions and debriefs to support staff and managers affected by Covid and the ever-improving staff rewards and benefits package.

2.4. **Time to hire** remains lower than the same period last year, however targeted interventions for improvements will start to come into effect by the end of Quarter 2. Factual references and the return to face-to-face ID checks will improve the time from interview outcome to unconditional offer stage. Improvements to the Resourcing Control Panel will also speed the pre-advertisement process up and reduce workload for recruiting managers.

2.5. The number of **Open Disciplinary Cases** continues to decrease as the team promote the Fair and Just Culture initiatives, emphasising the learning from events and incidents, promoting support and development and referring cases to the informal approach where appropriate. A detailed Employee Relations case report is produced on a quarterly basis for Workforce Board and JCNC.

2.6. **Statutory and mandatory training** compliance is at 96% and **appraisals** compliance has dropped to 89% as the Trust's reporting period enters the summer period. The Trust's Pay Progression policy, supported by the HR Services and Learning and Development teams, continues to positively impact on the workforce's motivation to remain compliant. HRBPs continue to raise underperformance against the targets with their Divisions.

3. Continuous Improvement, Transformation and Innovation

3.1. The Trust's Workforce Strategy 2021-24 was approved by Workforce and Development Assurance Committee in July and work has commenced on an underlying delivery plan, objectives and a review of internal (Workforce) KPIs. These will be considered through Workforce Board on 20 September.

3.2. Work on phase four of the Trust's **benefits and rewards** continues, including discounted gym membership options, and ethical financial benefits (savings and financial education, excluding loans) being considered. The Trust has launched another two providers for lease cars (NHS Fleet Services & GMP Drivercare) and a further benefits and reward survey will be undertaken in late Summer/early Autumn to inform future development of the packages available to colleagues.

4. Culture and Staff Engagement

4.1. The **National NHS Staff Survey** programme has made good progress since the last report. Along with bespoke working groups on violence and aggression and levels of unpaid working hours, the Divisions have continued with Listening Events, communicating outcomes with departments and engagement on how to support improvements to working lives. Action plans are being sent through to the HRBPs to monitor and support activity.

4.2. The Trust's **Living our Values** work has enabled meaningful and engaging *Leading with Values* and *Values into Actions* workshops to take place in June, July and August. The programme has entered its analysis phase with key words and statements arising from workshops due back with the OD team in early September. Work will then commence to establish a proposed standards and behaviours framework for review and approval.

4.3. Concurrently work has been underway to reshape Trust papers, policies, procedures and template frameworks. Underpinning these will be eLearning modules and a Train the Trainer period into Autumn 2021.

4.4. Arrangements are being made to establish the first **Inclusion Leadership Council** on 3 November 2021 – commencing with the appointment to roles on the council and a first pre-meeting of the Council in September.

5. Current Affairs & Hot Topics

5.1. The Trust's **Head of Staff Health and Wellbeing**, Liz Watson, steps down from post on 3 September. Rebecca Bason, Occupational Health Nurse Specialist has been appointed on an acting basis while options of future models of service delivery are reviewed in line with the Trust's Workforce Strategy.

5.2. The Trust's **Equality, Diversity and Inclusion (EDI) Leads**, Tim Brown and Idrees Mohamed will commence Trust employment on 1 September 2021. The strengthened EDI remit will support the focus and drive of the of the Workforce Strategy on culture, organisational development and the equalities agenda.

5.3. Workforce Assurance and Development Committee reviewed and approved the statutory EDI reports in Month 4. All have been uploaded and/or published ahead of their respective deadlines.

5.4. The 2021/22 Agenda for Change **pay award** of 3% has been applied to the national Electronic Staff Record system. The first month of uplifted pay is September 2021 with arrears pay applying for the period commencing 01 April 2021 to 31 August 2021.

5.5. The Trust was visited by Unite members from across Milton Keynes, led by the Regional Officer (South East), on their national day of action on 25 August 2021, ahead of a nationwide ballot. They were joined by colleagues from the Royal College of Nursing on the day and the action was facilitated in a safe location by the Head of Security, Assistant Director of Communications and Engagement, Staff Side Chair and Deputy Director of Workforce.

5.6. The pay awards for national medical and dental terms and conditions of service also apply from 1 April 2021. These are:

- Salary scales for medical and dental consultants have been increased by 3% to basic pay.
- Salary scales for doctors and dentists in training have already been increased by 2.0% to basic pay from 1 April 2021, as set out in the 2019 Framework Agreement.
- Salary scales for the staff grade, specialty and associate specialist group of practitioners on pre-2021 contracts have been increased by 3% to basic pay.

6. Recommendations

6.1. Trust Board is asked to note and receive the Workforce Report for Month 4.

Trust Performance Summary: M04 (July 2021)

1.0 Summary

This report summarises performance in July 2021 for key performance indicators and provides an update on actions to sustain or improve upon Trust and system-wide performance. This commentary is intended only to highlight areas of performance that have changed or are in some way noteworthy. It is important to highlight that the NHS Constitution Targets remain in situ and are highlighted in the table below.

Target ID	Target Description	Target
4.1	ED 4 hour target (includes WIC)	**95%**
4.2	RTT- Incomplete pathways < 18 weeks	**92%**
4.7	RTT- Patients waiting over 52 weeks	**0**
4.8	Diagnostic Waits < 6weeks	**99%**
4.9	All 2 week wait all cancers %	**93%**
4.10	Diagnosis to 1st Treatment (all cancers) - 31 days %	**96%**
4.11	Referral to Treatment (Standard) 62 day %	**85%**

Given the impact of COVID-19, the performance of certain key constitutional NHS targets for July 2021 have been directly impacted. To ensure that this impact is reflected, the monthly trajectories for 2021/22 are currently under review ensure that they are reasonable and reflect a level of recovery for the Trust to achieve and have not yet been finalised.

2.0 Sustainability and Transformation Fund (STF)

Performance Improvement Trajectories

July 2021 performance against the Service Development and Improvement Plans (SDIP):

ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1	ED 4 hour target (includes UCS)		Not Available		88.4%	85.4%	Not Available	▼	Not Available	
4.2	RTT Incomplete Pathways <18 weeks					69.3%		▲		
4.9	62 day standard (Quarterly)		85%	85%		74.6%	x	▼		

In July 2021 the ED performance was 85.4%. Although this was a deterioration in performance when compared to 87.9% in June 2021, MKUH performance was significantly higher than both the national overall performance of 77.7% and the majority of its Peer Group (see Appendix for details).

The Trust's RTT Incomplete Pathways <18 weeks performance stood at 69.3% at the end of July 2021. This was an improvement on the performance at the end of June 2021 of 67.3% and is the highest performance for this measure for 16 months.

The Trust has put in place robust activity recovery plans, which will support further improvement in RTT performance and closely manage the cancellation of any non-urgent elective activity and treatment for patients on an incomplete RTT pathway.

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

For Q1 2021/22, the Trust's provisional 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) was 74.6% against a national target of 85%.

The provisional performance of the percentage of patients who started treatment within 31 days of a decision to treat was 94.0% against a national target of 96%. The percentage of patients who attended an outpatient appointment within two weeks of an urgent referral by their GP for suspected cancer was 86.0% against a national target of 93%.

3.0 Urgent and Emergency Care

In July 2021, three of the six key performance indicators measured in urgent and emergency care showed an improvement:

ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.4	Cancelled Ops - On Day		1%	1%	0.69%	0.92%	✓	▼	✓	
3.2	Ward Discharges by Midday		25%	25%	15.8%	13.7%	×	▼	×	
3.4	30 day readmissions		7%	7%	6.9%	6.8%	✓	▲	✓	
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		53			73	×	▼		
3.9	Ambulance Handovers >30 mins (%)		5%	5%	10.0%	10.4%	×	▲	×	
4.2	RTT Incomplete Pathways <18 weeks		Not Available			69.3%	Not Available	▲		

Cancelled Operations on the Day

In July 2021, there were 21 operations cancelled on the day for non-clinical reasons as detailed below:

Cancellation Reason	Number of Cancellations
Emergency Priority	6
Insufficient Time	5
Further Investigation Required	2
Administration Error	2
Equipment Issues in Theatres	2
Staffing Issue	2
Bed Availability	1
Patient Did Not Isolate	1

Readmissions

The Trust's 30-day emergency readmission rate in July 2021 was 6.8% (please note that the readmission rate in July 2021 may include patients that were readmitted with Covid-19).

This was an improvement in performance when compared to the June 2021 rate of 7.1%; July 2021 saw a return to meeting the 7% target.

Delayed Transfers of Care (DTOC)

The number of DTOC patients reported at midnight on the last Thursday of July 2021 was 14 patients: 13 in Medicine and one in Surgery.

This was an improvement in performance when compared to the number of DTOC patients reported at midnight on the last Thursday of June 2021 (22) and the lowest value since February 2021 (9).

Length of Stay (Stranded and Super Stranded Patients)

The number of super stranded patients (length of stay of 21 days or more) at the end of the month was 73. This was a small increase on the 70 super stranded patients reported at the end of June 2021.

Ambulance Handovers

In July 2021, the percentage of ambulance handovers to the Emergency Department taking more than 30 minutes was 10.4%.

This was an improvement in performance when compared to the June 2021 value of 11.7%.

4.0 Elective Pathways

ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	87.0%	85.6%	✓	▲	✓	
3.5	Follow Up Ratio		1.5		1.38	1.34	✓	▲	✓	
4.2	RTT Incomplete Pathways <18 weeks		Not Available			69.3%	Not Available	▲		

Overnight Bed Occupancy

Overnight bed occupancy was 85.6% in July 2021, an improvement on the June 2021 occupancy of 87.4%. It remained well within the 93% threshold and was the lowest value reported so far this financial year.

Follow up Ratio

The Trust outpatient follow up ratio in July 2021 was 1.34 which was an improvement in performance when compared to the June 2021 ratio of 1.41.

RTT Incomplete Pathways

The Trust's RTT Incomplete Pathways <18 weeks at the end of July 2021 was 69.3% and the number of patients waiting more than 52 weeks without being treated was 445. These patients were in Surgery (406 patients), Medicine (31 patients) and Women and Children (8 patients).

Diagnostic Waits <6 weeks

The Trust did not meet the national standard of fewer than 1% of patients waiting six weeks or more for their diagnostic test at the end of July 2021, with a performance of 71.70%.

This was a deterioration in performance when compared to the June 2021 performance of 73.63% and the lowest performance for this measure since May 2020.

5.0 Patient Safety

Infection Control

In July 2021 there were three reported cases of MSSA, two cases in Medicine (one in Ward 2 and Ward 22 respectively) and one in Surgery (Ward 20). There was also one reported case of E. coli in Medicine (Ward 25)

There were no reported cases of C.diff or MRSA.

ENDS

Appendix 1: ED Performance - Peer Group Comparison

The following Trusts have been historically viewed as peers of MKUH:

- Barnsley Hospital NHS Foundation Trust
- Buckinghamshire Healthcare NHS Trust
- Homerton University Hospital NHS Foundation Trust
- Kettering General Hospital NHS Foundation Trust
- Mid Cheshire Hospitals NHS Foundation Trust
- North Middlesex University Hospital NHS Trust
- Northampton General Hospital NHS Trust
- Oxford University Hospitals NHS Foundation Trust
- Southport and Ormskirk Hospital NHS Trust
- The Hillingdon Hospitals NHS Foundation Trust
- The Princess Alexandra Hospital NHS Trust
- The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust

Burton Hospitals NHS Foundation Trust and Luton and Dunstable University Hospital NHS Foundation Trust were part of the peer group, but since Burton Hospitals NHS Foundation Trust merger with Derby Hospitals NHS Foundation Trust and Luton And Dunstable University Hospital NHS Foundation Trust merger with Bedfordshire Hospitals NHS Foundation Trust, these trusts have ceased to exist. Note: In May 2019, fourteen trusts began field testing new A&E performance standards and have not been required to report the number of attendances over 4hrs since then. Kettering General Hospital NHS Foundation Trust, part of the MKUH peer group, is one of the fourteen trusts and therefore data for this trust is not available on the NHS England statistics web site (https://www.england.nhs.uk/statistics/).

April 2021 to May 2021 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	May-21	Jun-21	Jul-21
Homerton University Hospital NHS Foundation Trust	92.5%	87.2%	87.5%
Milton Keynes University Hospital NHS Foundation Trust	89.4%	87.9%	85.4%
North Middlesex University Hospital NHS Trust	83.7%	82.9%	79.0%
Northampton General Hospital NHS Trust	89.0%	84.7%	78.7%
Southport And Ormskirk Hospital NHS Trust	80.9%	81.5%	77.2%
Buckinghamshire Healthcare NHS Trust	82.4%	80.3%	75.2%
Oxford University Hospitals NHS Foundation Trust	83.5%	80.5%	74.5%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	77.8%	76.4%	73.2%
The Hillingdon Hospitals NHS Foundation Trust	81.5%	77.3%	72.5%
The Princess Alexandra Hospital NHS Trust	73.9%	71.0%	70.0%
Mid Cheshire Hospitals NHS Foundation Trust	73.6%	67.6%	66.2%
Barnsley Hospital NHS Foundation Trust	78.0%	69.0%	66.1%
Bedfordshire Hospitals NHS Foundation Trust	-	-	-
Kettering General Hospital NHS Foundation Trust	-	-	-

*MKUH performance excludes the pending requirement to incorporate NHS 111 appointments at UCS.

OBJECTIVE 1 - PATIENT SAFETY										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
1.1	Mortality - (HSMR)		100	100	97.7		Not Available			
1.2	Mortality - (SHMI)		100	100		110.19	✗	▲		
1.3	Never Events		0	0	0	0	✓	▭	✓	
1.4	Clostridium Difficile		10	<4	2	0	✓	▲	✓	
1.5	MRSA bacteraemia (avoidable)		0	0	0	0	✓	▭	✓	
1.6	Falls with harm (per 1,000 bed days)		0.12	0.12	0.11	0.17	✗	▭	✓	
1.7	Midwife : Birth Ratio		28	28	28	28	✓	▭	✓	
1.8	Incident Rate (per 1,000 bed days)		60	60	57.27	54.97	✗	▲	✗	
1.9	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▲	✓	
1.10	E-Coli		18	6	7	1	✓	▭	✗	
1.11	MSSA		5	<2	4	3	✗	▼	✗	
1.12	VTE Assessment		95%	95%	97.9%	97.4%	✓	▼	✓	

OBJECTIVE 2 - PATIENT EXPERIENCE										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.2	RED Complaints Received				0	0		▭		
2.3	Complaints response in agreed time		90%	90%	94.0%	95.7%	✓	▼	✓	
2.4	Cancelled Ops - On Day		1%	1%	0.69%	0.92%	✓	▼	✓	
2.5	Over 75s Ward Moves at Night		1,800	600	388	105	✓	▲	✓	
2.6	Mixed Sex Breaches		0	0	0	0	✓	▭	✓	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	87.0%	85.6%	✓	▲	✓	
3.2	Ward Discharges by Midday		25%	25%	15.8%	13.7%	✗	▼	✗	
3.3	Weekend Discharges		70%	70%	58.6%	55.9%	✗	▼	✗	
3.4	30 day readmissions		7%	7%	6.9%	6.8%	✓	▲	✓	
3.5	Follow Up Ratio		1.5		1.38	1.34	✓	▲	✓	
3.6.1	Number of Stranded Patients (LOS>=7 Days)		184			190	✗	▼		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		53			73	✗	▼		
3.7	Delayed Transfers of Care		20			14	✓	▲		
3.8	Discharges from PDU (%)		15%	15%	7.2%	7.1%	✗	▼	✗	
3.9	Ambulance Handovers >30 mins (%)		5%	5%	10.0%	10.4%	✗	▲	✗	

OBJECTIVE 4 - KEY TARGETS										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1	ED 4 hour target (includes UCS)		Not Available		88.4%	85.4%	Not Available	▼	Not Available	
4.2	RTT Incomplete Pathways <18 weeks					69.3%		▲		
4.4	RTT Total Open Pathways					24,564		▼		
4.5	RTT Patients waiting over 52 weeks					445		▼		
4.6	Diagnostic Waits <6 weeks					71.7%		▼		
4.7	All 2 week wait all cancers (Quarterly) ✎		93%	93%		86.0%	✗	▼		
4.8	31 days Diagnosis to Treatment (Quarterly) ✎		96%	96%		94.0%	✗	▲		
4.9	62 day standard (Quarterly) ✎		85%	85%		74.6%	✗	▼		

OBJECTIVE 5 - SUSTAINABILITY										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
5.1	GP Referrals Received		Not Available		28,905	7,624	Not Available	▲	Not Available	
5.2	A&E Attendances				34,500	8,954		▲		
5.3	Elective Spells (PBR)				8,802	2,259		▲		
5.4	Non-Elective Spells (PBR)				10,520	2,815		▲		
5.5	OP Attendances / Procs (Total)				132,176	32,584		▼		
5.6	Outpatient DNA Rate		6%	6%	6.0%	6.4%	✗	▼	✓	

OBJECTIVE 7 - FINANCIAL PERFORMANCE										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
7.1	Income £'000		Not Available		104,485	25,552	Not Available	▼	Not Available	
7.2	Pay £'000				(66,910)	(16,379)		▲		
7.3	Non-pay £'000				(32,308)	(8,065)		▲		
7.4	Non-operating costs £'000				(6,295)	(1,574)		▼		
7.5	I&E Total £'000				(1,028)	(466)		▼		
7.6	Cash Balance £'000					48,376		▲		
7.7	Savings Delivered £'000				Not Available			Not Available		Not Available
7.8	Capital Expenditure £'000				3,535	2,755		▼		

OBJECTIVE 8 - WORKFORCE PERFORMANCE										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
8.1	Staff Vacancies % of establishment		10%	10%		11.8%	✗	▼		
8.2	Agency Expenditure %		5%	5%	3.2%	3.5%	✓	▲	✓	
8.3	Staff Sickness % - Days Lost (Rolling 12 months) ✎		4%	4%		4.5%	✗	▼		
8.4	Appraisals		90%	90%		89.0%	✗	▼		
8.5	Statutory Mandatory training		90%	90%		96.0%	✓	▭		
8.6	Substantive Staff Turnover		9%	9%		7.7%	✓	▼		

OBJECTIVES - OTHER										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
O.1	Total Number of NICE Breaches		10	10		41	✗	▲		
O.2	Rebooked cancelled OPs - 28 day rule		95%	95%	85.1%	71.4%	✗	▼	✗	
O.4	Overdue Datix Incidents >1 month		0	0		162	✗	▲		
O.5	Serious Incidents		20	<7	32	6	✗	▲	✗	
O.8	Completed Job Plans (Consultants)		90%	90%		88%	✗	▲		

Key: Monthly/Quarterly Change

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

YTD Position

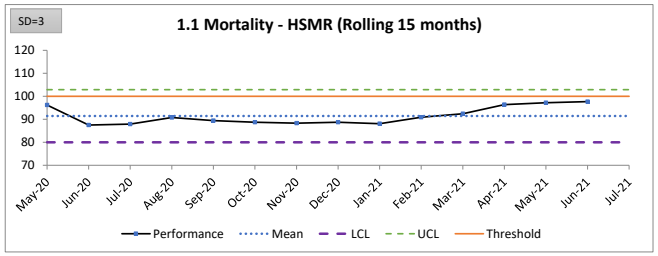
✓	Achieving YTD Target
	Within Agreed Tolerance*
✗	Not achieving YTD Target
✗	Annual Target breached

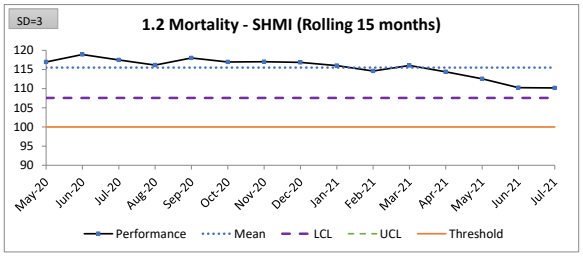
Data Quality Assurance Definitions

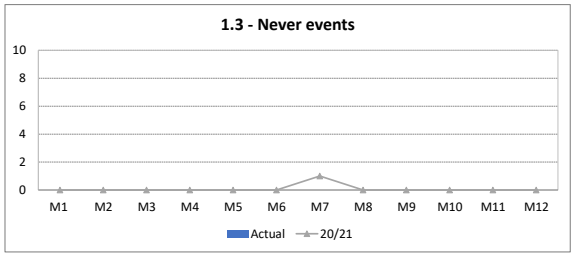
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory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

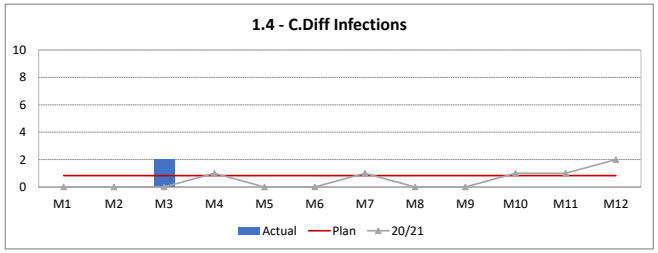
* Independently Audited – refers to an independent audit undertaken by either the Internal Auditor, External Auditors or the Data Quality Audit team.

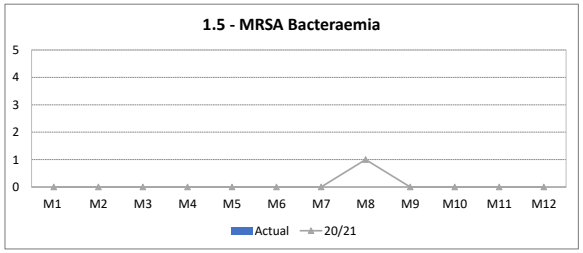
Date Produced: 13/08/2021

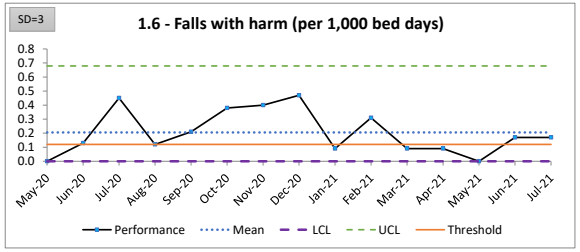


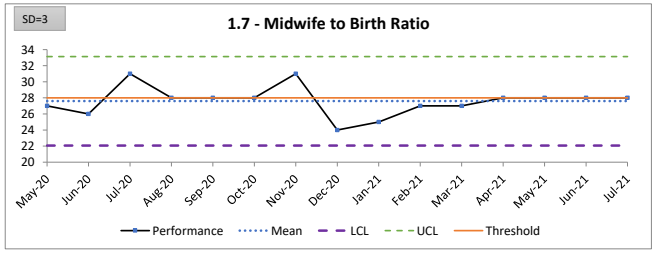


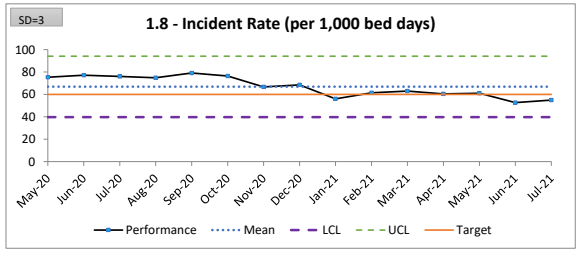


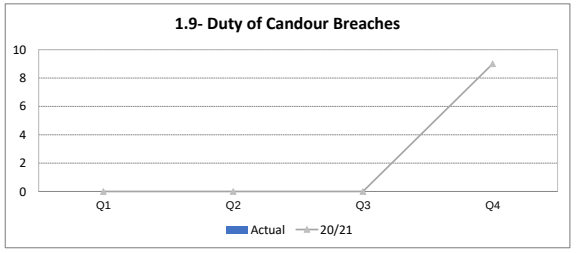


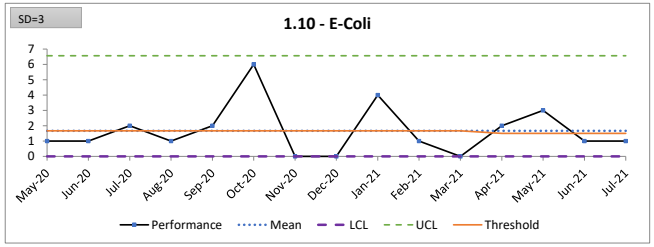


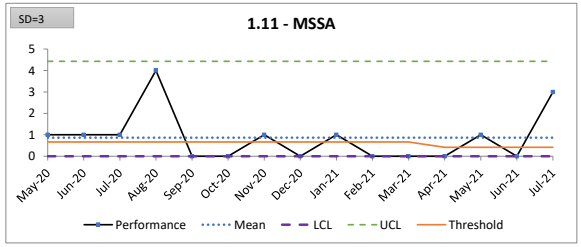


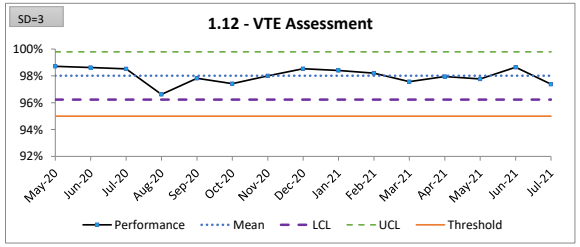








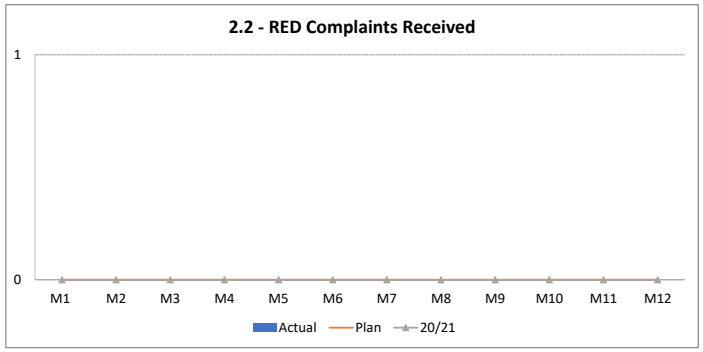


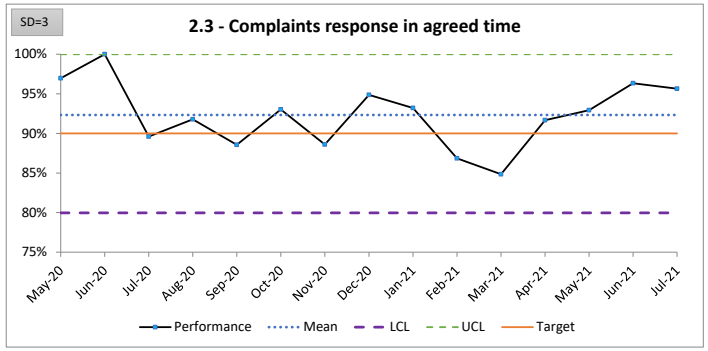


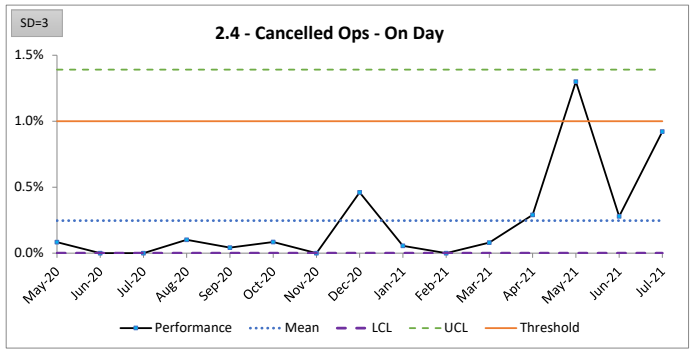
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

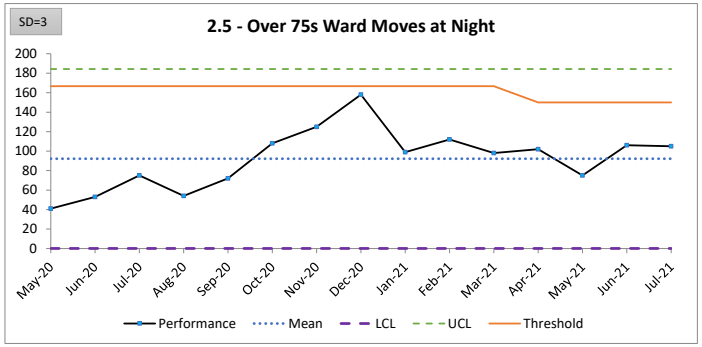
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

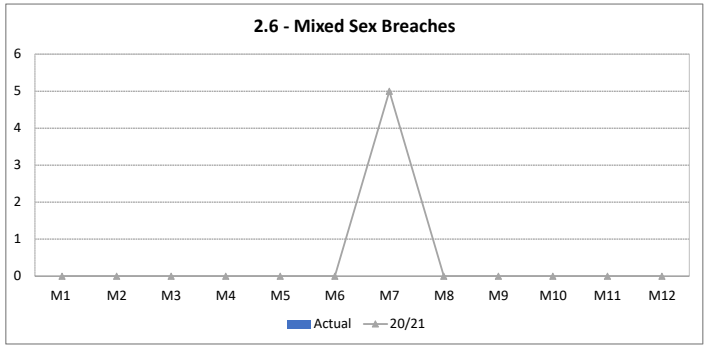
OBJECTIVE 2 - PATIENT EXPERIENCE











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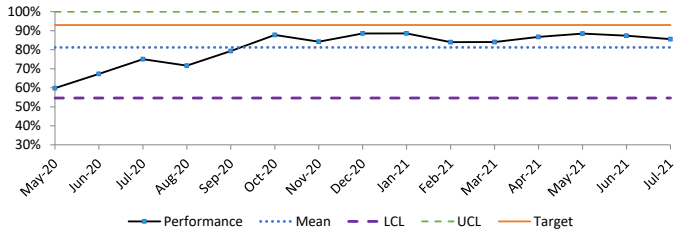
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

SD=3

3.1 - Overnight bed occupancy rate



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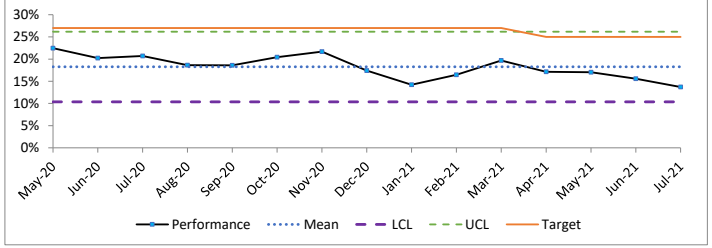
3.2 - Ward Discharges by Midday



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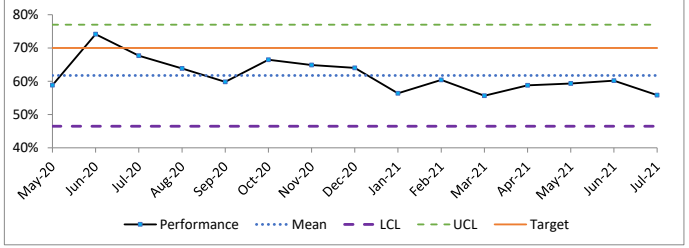
3.3 - Weekend Discharges



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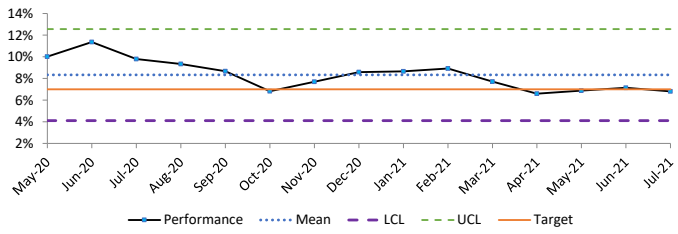
3.4 - 30 Day Readmissions



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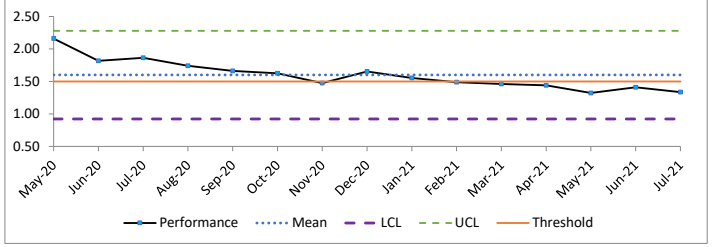
3.5 - Follow-up Ratio



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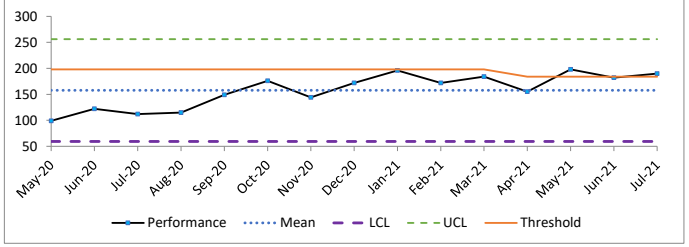
3.6.1 - Number of Stranded Patients (LOS>=7 Days)



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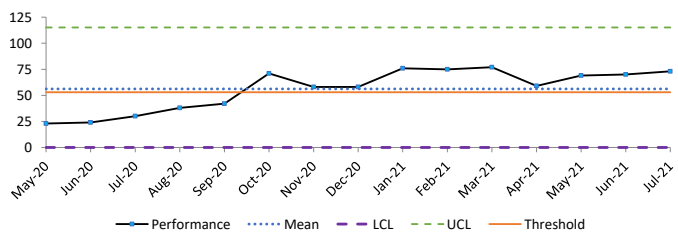
3.6.2 - Number of Super Stranded Patients (LOS>=21 Days)



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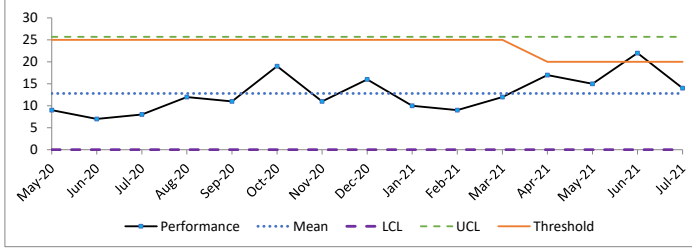
3.7 - Delayed Transfers of Care



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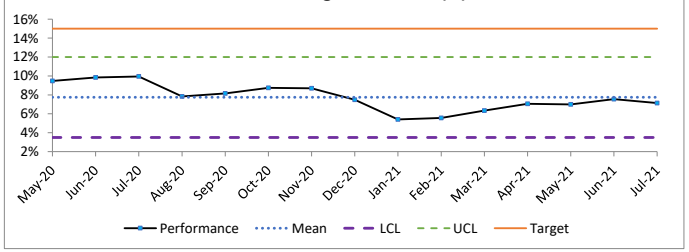
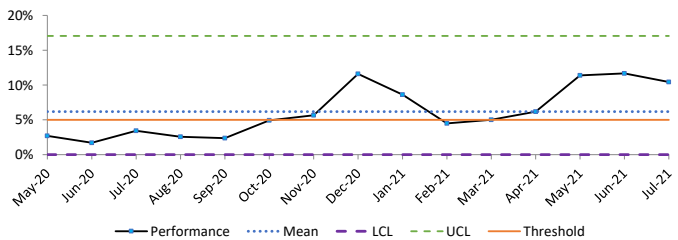
3.8 - Discharges from PDU (%)



SD=3

3.9 - Ambulance Handover > 30 mins(%)



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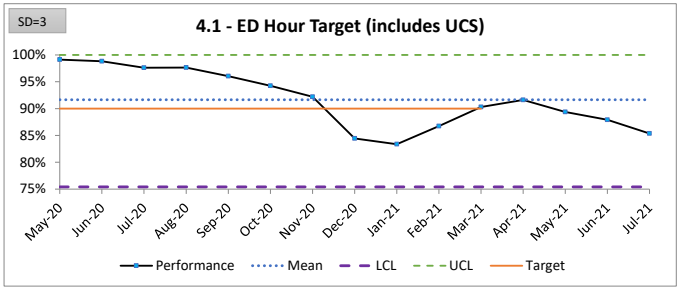
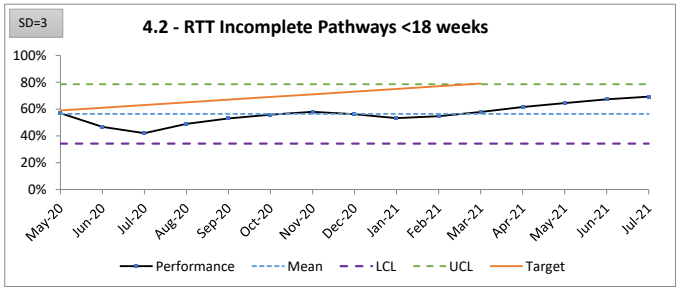
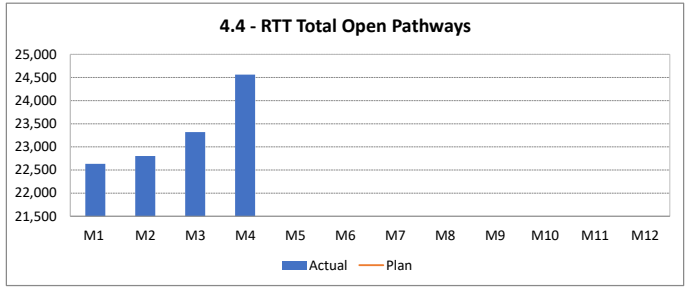
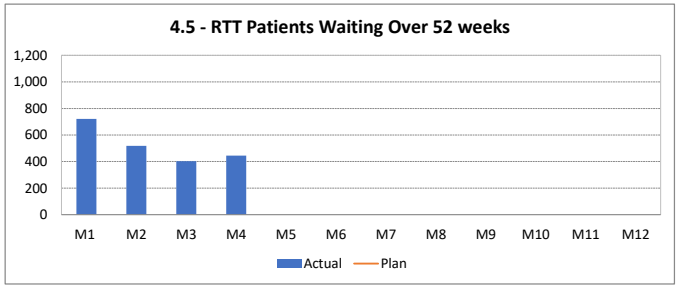
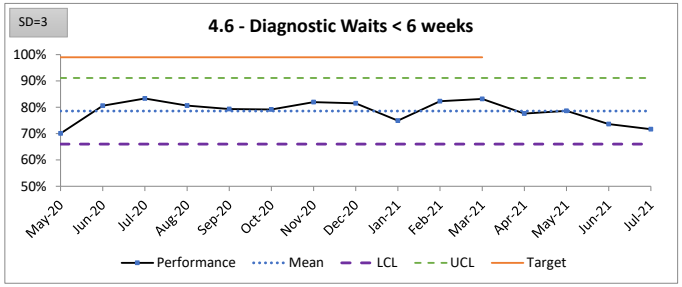
OBJECTIVE 4 - KEY TARGETS

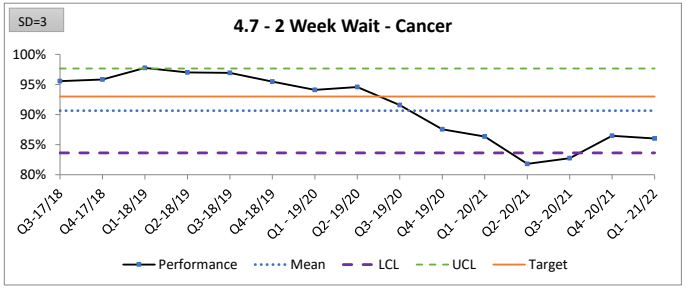


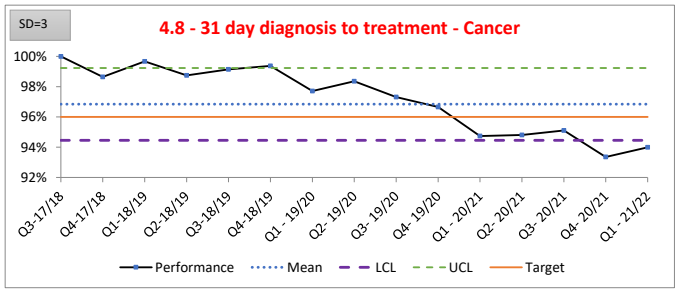


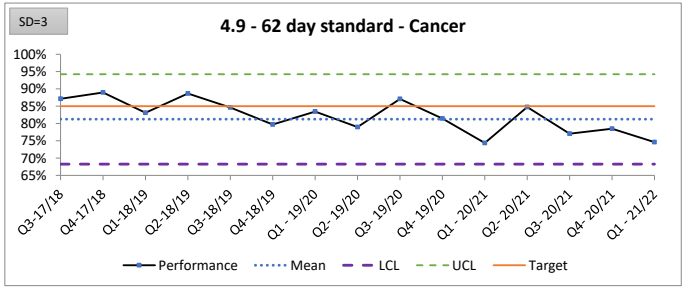












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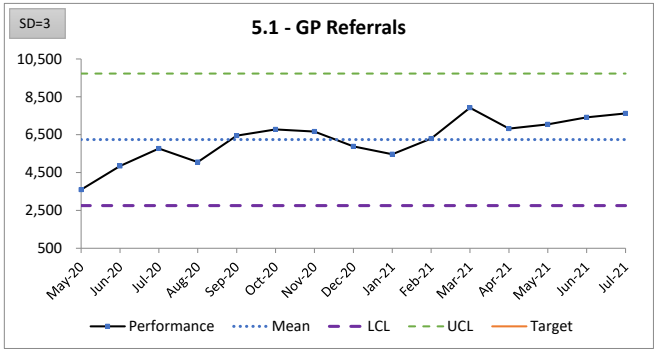
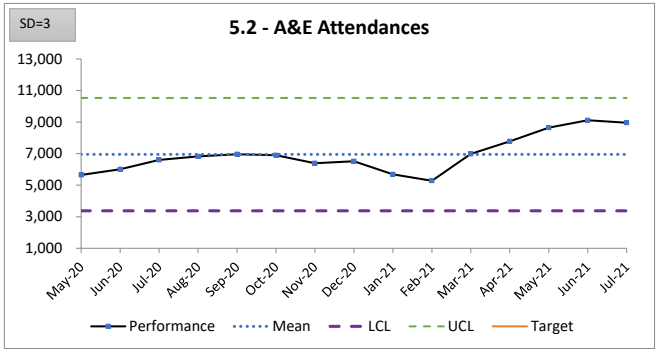
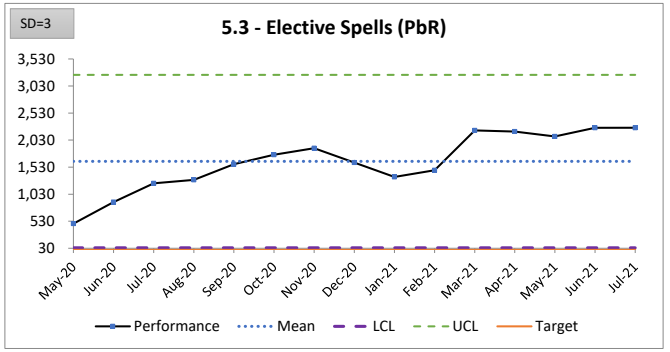
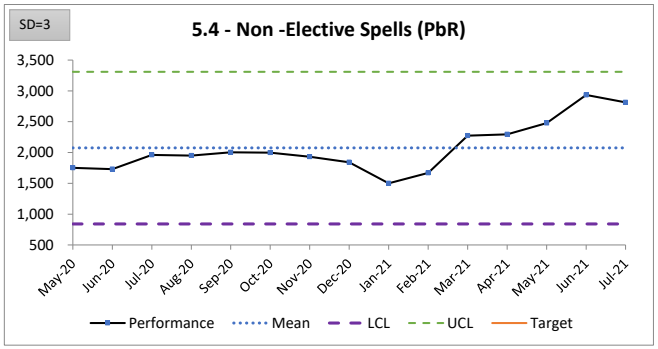
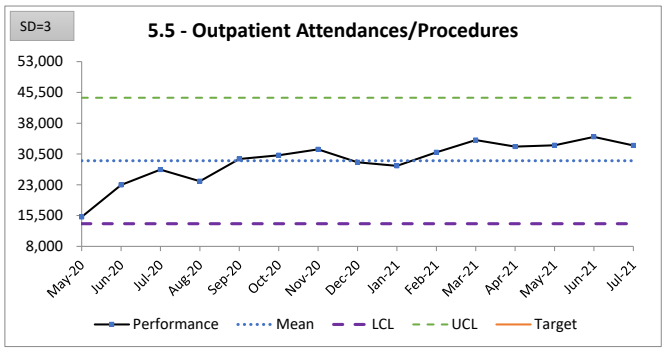
Milton Keynes University Hospital NHS Foundation Trust

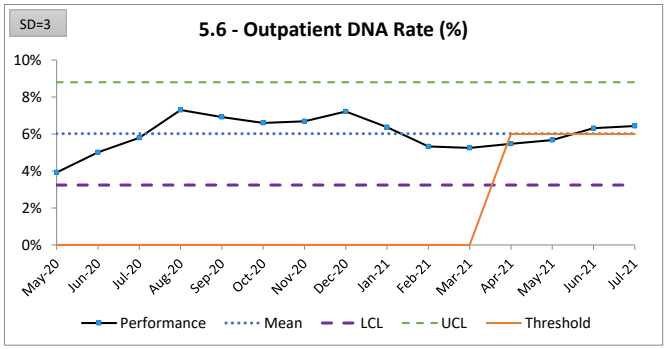












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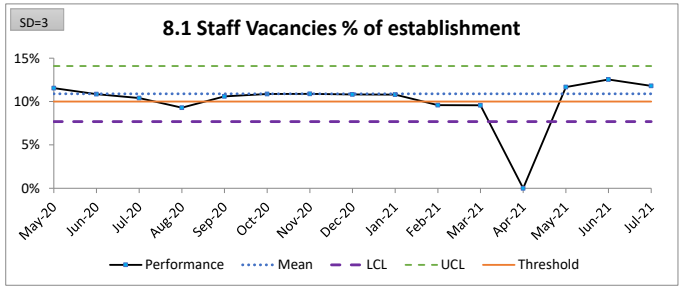
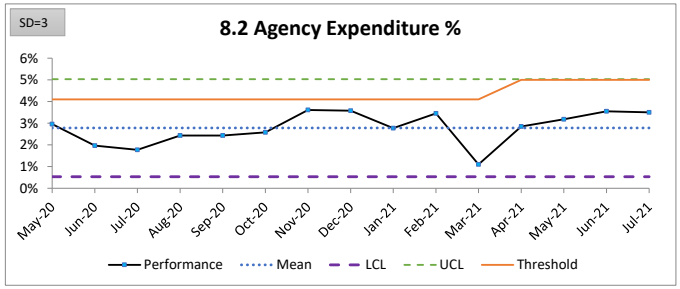
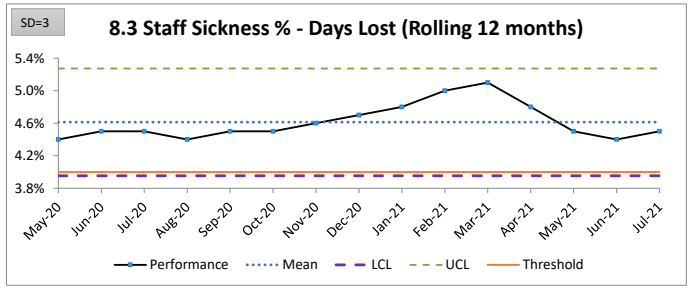
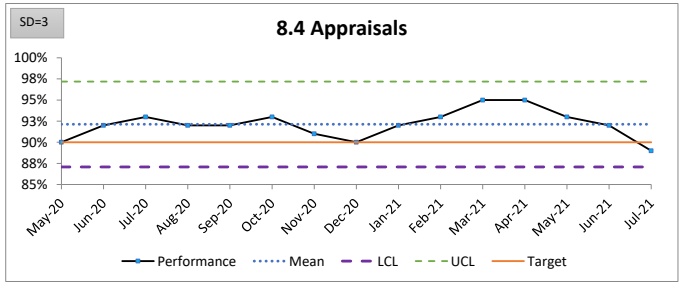
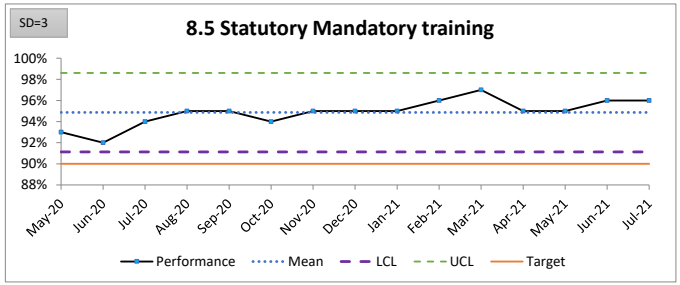
OBJECTIVE 8 - WORKFORCE PERFORMANCE

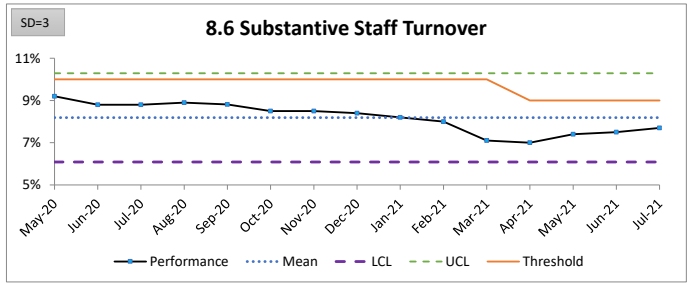












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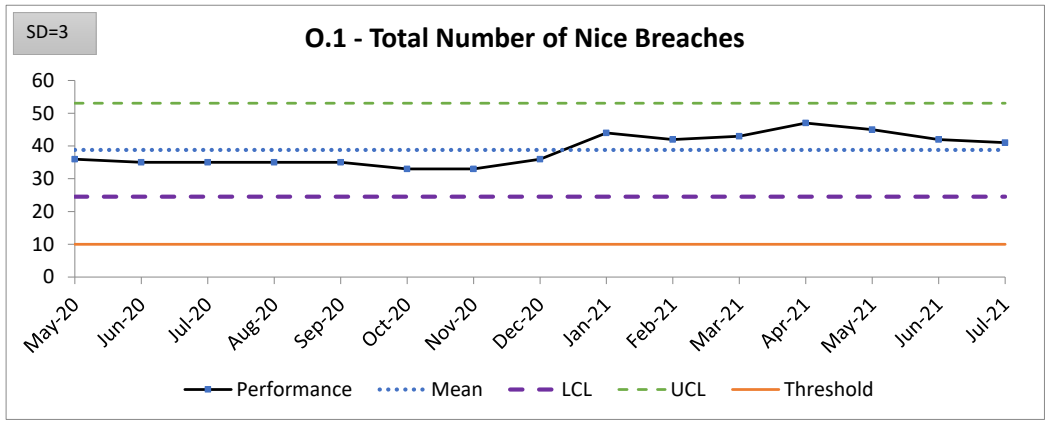

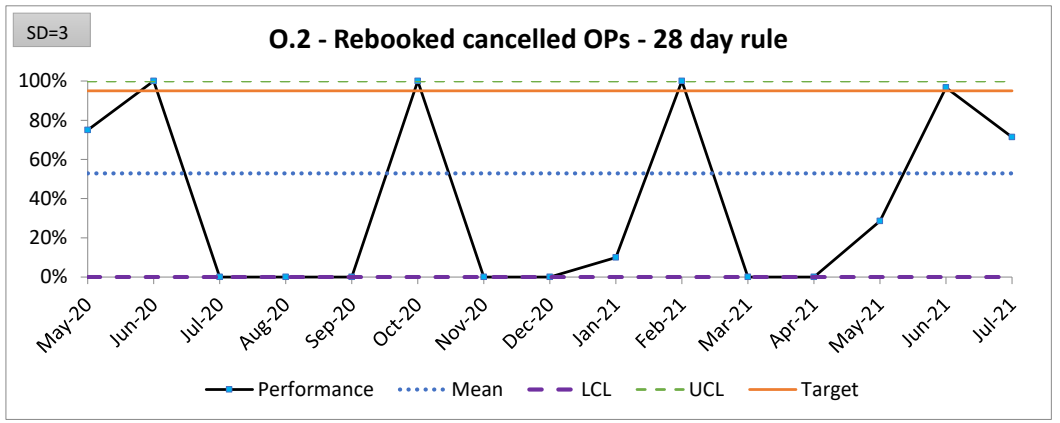

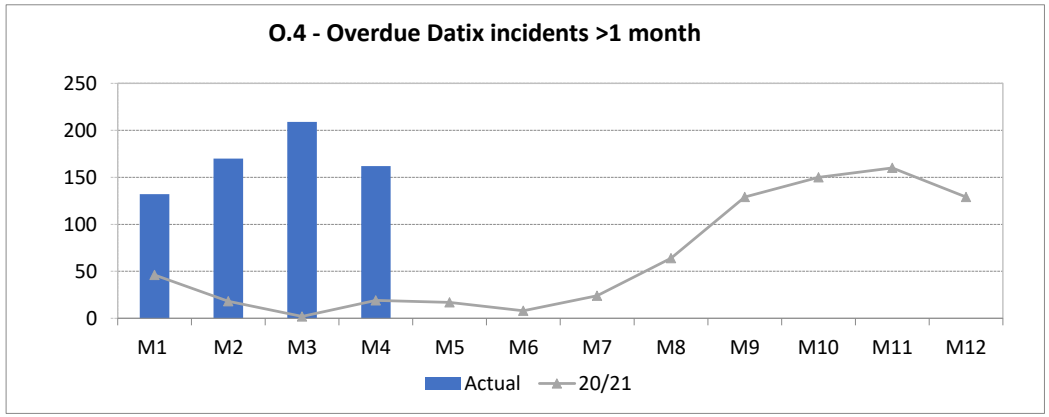

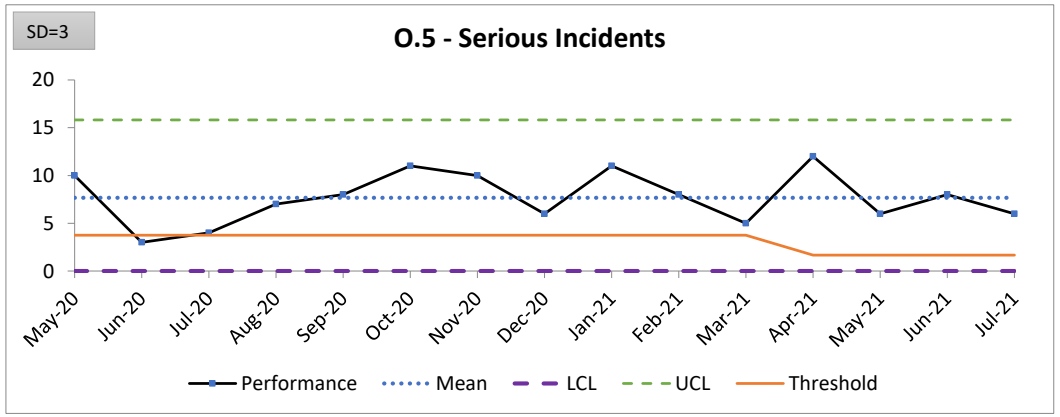

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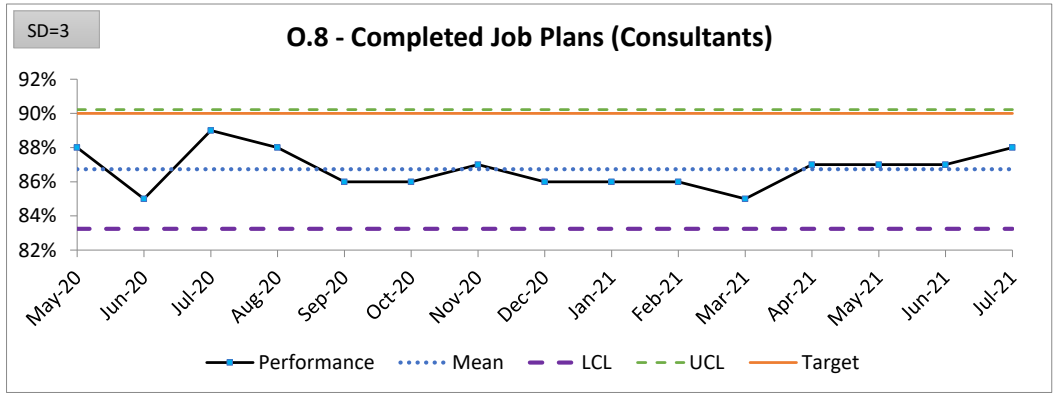


NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Meeting title	**Public Board**	**Date:**
Report title:	**Finance Paper Month 4 2021-22**	**Agenda item: 11**
Lead director	Terry Whittle	Director of Finance
Report authors	Chris Panes	Head of Management Accounts

Key Highlights/Summary	An update on the financial position of the Trust at Month 4 (July 2021)			
Recommendation *(tick one box only)*	**For Information** ☐	**For Approval** ☐	**For noting** x	**For Review** ☐

Strategic objectives links	5. Developing a Sustainable Future 7. Become Well-Governed and Financially Viable 8. Improve Workforce Effectiveness
Board Assurance Framework BAF/Risk Register links	

Report history	None
Next steps	
Appendices	Pages 14-16

FINANCE REPORT FOR THE MONTH TO 31st July 2021

PUBLIC BOARD MEETING

CONTENTS

EXECUTIVE SUMMARY

(1. & 2.) Revenue – Clinical revenue is under a block contract. The positive variance to plan YTD is due to additional funding through ERF (£4,500k) and specialised drugs. Non-clinical revenue is favourable to plan due to donated income.

(3. & 4.) Operating expenses – Both pay, and non-pay are overspent to plan due to the cost of additional activity completed as part of elective care recovery, costs are covered by ERF income. High A/L has led to an increase in temporary staffing costs.

(5.) Non-operating expenditure – slight variance on non-operating expenditure is due to higher than planned PDC.

(8.) Covid expenditure– Incremental COVID expenditure. This value excludes underlying, diverted expenditure and loss of efficiency due to COVID.

(10.) CIP delivery– £2,320k has been removed from budgets as efficiency. Delays in the governance process has led to 0 schemes being recorded, however the Trust has delivered within the efficiency target YTD.

(11.) Working capital – The Trust has maintained a healthy cash balance of £48m at the close of M4.

(12.) Capital – The Trust is £1,161k behind plan on its capital expenditure YTD. The variance is driven by timing differences on strategic cases. BAU capital expenditure is on plan YTD

(13.) Elective Recovery Fund– Lower than planned levels of ERF were recorded for M4. Operational issues and high A/L has affected delivery against original targets

(14.) ICS Financial Position – The ICS is on plan at a breakeven position YTD

Ref	All Figures in £'000	Month 4 YTD Plan	Month 4 YTD Actual	Month 4 YTD Var	M1-6 Plan Plan	M1-6 Plan Forecast	M1-6 Plan Var	RAG
1	Clinical Revenue	93,610	98,196	4,586	179,093	179,093	-	
2	Other Revenue	6,039	6,290	250	(17,099)	(17,020)	79	
3	Pay	(64,745)	(66,910)	(2,165)	(104,531)	(104,531)	-	
4	Non Pay	(29,705)	(32,308)	(2,603)	(49,662)	(49,812)	(150)	
5	Financing & Non-Ops	(6,249)	(6,294)	(45)	(9,374)	(9,374)	-	
6	Surplus/(Deficit)	(1,050)	(1,027)	22	(1,573)	(1,644)	(71)	
7	Control Total Surplus/(Deficit)	(754)	(830)	(77)	(1,133)	(1,283)	(150)	
8	Inc. COVID expenditure	(3,732)	(1,421)	2,311	(5,598)	(5,598)	-	
9	High Cost Drugs	(6,288)	(7,340)	(1,052)	(9,486)	(9,486)	-	
10	CIP Delivery	2,320	-	(2,320)	3,480	3,480	-	
11	Cash	44,481	48,376	3,895	38,700	38,700	-	
12	Capital Programme	4,696	3,535	(1,161)	8,754	6,514	(2,240)	
13	ERF Delivery	5,747	4,533	(1,214)	9,532	6,086	(3,446)	
14	ICS Finacial Position	-	-	-	100	100	-	

Key message
The Trust is reporting cumulative financial performance broadly in-line with plan. The Trust is tracking behind trajectory for ERF activity and income. The Trust has a robust cash position and is paying creditors promptly. The capital programme is ahead of plan for business-as-usual schemes, with slippage to plan reported for strategic (e.g., NHP) developments. There have been no changes to the BAF during the month.

FINANCIAL PERFORMANCE- OVERVIEW MONTH 4

2. Summary Month 4

For the month of July 2021, the position on a Control Total basis is a deficit of £397k. This is £177k adverse to the planned deficit of £220k. Overspends on Pay and Non-Pay related to delivery of ERF are offset by additional clinical income.

All Figures in £'000	Month 4 Plan	Month 4 Actual	Month 4 Var	Month 4 YTD Plan	Month 4 YTD Actual	Month 4 YTD Var	M1-6 Plan Plan	M1-6 Plan Forecast	M1-6 Plan Var
Clinical Revenue	19,040	19,490	449	76,158	80,744	4,586	152,915	152,915	0
Other Revenue	1,528	1,700	171	6,039	6,211	171	(17,099)	(17,099)	0
Total Income	20,568	21,189	621	82,198	86,954	4,757	135,816	135,816	0
Pay	(16,194)	(16,379)	(185)	(64,745)	(66,910)	(2,165)	(104,531)	(104,531)	0
Non Pay	(7,468)	(8,065)	(598)	(29,705)	(32,308)	(2,603)	(49,662)	(49,812)	(150)
Total Operational Expenditure	(23,661)	(24,445)	(783)	(94,450)	(99,219)	(4,768)	(154,193)	(154,343)	(150)
EBITDA	(3,093)	(3,255)	(162)	(12,252)	(12,264)	(12)	(18,377)	(18,527)	(150)
Financing & Non-Op. Costs	(1,490)	(1,505)	(15)	(5,953)	(6,018)	(65)	(8,934)	(8,934)	0
Control Total Deficit (excl. PSF)	**(4,583)**	**(4,760)**	**(177)**	**(18,206)**	**(18,282)**	**(77)**	**(27,311)**	**(27,461)**	**(150)**
Adjustments excl. from control total:									
National Top up	3,430	3,430	0	13,720	13,720	0	20,580	20,580	0
COVID Top up	933	933	0	3,732	3,732	0	5,598	5,598	0
Control Total Deficit (incl. PSF)	**(220)**	**(397)**	**(177)**	**(754)**	**(830)**	**(77)**	**(1,133)**	**(1,283)**	**(150)**
Donated income	0	0	0	0	79	79	0	79	79
depreciation	(68)	(69)	(1)	(272)	(276)	(4)	(414)	(414)	0
Impairments & Rounding	(4)	0	4	(24)	0	24	(26)	(26)	0
Reported deficit/surplus	**(292)**	**(466)**	**(174)**	**(1,050)**	**(1,027)**	**22**	**(1,573)**	**(1,644)**	**(71)**

Key message
For the month of July 2021, the position on a Control Total basis is a deficit of £397k. This is £177k adverse to the planned deficit of £220k. Overspends on Pay and Non-Pay related to delivery of ERF and additional temporary staffing costs. These costs are offset by additional clinical income.

3. Clinical Income

Clinical income shows a favourable variance of £449k. In month the Trust has recognised £700k related to ERF. Further detail is included in Appendix 1.

4. Other Income

Other income shows a favourable variance of 171k. In month the Trust recognised higher education and training and R&D income than planned.

5. Pay

There is a negative variance to plan in June of £185k, £245k cost relates to additional ERF activity. Further detail is included in

6. Non-Pay

There is a negative variance in June of £598k. £296k is owing to additional ERF activity and £306k is due to higher than planned prescribing of high-cost drugs.

7. Non-Operating Expenditure

Non-operating expenditure is £15k over plan in-month due to PDC charges.

FINANCIAL PERFORMANCE- OVERVIEW YTD

8. Summary Year to Date

YTD as of July 2021, the position on a Control Total basis is a deficit of £830k. This is £77k adverse to the planned deficit of £754k. Overspends on Pay and Non-Pay related to delivery of ERF are offset by additional Clinical Income.

9. Clinical Income YTD

Clinical Income shows a favourable variance of £4,586k YTD the Trust has recognised £4.5m related to ERF. Further detail is included in Appendix 1.

10. Other Income YTD

Other income is £175k above plan YTD due to receipt of additional E&T and R&D income above planned levels.

11. Pay YTD

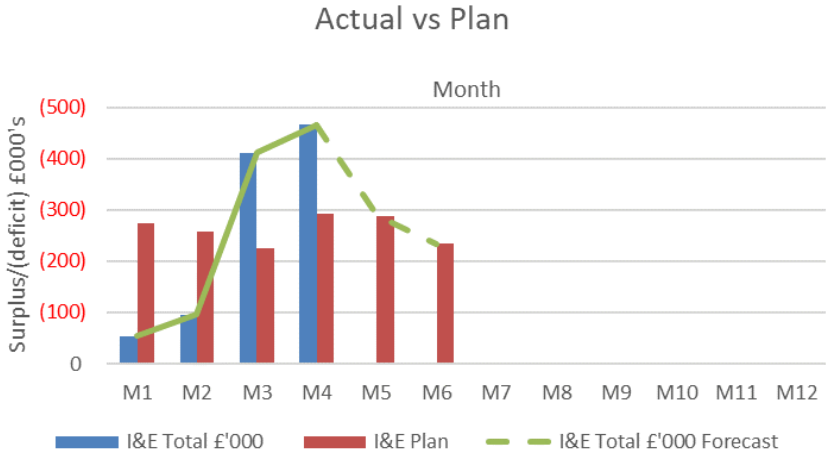
There is a negative variance YTD of £2,165k. £2,720k of pay expenditure has been reported as a direct result of additional activity due to ERF.

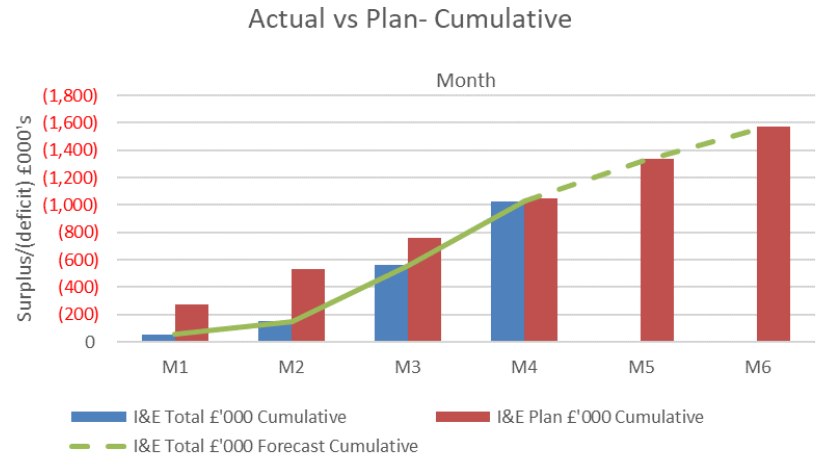
12. Non-Pay YTD

There is a negative variance YTD of £2,603k. £1,813k of non-pay expenditure has been reported as a direct result of additional activity due to ERF. A further £1m of variance is against drugs expenditure.

13. Non-Operating Expenditure YTD

Non-operating expenditure is £65k over plan in YTD due to additional PDC charges.





Key message
YTD as of July 2021, the position on a Control Total basis is a deficit of £830k. This is £77k adverse to the planned deficit of £754k. Overspends on pay and non-pay relate to the delivery of ERF activity and are offset by additional clinical income.

The Trust will continue to monitor expenditure to ensure the cost of additional activity is covered through ERF incentive payments.

ACTIVITY PERFORMANCE & ERF

14. Activity in the first half of 2021/22 is to be measured against 2019/20 baseline, with expectations set by NHSE as a percentage of 2019/20 levels (adjusted for working days) Starting with 70% target in April rising by 5% each month, with 85% being highest target. Under this guidance the Trust developed its own recovery plan in line with activity requirements of the Accelerator programme, by which the Trust plans to meet 120% of 2019/20 baseline by July, however the Trust has reforecast delivery downwards from July onwards to take in to account performance YTD, known factors limiting activity over July and August and change a change in the baselines from July onwards as set out by central guidance.

15. <u>Activity vs Plan (as per CIVICA excluding accelerator target)</u>

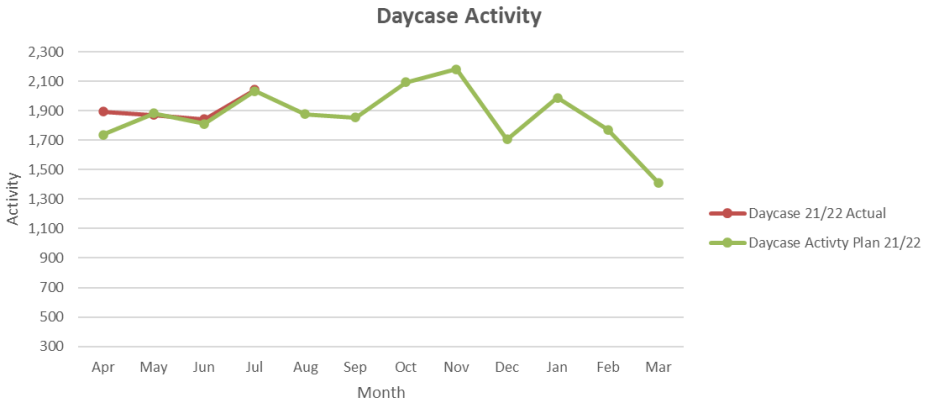
Day case activity-
Day case activity is above plan in month and YTD. However, this is below the planned recovery levels set out in the Accelerator business case. Operational issues and A/L is expected to further affect performance from August.

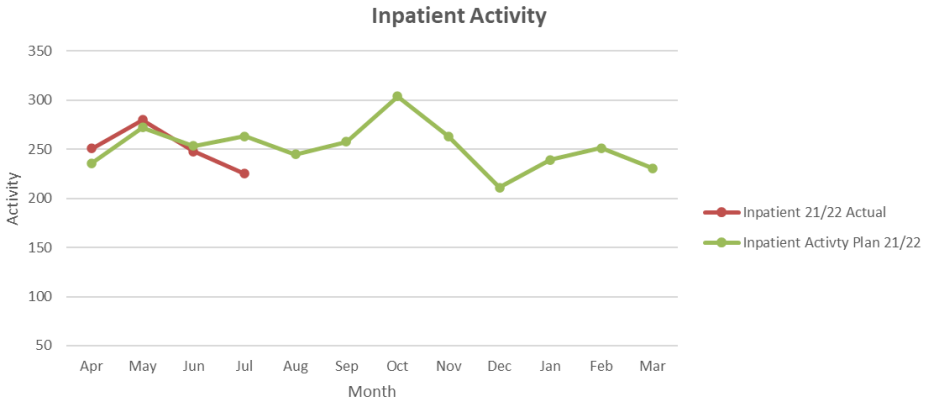
Elective Inpatient Activity-
Elective IP activity has seen good recovery in Q1; however, July saw a reduction in performance due to operational pressures (incl. Theatre downtime) and A/L.

Outpatient Activity-
Outpatient activity has continued to improve as extra capacity has been utilised, however activity is still behind plan YTD and has been affected by A/L. Outpatient activity is expected to continue to improve as the Trust proceeds with recovery plans.

Non-Elective spells-
Non-elective activity is below the originally set plan in month and YTD. While still at lower levels than the 19/20 baseline, the hospital is seeing greater numbers of non-elective activity month on month.

A&E activity-
A&E activity is contacts higher than plan in month and YTD, the hospital is experiencing high levels of A&E attendances.





Key message
Month 4 has been affected by operational issues and high use of annual leave which has limited performance against the Accelerator target of 120%. This is expected to continue into August before improving in September.

ERF position summary

16. NHSE/I have introduced the Elective Recovery Fund (ERF) for the first half of 2021/22. A financial adjustment will be made if 2019/20 activity targets are exceeded. If the activity levels exceed the targets 100% of the financial value of that activity will be paid above block funding levels. If activity levels exceed 85%, the value above 85% will be paid at 120%. This target was amended in Q2 to 95% therefore reducing the available ERF.

    It must be noted that any adjustment is calculated on overall system performance with the addition of specific gateway criteria and there is no guarantee MKUH will received funds if over perform. It is important to note that the ERF achievement is calculated as a financial value of the activity, with specific methodology used to price that activity (it is different to standard National Tariff rules). The case-mix of the activity therefore is very significant in the calculations – for example it is quite possible that activity targets could be exceeded but the financial value of that activity does not exceed 2019/20 levels and no additional funding will be received.

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

18. The elective recovery fund offers additional funding at an ICS level for achievement of activity over a set baseline set at 70% of 19/20 activity in M1, 75% in M2 and 80% in M3. From M4 this baseline has been reset at 95% of 19/20 activity from a previously stated 85%. The funding is dependent on the activity levels being met as well as specific gateway criteria being met at an ICS level. As at M4 MKUH is on track to meet the gateway criteria and will continue to progress and monitor going forward.

19. Dependent on the ICS meeting the gateway criteria MKUH activity performance is expected to deliver additional ERF funding of approximately £0.0m in month 4, £4,500k YTD and £6,100kover the first six months. The FOT value is £6,000k lower than originally planned, £3,000k is due to the change in baselines and an additional £3,000km is due to operational issues and high uptake of staff A/L.

20. The Accelerator funding offers an additional £3,000k funding for the Trust to meet a target of 120% of 19/20 activity by July 2021. Income is recognised in-line with the additional expenditure in the upcoming months.

	Actual	Actual	Actual	Actual	FC	FC
%19/20	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
DC	100%	102%	98%	100%	87%	115%
EL	98%	94%	78%	64%	70%	116%
OPA	95%	104%	96%	102%	108%	114%
OPROC	92%	90%	90%	22%	100%	100%

	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Total**
£ Totral ERF Value	£1,749,037	£1,756,264	£1,027,332	£0	£138,689	£1,414,324	£6,085,646

Key message
July has shown a significant variance to the planned in month ERF figure of £2,800k. The underperformance can be attributed to the change in baseline from 85% to 95% as well as operational issues (theatre 2 downtime) and high uptake of staff A/L. Performance is expected to increase from September.

EFFICIENCY & COST SAVINGS

21. As of July the Trust has reported a £77k surplus to plan, included within this position is £2,320k of efficiency target.

22. The Divisional and Transformation teams are working towards identifying and delivering recurrent cost saving, however due to delay's related to COVID, identified schemes are yet to be taken through the Trusts governance process to enable them to be recorded on the Trust Transformation tracker.

23. A further £1,160k is expected to be delivered in M5-6 totalling a M1-6 delivery of £3,480k

Key message
YTD the trust has delivered its £2,320k efficiency requirement. This has been achieved through productivity savings against activity and individual schemes yet to be formalised on the Trust tracker. Work is continuing through the Trust 'Better Values and Better Outcomes' programme to identify, deliver and ensure that governance processes are maintained to enable the Trust to deliver its H1 efficiency target of £3,500k.

CAPITAL

24. The YTD spend on capital excluding donated assets and de-regonised assets is £3,500k, which is behind the net CDEL plan by £1,200k. The CBIG allocation is above plan by £700k due to early approval of some schemes offset by the timing of the costs for the Maple unit which are expected later in the year. However, the Year End forecast is £1,900k above the CDEL due to the prior year schemes that were not part of the CDEL allocation

25. The Trust's ICS CDEL allocation is £14,000k which is funded by depreciation £13,600km, internal funds of £300k and £100k from externally funded diagnostics allocation. The £14,000k excludes the National funded schemes for the Maple Unit £8,300k and New Hospital Programme £28,000k.

26. The funding for the Maple Unit has been confirmed as £8,280k for 21/22. The New Hospital Programme funding is now not expected to be £28,000k but the Trust has submitted a three year proposal of £11,400k for continuing the development work for this scheme. The 21/22 proposal is £1,800k. The full breakdown of all proposed funding can be seen in the table below.

	ICS Approved CDEL Allocation 2021/22			National CDEL Allocation 2021/22		
				Externally Funded		
Scheme Subcategory	**Internally funded**	**Externally Funded Awaiting Approval**		**Planned**	**Approved**	**Awaiting Approval**
	£m	£m		£m	£m	£m
Depreciation	13.6					
Self Funded	0.26					
PDC						
Diagnostic funding		0.15				
New Hospital Programme				28.0		1.8
Maple Unit				8.3	8.3	
Sub Total CDEL	**13.86**	**0.15**		**36.30**	**8.3**	**1.8**
CDEL Allocation	***14.01***			***36.30***	***8.3***	***1.8***
TOTAL Planned CDEL	**50.3**					

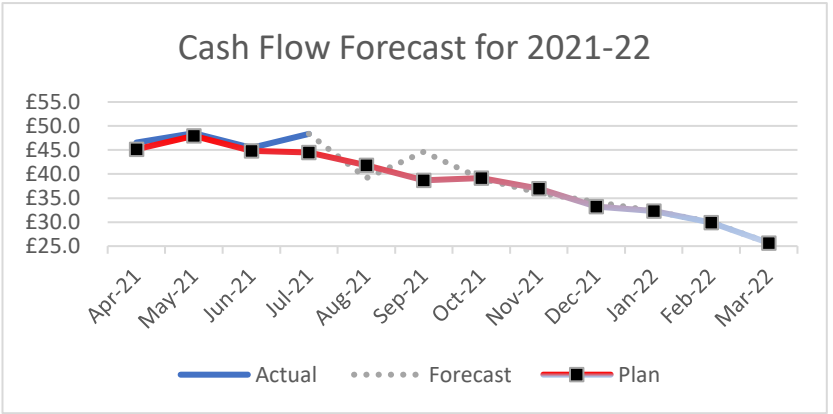
Capital Item	**Full Year Plan** £m	**YTD Plan up to end of July 21** £m	**Actual up to end of July 21** £m	**Variance YTD** £m	**Full Year Forecast for end of March 22** £m	**Variance** £m	**Status**
CBIG Allocation	**5.12**	**0.58**	**1.26**	**0.68**	**4.58**	**-0.54**	
Finance Leases	0.30			0.00	0.30		
Capitalised Staffing - IT and Estates	0.27		0.07	0.07	0.27		
IT equipment	1.50		0.05	0.05	1.50		
Cerner Phase C	0.45		0.02	0.02	0.41		
LIMS (Pathology IT System)	0.02		0.02	0.02	0.02		
HR IT system	0.10			0.00	0.10		
Mammography Installation for 2 machines	0.39		0.10	0.10	0.39		
Breast Unit Building Works	0.50			0.00	0.50		
Sub Total Other	***3.53***	***0.00***	***0.25***	***0.25***	***3.49***	**-0.04**	
Donated & Derecognised Assets (are excluded from CDEL)							
Baby Leo 3 incubators	0.08	0.08	0.08	0.00	0.08		
Pathlake	0.43			0.00	0.43		
Derecognition of assets			-0.32	-0.32	-0.32		
Sub Total Donated & Recognised Assets	***1.02***	***0.08***	***-0.24***	***-0.32***	***0.19***	**-0.82**	
Strategic Schemes							
Staff Room Refurbishment	0.20				0.20		
CT Scanner (prior year COVID funding)	0.53				0.53		
Endoscopy (prior year COVID funding)	0.23				0.00		
Xray Interventional	1.20				1.20		
Angio Interventional	1.40				1.40		
Unallocated offsetting schemes with no CDEL allocation	***1.81***						
Prior year schemes not allocated CDEL							
Endoscopy Fit Out (Whitehouse)	0.76				0.76		
MRI installation	0.50				0.50		
Flat roofs	1.41				1.41		
HIP2 Infrastructure schemes	1.83				1.83		
Sub Total Strategic Schemes	***8.06***				***7.83***	***- 0.24***	
Total NET ICS CDEL Plan (excluding donated & derecog assets)	**16.71**	**0.58**	**1.51**	**0.93**	**15.90**	**-0.81**	
Total ICS CDEL Allocation (excluding donated & derocog assets)	**14.01**	**0.58**	**1.51**	**0.93**	**14.01**		
Current shortfall against CDEL Allocation	**-2.70**				**-1.89**		
Other National Approved funding approved							
Maple Unit	8.28	3.18	1.94	-1.24	8.28		
Awaiting Approval							
New Hospital Programme (NHP)	28.00	0.85		-0.85	28.00		
Total Capital Requirements	**52.99**	**4.62**	**3.45**	**-1.17**	**52.18**		
Total Capital Plan	**50.29**				**50.29**		
Current shortfall against CDEL Allocation	**-2.70**				**-1.89**		

Key message
The capital scheme is YTD behind plan by £1,200k which is mostly due to the timing of costs for the Maple Unit however this is expected to come back on plan later in the year. However, the Year End forecast is £1,900km above the CDEL plan.

CASH

27. Summary of Cash Flow

The cash balance at the end of July was £48,400k which was above the plan fig of £44,500k by 3,900k. This is an increase on last month's fig of £45,500k. See appendices 6-8 for the cashflow detail. The Trust is still forecasting a year end cash balance of 25,700k which is shown on the graph opposite.



28. Cash Financial arrangements 2021/22

The current cash funding arrangements for H1 are that the Trust is receiving monthly block payments as per its plan plus any additional funding for high-cost drugs on a pass-through basis. The Trust is still waiting for its first ERF payments which are expected in new few weeks.

29. Better Payment Practice

The Trust is tracking at national target of 95% of all bills paid within the target timeframe. NHS bills are an area of focus that requires improvement. This metric will continue to be monitored in accordance with national guidance and best practice

Better payment practice code	Actual M4 YTD Number	Actual M4 YTD £'000	Actual M3 YTD Number	Actual M3 YTD £'000
Non NHS				
Total bills paid in the year	19,399	57,019	15,002	45,992
Total bills paid within target	18,663	54,737	14,377	44,147
Percentage of bills paid within target	**96.2%**	**96.0%**	**95.8%**	**96.0%**
NHS				
Total bills paid in the year	637	2,058	426	1,757
Total bills paid within target	530	1,290	359	1,078
Percentage of bills paid within target	**83.2%**	**62.7%**	**84.3%**	**61.4%**
Total				
Total bills paid in the year	**20,036**	**59,077**	**15,428**	**47,748**
Total bills paid within target	**19,193**	**56,027**	**14,736**	**45,225**
Percentage of bills paid within target	**95.8%**	**94.8%**	**95.5%**	**94.7%**

Key message
Cash is above plan by £600k and the Trust is within the 95% target for BPPC when looking at number of invoices paid.

BALANCE SHEET

30. Statement of Financial Position

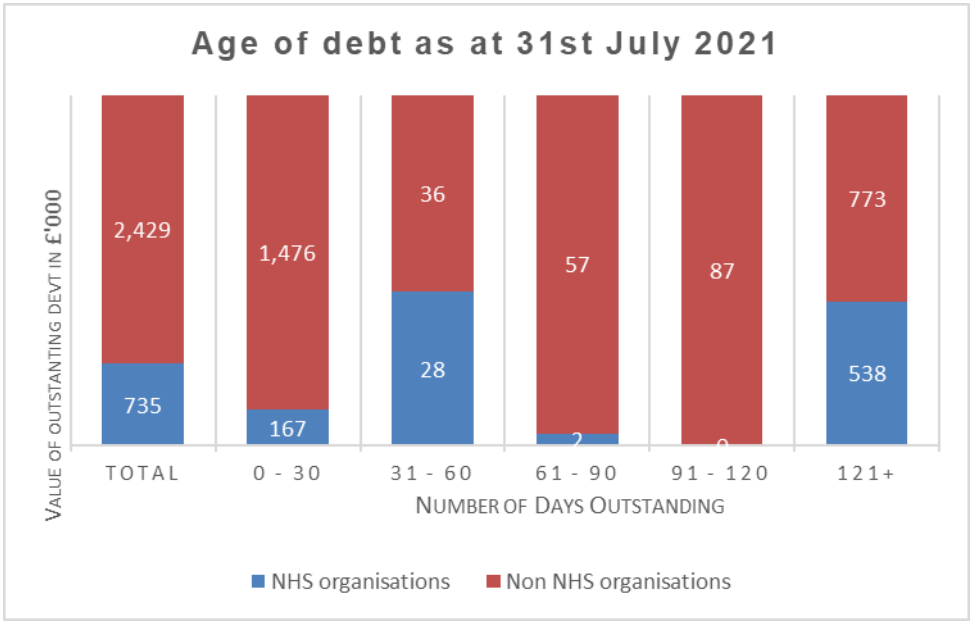
The statement of financial position is set out in Appendix 9. The key movements are summarised below

- Non-Current Assets have decreased from March 21 by £1m; this is driven by YTD depreciation.
- Current assets have increased by £2,700k, this is mainly due to the increase in receivables £3,200k offset by a decrease in cash £500k.
- Current liabilities have increased by £2,700k, this is mainly due to the increase in Trade Payables £900k and deferred income £2,000k, offset by a decrease in provisions £100k.
- There has been no change in Non-Current Liabilities in month.

31. Aged Debt

The debtor's position as of 31st July'21 is £3,200k, which is a slight increase of £900k from the Jun'21 position. Of this £1,300k is over 121 days.

The three largest NHS debtors are Bedford Hospital £278k for salary recharges, Oxford Health 131k for non-domestic rates and NHS England £107k for 19/20 final year reconciliation. The largest non-NHS debtors include 216k for overseas patients, £192k with Bedfordshire, Northampton and Buckinghamshire councils for sexual health, £1,300k with Buckinghamshire University for medical services placement recharges and £70k with Northampton University for library..



32. Creditors

The creditor's position as of 31st July'21 is £4,400k, which is a slight increase of £400k from the Jun'21 position. Of this £1,560k is over 30 days, with £904k approved for payment.

Key message
No significant movements on the statement of financial position, debtors are similar to the prior month but there is aged debtor of over 121 days of £1,200k that needs to be closely monitored

BAF

33. Key Changes to Finance risks on BAF

34. There are currently 12 risks on the Financial Risk Register which are reviewed on a monthly basis with two of these being rated a significant risk [16] which relates to the future funding regime and CDEL allocation. All the risks remain at the same levels apart from the risk relating to cash which has been reduced from 12 to 9 which is at the determined acceptable risk level due to the Trust continuing to have significant cash balances and forecasting to above its planned cash balance by the end of March.

Key message
There has been little change to the Finance risks with only 2 being rated as significant risk relating to the future funding regime

RECOMMENDATIONS TO BOARD

35. Trust Board is asked to note the financial position of the Trust as of 30th July and the proposed actions and risks therein.

APPENDICIES

Appendix 1

Statement of Comprehensive Income
For the period ending 30th July 2021

	FY22	M4 CUMULATIVE			M4			PRIOR MONTH	
	Annual Budget	Budget	Actual	Variance	Budget	Actual	Variance	M2 Actual	Change
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME									
Outpatients	53,716	18,117	19,278	1,162	7,557	8,192	635	3,771 ▲	4,422
Elective admissions	26,165	8,880	8,476	(404)	2,334	1,859	(475)	2,218 ▼	(359)
Emergency admissions	77,583	26,480	23,513	(2,967)	6,693	6,287	(407)	6,489 ▼	(202)
Emergency adm's marginal rate (MRET)	0	0	0	0	0	(19)	(19)	6 ▼	(25)
Readmissions Penalty	0	0	0	0	0	0	0	0 ▲	0
A&E	16,398	5,607	5,810	203	1,468	1,499	30	1,514 ▼	(15)
Other Admissions	2,674	969	675	(293)	212	112	(100)	205 ▼	(93)
Maternity	21,670	7,488	7,566	78	2,137	2,065	(72)	1,931 ▲	134
Critical Care & Neonatal	7,001	2,187	2,339	152	626	770	144	556 ▲	214
Imaging	5,643	1,940	1,928	(12)	497	514	17	521 ▼	(7)
Direct access Pathology	4,818	1,662	1,550	(111)	485	452	(33)	368 ▲	83
Non Tariff Drugs and Devices (high cost/individual drugs)	18,900	6,288	7,340	1,052	1,576	1,881	306	2,051 ▼	(170)
Other (inc. home visits and best practice tariffs)	6,467	2,131	6,228	4,097	557	970	412	1,531 ▼	(561)
CQUINS	0	0	0	0	0	0	0	0 ▲	0
Contract Risk Provision - General challenge & CIP offset	0	0	0	0	0	0	0	0 ▲	0
National Block/Top up	39,794	11,861	13,492	1,631	(740)	(730)	10	3,425 ▼	(4,155)
MKCCG Block adj	0	0	0	0	0	0	0	0 ▲	0
Clinical Income	**280,829**	**93,610**	**98,196**	**4,586**	**23,403**	**23,853**	**449**	**24,586 ▼**	**(733)**
Non-Patient Income	18,028	6,039	6,210	171	1,528	1,700	171	1,599 ▲	101
PSF Income	0	0	(0)	(0)	0	0	0	0 ▲	0
Donations	0	0	79	79	0	0	0	0 ▲	0
Non-Patient Income	**18,028**	**6,039**	**6,290**	**250**	**1,528**	**1,700**	**171**	**1,599 ▲**	**101**
TOTAL INCOME	**298,857**	**99,650**	**104,485**	**4,836**	**24,931**	**25,552**	**621**	**26,184 ▼**	**(632)**
EXPENDITURE									
Pay - Substantive	(175,531)	(58,354)	(57,208)	1,146	(14,625)	(13,914)	711	(14,595) ▲	682
Pay - Bank	(10,711)	(3,600)	(5,299)	(1,699)	(902)	(1,414)	(513)	(1,239) ▼	(175)
Pay - Locum	(1,819)	(620)	(1,603)	(982)	(161)	(409)	(248)	(389) ▼	(20)
Pay - Agency	(5,849)	(1,980)	(2,554)	(575)	(460)	(580)	(120)	(600) ▲	20
Pay - Other	(663)	(221)	(246)	(25)	(55)	(62)	(7)	(60) ▼	(2)
Pay CIP	41	14	0	(14)	3	0	(3)	0 ▲	0
Vacancy Factor	56	16	0	(16)	5	0	(5)	0 ▲	0
Pay	**(194,476)**	**(64,745)**	**(66,910)**	**(2,165)**	**(16,194)**	**(16,379)**	**(185)**	**(16,884) ▲**	**505**
Non Pay	(70,433)	(23,417)	(24,969)	(1,551)	(5,892)	(6,184)	(292)	(6,088) ▼	(96)
Non Tariff Drugs (high cost/individual drugs)	(18,900)	(6,288)	(7,340)	(1,052)	(1,576)	(1,881)	(306)	(2,051) ▲	170
Non Pay	**(89,334)**	**(29,705)**	**(32,308)**	**(2,603)**	**(7,468)**	**(8,065)**	**(598)**	**(8,140) ▲**	**74**
TOTAL EXPENDITURE	**(283,810)**	**(94,450)**	**(99,219)**	**(4,768)**	**(23,661)**	**(24,445)**	**(783)**	**(25,024) ▲**	**579**
EARNINGS BEFORE INTEREST, TAXATION, DEPRECIATION AND AMORTISATION (EBITDA)	**15,047**	**5,200**	**5,267**	**67**	**1,270**	**1,108**	**(162)**	**1,160 ▼**	**(53)**
Interest Receivable	12	4	0	(4)	1	0	(1)	0 ▲	0
Interest Payable	(264)	(88)	(89)	(1)	(22)	(23)	(1)	(22) ▼	(0)
Depreciation, Impairments & Profit/Loss on Asset Disposal	(12,742)	(4,247)	(4,243)	4	(1,062)	(1,061)	1	(1,059) ▼	(1)
Donated Asset Depreciation	(816)	(272)	(276)	(4)	(68)	(69)	(1)	(69) ▲	0
Profit/Loss on Asset Disposal & Impairments	0	0	0	0	0	0	0	0 ▲	0
Unwinding of discounts	0	0	0	0	0	0	0	0 ▲	0
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**1,237**	**596**	**659**	**62**	**119**	**(45)**	**(164)**	**10 ▼**	**(54)**
Dividends Payable	(4,938)	(1,646)	(1,686)	(40)	(412)	(422)	(10)	(422) ▲	0
OPERATING SURPLUS/(DEFICIT) AFTER DIVIDENDS	**(3,701)**	**(1,050)**	**(1,027)**	**22**	**(292)**	**(466)**	**(174)**	**(412) ▼**	**(54)**

Statement of Cash Flow
As of 31st July 2021

	Mth 4 £000	Mth 3 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	747	770	23
Operating surplus/(deficit) of discontinued operations			
Operating (deficit)	**747**	**770**	**23**
Non-cash income and expense:			
Depreciation and amortisation	4,519	3,390	(1,129)
(Increase)/Decrease in Trade and Other Receivables	(3,110)	(2,859)	251
(Increase)/Decrease in Inventories	(10)	(2)	8
Increase/(Decrease) in Trade and Other Payables	8,421	(2,981)	(11,402)
Increase/(Decrease) in Other Liabilities	1,912	9,074	7,162
Increase/(Decrease) in Provisions	(24)	(20)	4
NHS Charitable Funds	(79)	(79)	0
Other movements in operating cash flows	(4)	(3)	1
NET CASH GENERATED FROM OPERATIONS	**12,372**	**7,290**	**(5,082)**
Cash flows from investing activities			
Purchase of intangible assets	(1,729)	(1,593)	136
Purchase of Property, Plant and Equipment, Intangibles	(10,958)	(8,970)	1,988
De-recognition of PPE			
Net cash generated (used in) investing activities	**(12,687)**	**(10,563)**	**2,124**
Cash flows from financing activities			
Capital element of finance lease rental payments	(64)	(48)	16
Interest element of finance lease	(89)	(66)	23
Receipt of cash donations to purchase capital assets	79	79	0
Net cash generated from/(used in) financing activities	**(74)**	**(35)**	**39**
Increase/(decrease) in cash and cash equivalents	**(389)**	**(3,308)**	(2,919)
Opening Cash and Cash equivalents	**48,765**	**48,765**	32,479
Closing Cash and Cash equivalents	**48,376**	**45,457**	**29,560**

Statement of Financial Position as of 31st July 2021

	Audited Mar-21	Jul-21 YTD Actual	YTD Mvmt	% Variance
Assets Non-Current				
Tangible Assets	169.5	169.2	(0.3)	(0.2%)
Intangible Assets	22.0	21.3	(0.7)	(3.2%)
Other Assets	1.0	1.0	0.0	0.0%
Total Non Current Assets	**192.5**	**191.5**	**(1.0)**	**(0.5%)**
Assets Current				
Inventory	3.7	3.7	0.0	0.0%
NHS Receivables	7.3	11.0	3.7	50.7%
Other Receivables	12.5	12.0	(0.5)	(4.0%)
Cash	48.8	48.3	(0.5)	(1.0%)
Total Current Assets	**72.3**	**75.0**	**2.7**	**3.7%**
Liabilities Current				
Interest -bearing borrowings	(0.2)	(0.1)	0.1	(50.0%)
Deferred Income	(14.9)	(16.9)	(2.0)	13.4%
Provisions	(2.9)	(2.8)	0.1	(3.4%)
Trade & other Creditors (incl NHS)	(58.5)	(59.4)	(0.9)	1.5%
Total Current Liabilities	**(76.5)**	**(79.2)**	**(2.7)**	**3.5%**
Net current assets	**(4.2)**	**(4.2)**	**0.0**	**(0.0%)**
Liabilities Non-Current				
Long-term Interest bearing borrowings	(5.6)	(5.6)	0.0	0.0%
Provisions for liabilities and charges	(1.7)	(1.7)	0.0	0.0%
Total non-current liabilities	**(7.3)**	**(7.3)**	**0.0**	**0.0%**
Total Assets Employed	**181.0**	**180.0**	**(1.0)**	**(0.6%)**
Taxpayers Equity				
Public Dividend Capital (PDC)	259.9	259.9	0.0	0.0%
Revaluation Reserve	50.1	50.1	0.0	0.0%
Financial assets at FV through OCI reserve	0.2	0.2	0.0	0.0%
I&E Reserve	(129.2)	(130.2)	(1.0)	0.8%
Total Taxpayers Equity	**181.0**	**180.0**	**(1.0)**	**(0.6%)**

GLOSSERY OF TERMS

Abbreviation/Acronym	Name	Explanation
ERF	Elective Recovery Fund	Additional non recurrent funding linked to recovery
A/L	Annual Leave	Impact of staff annual leave
CIP	Cost Improvement Programme	Scheme designed to improve efficiency or reduce expenditure
BAU	Business as usual	Standard practice
YTD	Year to date	Cumulative costs for the year
R&D	Research & Development	
E&T	Education & Training	
PDC	Public Dividend Capital	
HCD	High Cost/Individual Drugs	
COVID	COVID-19	Costs associated with COVID-19 virus
CDEL	Capital Departmental Expenditure Limit	
BPP	Better payment practice	
	Accelerator Funding	Additional funding linked to recovery
	Block value	Block income value linked to 19/20 values
	Top up Funding	Additional block income linked to 19/20 values
	COVID Funding	Additional block funding to cover incremental COIVD-19 expenditure

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: 09 September 2021**
Report Title	**Milton Keynes Radiotherapy**	**Agenda Item: 12**
Lead Director	**Name: Prof Joe Harrison**	**Title: CEO**
Report Author	**Name: Dr Ian Reckless**	**Title: Medical Director**

Key Highlights/ Summary	*The purpose of this paper is to brief Trust Board on the background to this issue with a view to approving the investment required to progress to a Full Business Case (FBC) at the appropriate time.*			
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Noting** [ ]	**For Review** [ ]

Strategic Objectives Links	a. Improving your experience of care; b. Ensuring you get the most effective treatment; c. Giving you access to timely care.
Board Assurance Framework (BAF)/ Risk Register Links	*N/A*

Report History	*New report.*
Next Steps	*A decision will be requested of Trust Board in respect of progression to Full Business Case at the appropriate time. This decision may be made in private session as commercially sensitive elements will inevitably be involved.*
Appendices/Attachments	*None*

Summary

It has long been the aspiration of MKUH to have radiotherapy provided to MK residents from the acute hospital site. Key stakeholders are now in agreement about the desirability – and shape – of a radiotherapy facility on the MKUH site. There are further formal steps to be taken, and given the progress made over the last few years, in the view of the Executive it is now timely for MKUH to develop this facility, recognising a modest financial / reputational risk in so doing.

Background

1. Historically MK patients typically accessed cancer services (chemotherapy and radiotherapy) through Northampton General Hospital.
2. In 2014, MKUH's primary cancer link switched from Northampton to Oxford (OUH) and this change was accompanied by an emphasis on care 'close to home' (where appropriate) and growth of a local service through collaborative recruitment: in the case of chemotherapy this has culminated in the opening of the Cancer Centre in 2020 (constructed and managed on behalf of the Trust by ADMK Ltd)[1] and in the case of radiotherapy, an arrangement was developed with a third party (Genesis Care) for radiotherapy to be provided at a private facility in MK (Linford Wood) under contract to OUH.
3. The arrangement between OUH and Genesis Care resulted in around 60% of radiotherapy for MK patients taking place in MK, with 30% taking place in Oxford and the remainder in Northampton. This contractual arrangement ended abruptly in late 2019, and most MK patients have been receiving radiotherapy in Oxford since this time.[2]
4. Radiotherapy is often very intensive for patients, requiring daily attendance for many weeks. It is acknowledged by all that travel times between MK and Oxford are excessive and contribute to poor patient experience. Local patient groups are vocal in their concern about 2019 developments and their wish to have radiotherapy provided in MK once again.
5. Radiotherapy is commissioned from large established NHS providers (often tertiary centres) and it is unlikely that commissioners would wish to commission directly from a new entrant. Operational Delivery Networks (ODNs) for radiotherapy, aligned to cancer alliances, reinforce this barrier to entry.[3]
6. Radiotherapy commissioners have been reluctant to support smaller radiotherapy units (a single linear accelerator, LINAC) on account of inefficiencies and reliability, but that reluctance has softened in recent years.
7. For many years OUH and MKUH have been in discussion about the provision of a radiotherapy facility at MKUH. OUH have developed a satellite radiotherapy unit at the Great Western Hospital (Swindon) which is due to open in 2022. We understand that this facility was funded through a ring-fenced DH capital allocation following many years of discussion.

[1] ADMK Ltd is a wholly owned subsidiary of MKUH focused on the design, delivery, and ongoing facilities management of healthcare premises.

[2] In a typical year, approximately 400 patients from the MKUH catchment receive 11,000 individual fractions (or doses) of radiotherapy.

[3] A few satellites to major NHS radiotherapy providers have been developed. Peterborough is a relative newcomer to radiotherapy provision and is directly commissioned having been extensively supported (protocols, governance) by Cambridge University Hospital. This model does not currently seem to be in favour.

8. Following the termination of the OUH / Genesis contract there has been renewed impetus to develop the case for a radiotherapy facility on the MKUH site. This work has been complicated by the impact of COVID-19 locally and on partners (both the clinical challenges and uncertainty about contractual form), the formation / maturation of the NHS regions and integrated care systems, and the recent introduction of capital spending limits by ICS (CDEL).[4]
9. In 2020/21, MKUH Board commissioned ADMK Ltd to undertake planning and design work in respect of the feasibility and cost of a radiotherapy facility at MKUH – an Outline Business Case (OBC). This OBC will be considered by Trust Board in due course.

Multi-agency process

Encouraged by MKUH, stakeholder NHS organisations have come together to form a working group which has met regularly since 2020/21 to develop proposals for the development of radiotherapy in MK.

Stakeholders included:

- Regions – the process has been co-chaired by NHSE/I East of England and NHSE/I Southeast
- Providers – MKUH and OUH
- Integrated Care Systems – representatives of BLMK and BOB
- National Radiotherapy Commissioning Lead
- Consultants – Edge Consulting have been supporting the relevant modelling work (Edge Consulting are trusted advisors to, and funded by, the national commissioning team and also work on proposed Mount Vernon radiotherapy reconfigurations)
- Others have also been engaged in the process at appropriate junctures including representatives of Bedfordshire Hospitals, Cambridge University Hospitals, and the East of England radiotherapy ODN.

This working group explored several options in terms of the optimal location of radiotherapy provision and the impact of various configurations upon existing patient flows and travel times. Following representations from Bedfordshire Hospitals, it was agreed that the option of a larger facility in MK (which would result in a switch of patient flows from Bedford / Cambridge to MK / Oxford) would not be taken forward. The working group agreed unanimously in June 2021 that it would be desirable for a facility with two bunkers, one LINAC and a planning CT to be built at MKUH to be operated by OUH. The model of a 'vacant bunker' has precedent elsewhere (to allow service continuity as and when the single LINAC requires replacement) and is supported by regional and national commissioning colleagues. Whilst a larger facility (two or three bunkers, one LINAC) may have had ramifications for the ongoing Mount Vernon review, the one LINAC model was supported irrespective of the potential outcomes from that review – at its core, this proposal is the reprovision of an existing Oxford service in MK (as was the situation until 2019, via a third party).

The 'what' is now agreed, and the question moves to the 'how'.

[4] CDEL – Capital Departmental Expenditure Limit. There is an inevitable tension in relation to allocation of CDEL by ICS where the natural 'provider' is domiciled in a different ICS to that in which the proposed activity (and capital investment) takes place.

Next Steps

There are three key elements to address in order to progress to the agreed goal:

Minimise risks of destabilisation of other services

With the consensus around the one LINAC model, no direct impact is anticipated on established services irrespective of Mount Vernon options appraisal (which might ultimately see satellites in either Luton or Stevenage). The ICS may also have concerns about overprovision of radiotherapy in BLMK – given that any development will be a satellite of an established service and will be re-provision (rather than new provision) this should not be of any concern.

Access to capital funding

Capital funding will be required. Under the previous financial regime, MKUH could have entered into a lease agreement with OUH, secured funds through any route (including commercial borrowing) and built the proposed facility. Provided the total cost had been below a specified ceiling of £15m, no formal external approvals would have been required (NHSI / DHSC / Treasury).

With the advent of the extant NHS architecture, annual capital spending limits set by ICS (CDEL) come into play. Irrespective of the source of funding (other than in the case of a donated asset), spending is limited within the ICS and is determined between the domiciled constituent NHS organisations. This leads to complexities and whilst Regional finance teams have been asked to assist in finding a route through this particular challenge, this does not seem to be straightforward.

It is important to note that there are several positive elements: a possibility of value engineering; the likelihood of a significant donation; and, the potential to split funding with OUH (for example, in respect of equipment including the LINAC). We should therefore be in a position to cover the capital costs between the present time and 2023/24.

Revenue funding

In providing a satellite radiotherapy service in MK, Oxford may be concerned that there are additional revenue costs (in comparison to the current position whereby radiotherapy is being provided at a large-scale facility at the Churchill Hospital). Additional costs arise from:

1. Cost of facilities (new facility versus old)
2. Economies / diseconomies of scale and staff costs
3. Inefficiencies of set-up (a new facility would ordinarily not function at full capacity in its early years)

These issues are offset to a degree given the MK-specific history (this being a re-provision of the prior service at Linford Wood), and MKUH may also have some flexibility to further offset and mitigate through variance of expected lease payments.

Formal Process

MKUH Board will receive the outline business case in due course to approve progress to full business case, with construction expected to start in Q4 2021/22 across financial years 2022/23 and 2023/24.

Replacement of Cardiac Catheter Laboratory C-Arm

1.Executive Summary

i) Purpose

The purpose of this paper is to seek notify the Board that the Division of Medicine is advancing a business case for the replacement of the Cardiology C-Arm unit used for cardiac angiography. It is important to note that this project has two key elements;

1. Core catheter laboratory refit in a manner conducive to subsequent use for PCI.
2. Additional elements will be required to allow commencement of PCI in a lab that has had this core refit with OUH engagement.

The current Cardiology C-Arm unit being more than 15 years old and outdated, is impacting on patient care and the ability to provide the required range of procedures. It is also a limiting factor in the development of a new planned PCI service. Image quality can be improved through replacement with key procedure benefits including;

- Improved visualisation of catheters and guide wires
- Reduced examination times
- Reduced radiation doses - in order to compete with up to date cutting edge facilities and IR(ME)R Guidelines, we require Imaging systems that have the capabilities of advanced software tools, that when used during the procedure minimise radiation dose.

There is an opportunity to replace this aged equipment this year pre strategic plans of PCI.

The costs of a replacement C-Arm and ancillary equipment is likely to be around £950k. if the Trust starts operating a planned PCI service then additional software and modules will be required that could cost up to another £200k.

The Division is seeking approval from the Board to delegate the approval of the final business case to the Chair of the Finance & investment Committee, in line with the Trusts SFIs, in the event the total cost exceeds £1m.

2. Brief Scheme Overview

The investment is being sought in response to risk(s) identified with the use of outdated equipment, delivering increased radiation doses and lack of flexibility of use, resulting in operational difficulties (poor image quality) extending procedure time.
Replacement has already been postponed twice now and should not be further delayed as this will impact on the provision of planned PCI's, which when commenced, are externally monitored to ensure that adequate numbers are performed to meet the requirements of clinical expertise and patient safety.

Patients will benefit from an improvement in diagnostic image quality and a reduction in radiation dose. The unit will have the ability to broaden the range of procedures offered thereby reducing patient transfers and assuring local provision of high-class Cardiology services. Procedure benefits include:

- Improved visualisation of catheters and guide wires
- Reduced examination times
- Reduced radiation doses. In order to compete with up to date cutting edge facilities and IR(ME)R, we require Imaging systems that have the capabilities of advanced software tools, that when used during the procedure minimise radiation dose.

The principal driver for change is due to the operational risk represented by the continuing use of the existing equipment. The elderly equipment is beyond clinical, and manufacturers recommended replacement age of 7 years, delivers higher radiation doses than modern equipment and poorer image quality.

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

Chief Executive: Professor Joe Harrison
Chair: Alison Davis

3. The Strategic Case

The investment is being sought in response to risk(s) identified with outdated equipment, delivering increased radiation dose and lack of flexibility of use, resulting in operational difficulties extending procedure time.

i) Currently, the Cardiology service enables provision of a wide range of diagnostic cardiac angiography, insertions of pacing wires & pacemakers and in April 2022, development of cardiac stenting and angioplasty. Without a suitable C-Arm unit these aspects of cardiology will not be possible within the Trust which will inevitably lead to consideration of downgrading of the specialty. We are currently unable to begin the planned PCI service with this unit. We do not deliver this service at this time because we do not have suitable equipment.

ii) The Cardiology service is supported by the Trust and under active development to support the increasing number and age of the local population who are expected to require access to diagnostic and interventional cardiology services.

iii) Provision of a Trust provided service is central to the management of a significant number of patients and support of other services including ED. Movement of cardiology provision away from the Trust will result in delayed medical management of patients and increase in-patient transfers and repatriations for the large number of patients requiring support from cardiology.

The proposed investment aligns with the following trust Strategies and Objectives

Objective	Description
1) Improve Patient Experience	Reduces the need to transfer patients off site for Imaging and interventions
2) Improve Clinical Safety	Radiation exposures reduced, Image quality improved, user confidence enhanced with a more up to date system
3)Improve Clinical Effectiveness	Image quality enhanced allowing improved accuracy of diagnosis and wider range of procedures performed. Reduced operation time for routine angiography can increase the number of patients imaged per session.
4) Deliver Key Targets	Enables expansion of cardiology services and effective development of the planned PCI service enabling cardiac stenting and angioplasty
5) Developing a Sustainable Future	Ensures that the cardiac specialty can continue to expand and use modern techniques, improving staff recruitment to further develop the specialty
6) Develop Robust and Innovative Teaching and Research	Improved image quality and machine capabilities will enable research to be within the most modern environment.
7) Remain Well-Governed and Financially Viable	Reduces potential increased costs from outsourcing patients and delays in bed management.
8) Improve Workforce Effectiveness	Enables rapid access to technology offering ease of use and improved image quality can reduce procedure time and increase throughput and quality of procedures
9) Make Best Use of the Estate,	Enables a full patient service to be rapidly offered rather than a lengthier process requiring patient transfers and delays to bed management = increased 'Finished Consultant Episodes'/Bed Days. Currently we are housing a piece of kit which is past its shelf life and does not support collaborative working between integrated care pathway sites ie Luton, Oxford, Bedford.

The Division is seeking approval from the Board to delegate the approval of the final business case to the Finance & investment Committee.

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Public Board	September 2021
Report title:	Significant Risk Summary Report	**Agenda item: 14.1**
Lead director **Report author** **Sponsor(s)**	**Paul Ewers** **Kate Jarman**	**Risk & Systems Manager** **Director of Corporate Affairs**
FoI status:	**Disclosable**	

Report summary	The report includes all significant risks across all Risk Registers, where the Current Risk Rating is graded as 15 or above, as at 1st September 2021			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [ ]	**Decision** [ ]
Recommendation	The Public Board is asked to note and discuss the contents within the report, in to ensure risks are being robustly and actively managed across the Trust.			

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

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

Executive Summary:

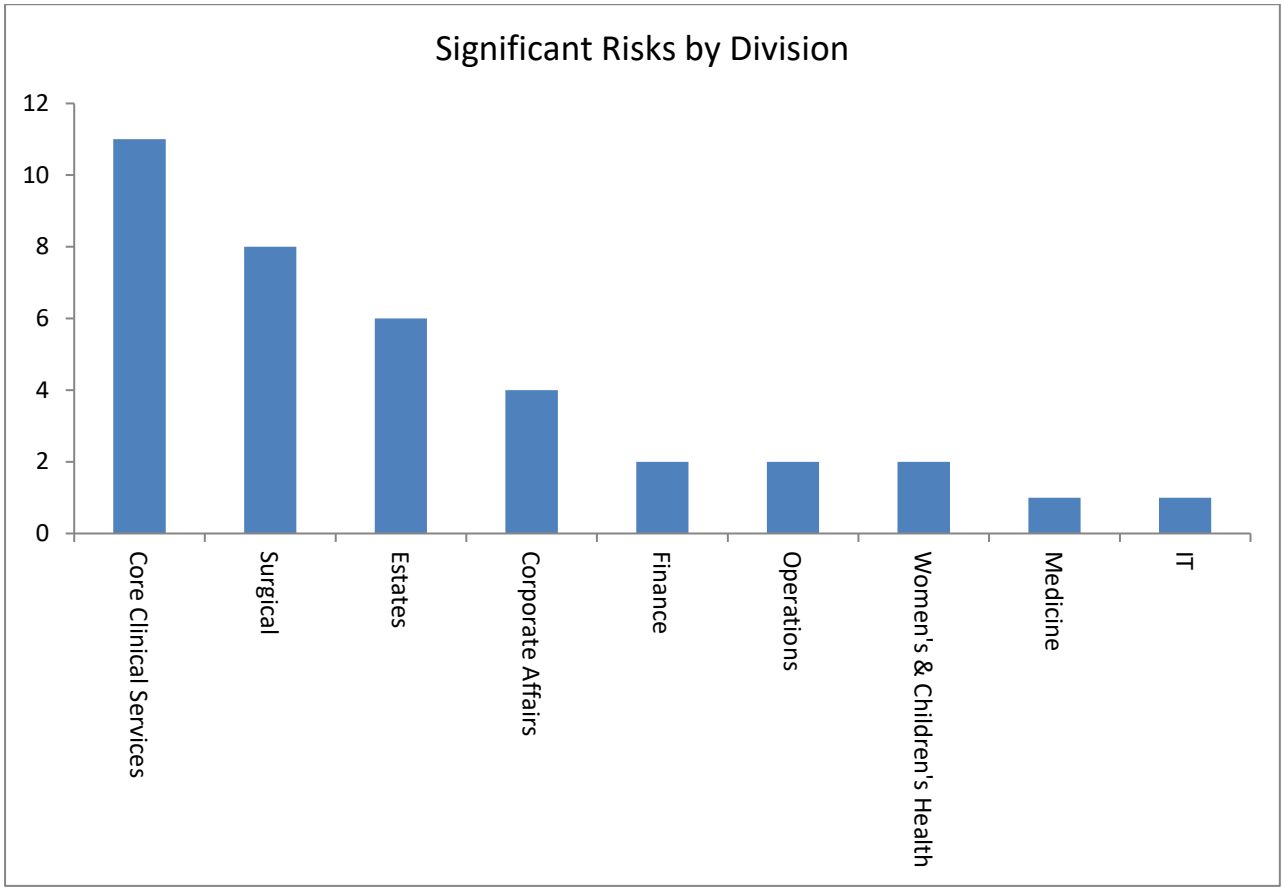
This report shows the profile of significant risks across the Trust by type and area.

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

The Board is asked to note the content of this report

Risk Profile

- There is a total 38 significant risks identified on Risk Registers across the Trust:



- Of these risks 14 are overdue their review date and have been escalated for corporate review.

- There were 0 new significant risks added during August 2021:

- There were 0 significant risks closed within the last month:

- There is 1 risk that is graded the same as the Target Risk rating

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

- There are no Actions identified for 14 of the risks (up two from the previous report). It should be noted that, for many of these risks, actions have been and are being undertaken, however the risks have not been updated on Datix. A process has commenced for all risks to have an additional formal annual review (see below). One of the aims of this new process is to ensure that all actions are added to the risk register for completeness and to support the ongoing management of the risk.

Recommendations:

The Board are asked to review and discuss this paper.

Definitions:

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

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

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

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

ID	Ref	Triumvirate Annual Review Date	Executive Responsible	Risk Owner	Division	Specialty	Description	Cause	Impact	C	L	Inherent Risk Raing	Inherent Risk Level	Controls in place	Assurance on Controls	C	L	Current Risk Rating	Current Risk Level	Gaps in Controls	C	L	Target Risk Rating	Target Risk Level	Treatment Category	Action Plan Summary	Date Risk Last Reviewed	Trend	Trend Rationale	Review Due?
666			Deputy CEO	Eagles, Mr Phil	Estates	Estates	IF staff and contractors are not made aware of the presence of asbestos in older areas of the hospital and the policy for dealing with this THEN Contractors and staff not being provided with details of asbestos register. LEADING to ill health, claims and loss of reputation could result in staff/contractors disturbing asbestos leading to accidental exposure. an increased safety risk to staff and contractors.	IF staff and contractors are not made aware of the presence of asbestos in older areas of the hospital and the policy for dealing with this THEN Contractors and staff not being provided with details of asbestos register.		5	3	15	HIGH	1. Asbestos policy, staff training, manual asbestos register available for contractors. Results of updated survey, policy and training received and currently being processed for actions. 2. Annual Refresher Training takes place. 3. ARP identified areas for remedial works. 4. Final audit of areas with no asbestos completed March 2018. 5. Permit to work system exists 6. Independent Asbestos Advisor appointed. 7. All maintenance staff have access to MICAD asbestos information for every ticket raised.		5	3	15	HIGH	MiCAD Asbestos register is awaiting update from the surveyor. Review completed, waiting on data to be uploaded. Issue with some additional rooms created in MiCAD that are to be updated with current asbestos details	5	2	10	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Trust Asbestos register update being undertaken. Trust policy updated and awaiting approval. Staff training and contractor training underway. Final audit of areas with no asbestos identified to be undertaken Appointed person training to be completed	25/08/2021	Increased	see comments	29/11/2021
824			Deputy CEO	Eagles, Mr Phil	Estates	Estates	IF the estates infrastructure contingency plans are not adequately tested THEN in the event of a infrastructure failure plans may not succeed LEADING TO contingency plans not being effective and to potential loss of services, poor patient experience, financial loss and loss of reputation	untested contingency plans, in the event of a infrastructure failure plans may not succeed	an increased safety and service disruption risk to patients and staff.	5	4	20	HIGH	1. Partially tested Contingency Plans. 2. Review of Business Continuity Plan review process completed in conjunction with Gordon Austin assisting with reviewing process and plans. 3. Continuity plans reviewed and shared with team. 4. Noted that plans partially tested during the recent flooding incident. 5. Emergency Planning Officer has been sent the plan for review and comment. 6. Met EPO and reviewed document, awaiting publication.		5	3	15	HIGH	Waiting publication of agreed document.	5	1	5	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Testing regimes to be further developed with Gordon Austin	25/08/2021	No Change	see comments	25/10/2021
1740		24/03/2021	Director of Corporate Affairs	Worth, Mrs Tina	Corporate Affairs	Clinical Governance	There is a risk that changes required to practice are not implemented and we are not meeting best practice criteria	If recommendations and actions from audit are not evidenced, monitored and completed in the Trust	Potential impact on the top 3 Trust objectives (patient Safety, Clinical Effectiveness, Patient Experience) Potential poor quality of service and associated impact on resources CQC concerns re audit activitu & learning from national audits	3	5	15	HIGH	Audit report templates available to identify audit action plans. However these are not always being utilised and actions are not Always evidenced and monitored Monitoring via Clinical Audit & Effectivess Committee (CAEB) TOR CAEB revised to include quality improvement, GIRFT etc Escalation/exception reporting to Management Board Refresh of Sharepoint data base to assist with data capture, with Level 1 audit a priority Transformation Team audit Structure review - staff realignment to support audit agenda Scheduled implementation of Radar audit module Autumn 2021 onwards Pilot of new governance approach to reports/CIG meetings (ED pilot area)	Limited assurances from RSM audit review Sharepoint has ability for audit action plans to be attached with evidence of completion but audit cycle not completed to this level Jan - Feb 2020 repeat RSMUK reveiw due Limited assurances from RCB?CAEB - pals to move to integrated governance & divisional meetings approach	3	5	15	HIGH	Capturing audit evidence at specialty CIG meetings including actions to improve practice or examples of good practice. Divisional audit reports at CAEB detailing compliance on Level a audits Sharepoint evidence to support action plan from audits - review & overhaul of system scheduled for November at Risk Management Team Divisional accountability at Performance Management Board Effectiveness of CAEB - corporate level meetings to be reviewed Roll out of new governance approach Radar build Realigned staff moved across with new Implementation of new integrated governance agenda National audits on hold & local audits & audit meetings limited due to Covid pandemic	1	3	3	VLOW	TREAT - above tolerable level - appropriate cost-effective control required	Implementation of KPMG action plan, to be monitored by Audit Committee Meeting with CGLs to review Sharepoint format for capturing audit completion/complinace to best ensure this helps give accurate data & evidence Risk Systems Business Case with potential for Document Management system	06/07/2021	Increased	KPMG Audit / CQC	31/08/2021
1874			Director of Patient Care / Chief Nurse	Goodman, Mrs Julie	Directorate of Patient Care	PPI	The MUST conformance criteria were set out in the NHS accessible information specification for compliance by the 31st July 2016	The Trust currently cannot meet all of requirements set out in this specification which is driven by the NHS England, the Equality Act 2010 and Care Act 2014 to ensure patients with a disability are not discriminated against.	1. The CCG as part of the Quality Schedule 2. The CQC recognise the role of this standard as an indicator of high quality care for people with particular information and communication support needs and will be included as part of their inspections of a service. 3. A workstream to the patient led assessment of the care environment (PLACE). Identiication of non compliance could lead to an enforcement action from any of the above performance monitoring stakeholders.	3	5	15	HIGH	Some of the meeting individual needs resources identified i.e.BSL sign language interpreters, braille, easy read Ongoing EPR agile preparation events E Care launch plan in progress	Patient Experience team are working with external providers and will be picked up as part of the Quality Account	3	5	15	HIGH	Go live date agreement for EPR - Cerner have confirmed that the system will allow the required alert flags etc. Equality and Diversity Trust legal requirements to be identified, documented in policy and staff advised. This impacts on all policies and guidelines. Interpreting and translation policy - contract now agreed Gap analysis of patient information (sits with Patient Experience) - what is available?	3	2	6	LOW	TOLERATE - at lowest practicable/cost-effective level	Steering Group to monitor progress Review of proces for patient information publication & availability	28/02/2019	No Change	First review	28/08/2019
1970			Director of Clinical Services	Hyem-Smith, Ms Celia	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	Unable to meet the demand for existing patients leading to increased waiting times Unable to develop exisitng outpatient services Unable to optimse student placements	The cause is the lack of clinical space available for patient treatment	The impact is failure to meet contracts, lost revenue, poor patient experience and poor staff morale	3	5	15	HIGH	1. Extended working hours 2. Introduction of shift pattern 3. Introduction of telephone triage clinics 4. Group treatment sessions		3	5	15	HIGH	Amalgamation and integration of department space and teams to utilise current space more efficiently. Potential to increase clinical space but this would require significant investment.	3	5	15	HIGH	TREAT - above tolerable level - appropriate cost-effective control required	Review of space in Therapies	17/02/2021	No Change	No change	31/05/2021

2297		07/05/2021	Director of Clinical Services	Thwaites, Elizabeth	Core Clinical & Support Services - Diagnostic & Screening	Pathology	There is a risk that the available space within Cellular Patholgy will not be enough to meet the demands of the service as workload continues to expand	Increasing workload requiring additional specimen storage, workspace additional equipment and additional staff	The department will be unable provide the storage space required to accommodate the increasing workload leading to 1. An inability to retain specimens for the period of time required to meet RCPath guidance 2. An increased risk of formalin spillage / increased levels of formalin vapour 3. Increasing risk to staff and to specimens because of cramped workspace e.g. Specimen reception area encroaches on cut-up area 4. Inability to safely operate and / or validate equipment 5. Insufficient space for record storage	3	5	15	HIGH	Storage of specimens minimised. Review of work flow and processes to improve space efficiency. Business Case has been accepted - plans to be confirmed regarding building work and expansion. Business case required for Laboratory furnishings and layout.	Controls are currently not effective due to increased workload and pressure of social distancing.	3	5	15	HIGH	Social distancing pressures in addition to digital expansion requiring further space.	3	2	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Identify additional storage space Review space and workflow and identify activities that can be relocated Supervise build of new expansion Develop BC for internal build - Lab layout and furnishings Develop business case for space expansion into courtyard area	23/08/2021	No Change	Building work ongoing	30/11/2021
2341			Director of Clinical Services	Stamp, Mr Jamie	Core Clinical & Support Services - Clinical Support Services	Dietetics	The risk is that the paediatric team can not provide a full dietetic service to children and young people in the Milton Keynes area	Insufficient capacity and on-going unsustainable demand for dietetic input for Paediatric patients (both inpatient and outpatient) Home Enterally Fed Paediatrics patients should be seen as part of community contract, currently this group of patients is being seen through our outpatient structure which is not adequate to meet their demands and needs. As a results of this staff are be stretched to cover a service that has not been resourced correctly which in turn impacts on the wider outpatient and inpatient work load. The current dietetic workforce is not able to meet the Increasing referral for children with diabetes, this means that these high risk groups of Children and Young People are not accessing the necessary specialist nutritional support at the appropriate time in their development. This was	1. Patient care and patient safety will be at risk 2. Vulnerable children becoming nutritionally compromised. 3. Unable to assess and advise new patients and review existing patients in a timely manner. 4. Impacting on patients nutritional status and longer term dietary management on what is a very vulnerable group of patients. The majority of our caseload is infants or tube fed infants and children where there nutrition and growth is a priority.	3	5	15	HIGH	Existing staff are working some additional hours but this remains insufficient to meet the needs of the service.	Number of children / babies on HEF is monitored - 91 Dec 2020 Waiting list / request queue for paediatric dietetic OP's monitored	3	5	15	HIGH	There is insufficient to paediatric dietetics to manage the demand for outpatients, inpatients specifically the paediatric dietetic service is unable to deliver the national standards for Home Enterally Fed and Diabetic patients on the caseload.	1	3	3	VLOW	TREAT - above tolerable level - appropriate cost-effective control required	The need for a paediatric community dietetic service for patients on HEF being raised with CCG Current staffing provision is not sustainable and is not adequate for delivery the Home Entral feeding serivce which is not commissioned	07/07/2021	No Change	No change	01/09/2021
2640		24/03/2021	Director of Corporate Affairs	Worth, Mrs Tina	Corporate Affairs	Clinical Governance	Clinical Governance and Imaging staff are unable to meet statutory and mandatory Good Governance requirements and accreditations if IT systems do not support their remit.	Existing governance systems do not support meeting Trust /legal/stakeholder requirements and are unsupported by the Trust IT department or an external IT provider	Unable to meet statutory and mandatory Good Governance requirements and accreditations if IT systems do not support their remit.	5	5	25	HIGH	System in place but requires updating and Q pulse which manages Trust documentation is no longer able to archive since the shared drive was moved. Updates made to Q-Pulse and SharePoint Scheduled implementation of new system Radar (documents module)Autumn 2020 onwards	The controls are ineffective to manage documentation on such a scale to support accreditation. No response from Datix regarding system capabilities. IT support staff no longer able to support - new member of staff commences July 2018 for project to be handed over. Scoping exercise with other IT systems to Datix that may include a document management service. QPulse move to Microsoft Teams pending - further review of how manage documents	5	3	15	HIGH	Systems require updating Purchase of additional modules on Datix (business case for Datix cloud/other system progressing). Since approved move to Radar	2	1	2	VLOW	TREAT - above tolerable level - appropriate cost-effective control required	Risk Systems Business Case with potential for Document Management system	06/07/2021	No Change	New risk	31/08/2021
2740			Deputy CEO	Eagles, Mr Phil	Estates		The current bleep system (main system A and back-up system B) is obsolete and no maintenance support contract is available from the company. The risk is that the equipment may not be able to be repaired if failed.	the equipment failure	failure of the current bleep system will have impact on patient care due to clinicians not being contacted via the bleep system	5	4	20	HIGH	-DISCUSSED WITH LINE MANAGER AND ESCALATED -TEMPORARY RADIO COMMUNICATION SYSTEM 3. User group formed with IT & EBME to identify options		5	3	15	HIGH	Identify costs of possible solutions and draft business case. Estates to own crash bleep solution; IT will own the clinical messaging and task-orientated communication functions. Digital Information Manager for Strategic estates will be driving the project to replace the emergency/urgent bleep replacement.	5	1	5	LOW	TREAT - above tolerable level - appropriate cost-effective control required		07/05/2021	No Change	no change	31/08/2021
2958			Deputy CEO	Ahmed, Ayca	Estates	Capital Planning	The current risk is that there is not enough space in the Medical Equipment Library(MEL) to carry out the required cleaning process to comply with the appropriate guidelines set by CQC and MHRA.	Space pressure increasing due to growth of the MEL and additional tasks	Lack of cleaning and processing space due to the growth of the MEL over the years means not keeping unprocessed and processed equipment separately, not complying with CQC Regulation 15: Premises and equipment and MHRA Documentation: Managing Medical Devices April 2015	3	5	15	HIGH	Staff members are taking processed equipment straight to the shelving areas as soon as it is cleaned to avoid cross contamination. This ensure equipment is kept separate, but this is not a productive method of working. Issue being raised at next Space Committee (June 2021)		3	5	15	HIGH	Nil	3	1	3	VLOW	TREAT - above tolerable level - appropriate cost-effective control required		27/05/2021	No Change	New Risk	30/09/2021
2968			Director of Corporate Affairs	Noble, Deborah	Core Clinical & Support Services - Diagnostic & Screening	Imaging	Delayed detection of breast screening cancers due to COVID 19	The cessation of the programme has meant that women have been delayed an invite for screening. The programme has restarted but with reduced capacity to enable social distancing in both the mobile and static sites.	Women of screening age may receive a positive diagnosis that has been delayed due to the cessation of the programme. Treatment regimes will be delayed as a result.	5	4	20	HIGH	Restart proposal approved by the Trust, SQAS and PHE. Guidance issued as to the management of the women to ensure that no-one is missed has been issued by Hitachi/PHE and has been implemented by the programme.	KPI's monitored buy NHSBSP Regular communication with QA team and commissioners.	5	3	15	HIGH	No Gaps	2	2	4	LOW	TREAT - above tolerable level - appropriate cost-effective control required		24/04/2020	Decreased	No change	25/06/2021

2973		30/03/2021	Director of Clinical Services	Burns, Ms Samantha	Surgical - Musculoskeletal	Trauma & Orthopaedics	With the implementation of green pathways for elective care patients, the Trauma and Orthopaedic department has lost capacity to escalate on to elective lists for trauma patients. As such with just one trauma list per day, there may be insufficient capacity to meet trauma needs.	Increasing trauma activity beyond existing capacity (5 cases per day on trauma list)	Without sufficient trauma capacity in place, the department may not be able to operate on all trauma patients within the required timelines leading to poor outcomes. The Trust may be required to close to trauma or cancel all elective lists for the day in theatres 11 and theatres 12 in order to facilitate trauma patients who are not covid swabbed, isolated for 72 hours or given social distancing advice. This will lead to longer elective wait times and possible 52 week breaches. Alternatively, the Trust may be required to close to trauma due to insufficient capacity	3	4	12	MOD	Divisional Director for Operations to work with T&O and Theatre teams to implement all day weekend emergency theatre lists. Utilisation of theatre pm 1 for procedures that do not include metal work twice a week if staffing is available. Cancellation of elective activity if required.	24/06/2021 - team report that main theatre used by T&O is closed whilst laminar flow is being repaired. This is likely to be for 6 weeks therefore this will impact on the red/ green pathways - number of elective operations will reduce, and there may be delays for emergency operations. Options to address are being considered at present. 27/04/2021 - team believe risk may be increasing therefore to continue monitoring progress. 30/03/2021 - Divisional Director for Operations to liaise with Operational Manager and teams to consider implementing all day weekend theatre lists. 19/01/21 Currently elective surgery is suspended.	3	5	15	HIGH	There are occasional surges in trauma cases especially at the weekend which impacts on trauma/ elective lists on Mondays.	3	2	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required		20/07/2021	Increased	Ongoing risk	30/09/2021
2983			Director of Clinical Services	Hyem-Smith, Ms Celia	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	There is a risk that the Women & Men's Health Physiotherapy Service is unable to meet its referral demand	Insufficient staffingleading to increased waiting times Referral number into service via multiple routes	Potential for poor clinical outcome, poor patient experience, complaints and staff stress Potential delay to patient treatment Potential for patients with new diagnosis of cancer and pregnant women are not seen in a timely fashion further	3	5	15	HIGH	Non clinical time including training,development and audit are being minimised to increase the number of available patient appointments Job plans are being completed by all staff to show impact on workload Patients are ebing booked into group where possible instead of individual appointment slots Recruited to all vacant posts To explore options for supporting dictationn of letters to free up clinical capacity.	Patients requiring an individual slot are often not being treated in a timely manner to meet the needds of their clinical repsentation. Team is fully established and Band 4 assistant is being used to support	3	5	15	HIGH	Staff capacity to meet current referral demand	2	4	8	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Establish increasing referral rate trends, map against capacity and establish increase income vs uplift in staff to meet demand Budget reallocation and VCP for Band 6 post Therapy Strategy is being finalised to support investment for business case, to present strategy at management once shared with senior members of the Trust To discuss interim plans to manage staffing and impact on Women's division	19/06/2020	Increased	No changes to staffing	31/05/2021
2936			Director of Clinical Services	Hyem-Smith, Ms Celia	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	Increasing numbers of patients being added to the physiotherapy outpatient waiting list, in addition to those on hold due to the COVID-19 pandemic, resulting in waiting times of well over 18 weeks for any type of intervention. A further increase in referrals may result from patients with post-COVID symptoms	The COVID-19 pandemic has led to outpatients only reviewing urgent patients virtually by telephone or video call, pre-COVID waiting lists could be managed effectively by groups, this is no longer possible due to social distancing and patients shielding.	Litigation and/or complaints due to lack of timely treatment intervention, potentially resulting in permanent and unecessary disability.	3	5	15	HIGH	- Virtual management of patients - Video and telephone clinics - Additional IT sourced to support virtual management - Reconfiguration of department to support virtual working and enable social distancing along with staff working from home - recovery plans are being written/in place to enable essential patients to be seen in the department of a face to face basis - Educational material including exercise programmes and access to youtube clips are made available to patients		3	5	15	HIGH	To identify process for validate routine patient lists to ensure that clinical priorities are seen the correct order	2	3	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required	To develop strategy for validating routine patient waiting list	17/02/2021	No Change	new risk	31/05/2021
3056		30/03/2021	Director of Patient Care / Chief Nurse	Watson, Catherine	Surgical - Head & Neck	Oral Surgery	Insufficient qualified dental nurses to facilitate in assisting Clinicians with the running of OMFS Outpatient clinics.	The creation of an additional clinical room as the result of the recent refurbishment and the expansion of the Orthodontic service and subsequent employment of additional clinical staff has resulted in insufficient qualified Dental Nurses to be employed to support the Service	Shortage of dental nurse that assist the four handed approach that is employed in Dentistry will result in delayed treatment for patients, which are already lengthy for Orthodontic patients. Which would pose an additional risk for these patients. Outpatient clinics being cancelled on a regular basis. Increased waiting times.	3	5	15	HIGH	15/05/2021 business case is going to pain in May/June. Team are looking into using a specialised agency for Dental Nurses and are liaising with Matron/ HoN to establish feasibility of this. HCA`s can be utilised in a few Outpatient OMFS clinics that can be access via Trust Bank, these would need to be regular individuals due to the nature of the work required. However this will not mitigate the shortage of qualified dental nurses required to assist in the running of the Orthodontic and OMFS service.	Monitoring of staffing and rotas. 13/05/2021 - discussed in meeting that clinics have been cancelled when they are aware there will be nursing gaps, before booking patients to lists and this is not showing the true picture of the impact on lack of experienced Dental Nurses on the service. A plan is in place to manage clinics as per Trust standard. Although the team appreciates this may mean late cancellations on the day.	3	5	15	HIGH	Insufficient qualified dental nurses to run OMFS services.	3	2	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Business case to increase nursing staff numbers	16/08/2021	No Change	Ongoing risk	30/09/2021
3082		30/03/2021	Director of Patient Care / Chief Nurse	Watson, Catherine	Surgical - Head & Neck	Orthodontics	Insufficient qualified dental nurses to facilitate in assisting Clinicians with the running of Orthodontic Outpatient clinics.	The creation of an additional clinical room as the result of the recent refurbishment and the expansion of the Orthodontic service and subsequent employment of additional clinical staff has resulted in insufficient qualified Dental Nurses to be employed to support the Service	Shortage of dental nurse that assist the four handed approach that is employed in Dentistry will result in delayed treatment for patients, which are already lengthy for Orthodontic patients. Which would pose an additional risk for these patients. Outpatient clinics being cancelled on a regular basis. Increased waiting times.	3	5	15	HIGH	HCA`s can be utilised in a few Outpatient OMFS clinics that can be access via Trust Bank, these would need to be regular individuals due to the nature of the work required. However this will not mitigate the shortage of qualified dental nurses required to assist in the running of the Orthodontic and OMFS service.	Monitoring of staffing and rotas.	3	5	15	HIGH	Insufficient qualified dental nurses to run OMFS services. Orthodontic clinics may be cancelled if experienced Dental Nurses are not available.	3	2	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Business case to increase nursing staff numbers	16/08/2021	No Change	ongoing risk	30/09/2021

3104			Director of Clinical Services	Martucci, Mr Mark	Surgical - Anaesthetics & Theatres	Main Theatres	Staffing shortages within the theatre department. The staffing demands within theatres has significantly increased, these changes have arisen from changes and developments in our service. For the theatre team to safely cover the theatre sessions additional staff are required. Examples of the increased staffing demand below: Robotic lists x 5 days a week, COVID-19 secure pathway, increased elective activity & trauma activity & staffing the theatre procedure room.	Inability to cover the increased demand of both elective and emergency/trauma theatre sessions. Some staff currently in post are junior and are learning within their specialities. The lack of experienced staff creates issues around staff skill mix.	Patients being cancelled due to a lack of staff, we also experience issues due to the amount of junior staff within the department – creating difficulties with skill mix. This creates increased stress level with the clinical teams.	3	4	12	MOD	This risk is currently being mitigated by the use bank, approx. 80 /100 shifts of varying lengths per week. Agency staff approx. 300 hours per week. Even with the additional support from bank and agency staff we still struggle to provide staff for all sessions, this has recently led to cancelling lists. These risks are exacerbated when staff are off sick or absent for training / annual leave.	Monitoring of staffing levels and when theatre lists are taken down.	3	5	15	HIGH	There are significant gaps in the theatre rota - 26 WTE posts are required to meet latest review of theatre staffing requirements.	3	2	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required		18/08/2021	No Change	ongoing risk	15/09/2021
3106			Deputy CEO	Marsh, Tony	Estates	Estates	Obstructions stored in hospital street (main, fire-protected, circulation routes) hindering evacuation or access to fight a fire.	Items such as beds, mattresses, cages (both empty and full of combustibles), trolleys, cots for examples are stored in hospital streets due to a lack of storage facilities and/or due to operational constraints including excess stocking of essential items for ward use. This impedes on the safety of movement by individuals either walking, using mobility aids, beds, and staff delivering/manoeuvring equipment through the hospital streets.	Delays in attending fire, delayed fire evacuation could lead to smoke inhalation/burns/death	5	4	20	HIGH	Fire warning systems in place Fire doors in situ and close when fire occurs (safe to 60 Minutes) Ward/department fire risk assessments conducted and documented including personal evacuation plans for vulnerable individuals (sight, hearing, frailty/disability) Procedures for horizontal evacuation in place – evacuation or table top exercises take place. Staff training in fire safety procedures & measures completed and regular updates mandatory. Fire alarm points. Firefighting equipment in situ. Trained Fire Wardens to monitor fire safety in departments. Fire Safety Policy documented and available to all staff.		5	3	15	HIGH	Storage unit to be created to assist with safe location of excess stores.	5	1	5	LOW	TREAT - above tolerable level - appropriate cost-effective control required		25/08/2021	No Change	new risk	25/10/2021
3110		20/07/2022	Director of Finance	Hotchkin, Karan	Finance	Financial Services	If the Trust does not have a sufficient capital expenditure limit (CDEL) then the Trust will not be able to complete the level of planned capital investment	Following the FY21 year end audit the Trust had to adjust misstated capital expenditure of £4.5m relating to a capital bond. As a consequence, the Trust has brought forward capital spending commitments of £4.5m into FY22 .	Insufficient capital expenditure limit to accommodate the Trusts investment.	4	5	20	HIGH	The Trust is introducing enhanced in-year capital spend monitoring to proactively manage in-year underspends across other capital schemes. Where agreed by management (e.g., subject to risks and strategic need) underspends across other capital schemes could free-up capital expenditure limit for utilisation against bond schemes.	The Trust will report the capital expenditure position (MKUH and ICS) and associated risks to F&IC and regularly update the Audit Committee through the BAF.	4	4	16	HIGH	The Trust has limited control over the availability and reassignment of CDEL across the ICS and regional partners.	2	5	10	MOD	TREAT - above tolerable level - appropriate cost-effective control required		12/08/2021	No Change	New risk for July 21	09/09/2021
3087			Director of Workforce	Adderley, Jane	Surgical - Anaesthetics & Theatres	Anaesthetics	Psychological wellbeing of staff on the Intensive Care Unit is at risk due to managing complex patients and families specifically following extraordinary circumstances such as the Pandemic, sudden death, and distressing situations with relatives.	Managing complex clinical and communication needs with patients and families. Responsibility to manage a higher ratio of patients as required and dealing with challenging situations and death that is difficult to rationalise.	All staff may have an inability to function at their designated role in a high stress situation. Increased risk of ill health, fatigue, anxiety and post traumatic stress disorder (PTSD symptoms)leading to potential increase in sickness. Impact on staff retention and staff morale.	4	5	20	HIGH	Clear leadership and team support. Staff health and well-being initiatives. Access to external psychological support. Individual stress risk assessments for staff.	Embedded psychological support from practitioners who are knowledgeable and skilled in Intensive care. Provision of Mental health First aid. Increase in staff morale, improved sickness/absence rates and retention of staff.	4	4	16	HIGH	Currently there is no embedded psychological support from practitioners who are knowledgeable and skilled in Intensive care. Staff may have a longer wait to access skilled psychological support.	4	2	8	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Evidence to support business case	18/08/2021	No Change	Ongoing risk	15/09/2021
3091			Deputy CEO	Ahmed, Ayca	Estates	Estates	Lack of access to the current Medical Equipment Asset Management Database.	Clinical Engineering and Medical Equipment Library team will not be able to perform their procedures and be compliant.	Clinical Engineering (CE) and Medical Equipment Library. Lack of access to the current MEAM Database to record PPMs, repairs, loans, report on assets for training logs and associated tasks and provide KPI reports in compliance with MHRA standards and as per the CQC guidelines – Regulation 15 Premises and Equipment. As a result of not being able to run a report from the database the CE team are unable to follow up on the outstanding PPMs which may cause clinical safety impact.	4	4	16	HIGH	IT provided access to remote desktop to connect to the server directly (Medical Equipment Library only), CE is to follow. Business Case approved, out to mini competition to market for alternative asset database.		4	4	16	HIGH	TBA	4	1	4	LOW	TREAT - above tolerable level - appropriate cost-effective control required		25/08/2021	No Change	new risk	27/12/2021
3033		07/05/2021	Deputy CEO	Beech, Jill	Core Clinical & Support Services - Diagnostic & Screening	Pathology	The Pathology LIMS system is at risk of failure, virus infiltration and being unsupported by the supplier.	The IT system is outdated and contract has limited time left.	Pathology service would be halted and contingency plans would have to be implemented. Sensitive information could lost or security of the information could be breached.	4	4	16	HIGH	Systems manager regularly liaises with Clinysis to rectify IT failures. Meetings with S4 to establish joint procurement take place periodically. Project Manager role identified to lead project for MKUH.	Controls are ineffective. Increasing incidences of of downtime and LIMS issues.	4	4	16	HIGH	Current system continues to malfunction and collapses.	4	1	4	LOW	TREAT - above tolerable level - appropriate cost-effective control required	To establish a project Plan and Timeline To breakdown potential risks within the project for MKUH Develop BC for additional staffing resource to support project	23/08/2021	No Change	Implementation of new LIMS	30/11/2021

3050		20/04/2021	Director of Clinical Services	Matthews, Dr Lucy	Medicine - Specialty Medicine	Neurology	Staffing risk for epilepsy service. Consultant lead on extended leave and no epilepsy specialist nurse in post. Follow-ups, responding to queries and First Seizure- type appointments are delayed. NICE CG137 guidance for First Seizures is to see patients within 14 days. Delay in transitioning paediatric patients with Epilepsy to Adult service.	Epilepsy lead on extended sick leave, epilepsy nurse retired - currently recruiting to fill the post.	The team may be unable to meet the standard (NICE CG137) of reviewing all First Fit patients within 14 days. Epilepsy follow-up appointments will be delayed. Patients do not have the benefit of an appointment with an epilepsy specialist nurse following first seizures, the diagnosis of epilepsy, pregnancy and breast feeding counselling. Potential risk of sudden unexpected death in epilepsy patients + obstetric risk. Reduced consultant cover contributing to backlog of new patients to be seen.	4	4	16	HIGH	- Agency locum in post temporarily, and are actively recruiting for a further NHS locum. - Substantive neurology consultants are seeing patients ad hoc and through waiting list initiative work. - The substantive neurology consultants are answering queries from patients and GPs when possible. - Recruitment of an epilepsy specialist nurse is underway. -Paediatric patients are discharged back to their GPs and some remain under CNWL community paediatric nurses -Urgent patients to be flagged to consultant Neurologists covering the Epilepsy service - Transition waiting has been shared to Adult service Ops Manager and consultant Neurologists		4	4	16	HIGH	- Nurse ANP - Wait list 630+	3	2	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required		21/06/2021	No Change	New Risk	20/09/2021
2791			Director of Clinical Services	Orr, Mrs Julie	Operations	Patient Discharge	Risk that patient discharges will significantly be delayed, especially those requiring complex coordination of the discharge process	The Discharge Coordinators (Registered Nurses B6 level) are currently severely short staffed due to vacancies and sudden long term sickness, with an additional Discharge Coordinator due to have major surgery leading to additional long term sickness. The Discharge Team currently consists of 5 wte B6 Registered Nurses. At present there are 3wte in post however 2wte are on long term sick leave.	complex discharges, leading to a potential for an increase in hospital acquired infections, de-conditioning Potential to affect the stranded and super stranded patient numbers and a failure achieve National target set for 2019-20, with associated impact on ED performance Increased delayed transfers of care (DToC) Poor patient experience due to the delays in discharge/discharge planning and referrals Other services capacity not being fully utilised due to delays in internal assessments Need for the Head of Clinical Services & Trust Lead for Discharge to take on some of the functions impacting on their daily roles significantly Increased workload & stress level for the remaining Discharge Coordinators in post Reduction in mandatory training compliance due to inability to release staff	4	5	20	HIGH	Covering a small number of shifts with former Discharge Coordinator carrying out bank shifts, when available. Offered bank shift to train an Agency Nurse who has shown an interest in the role. Recruited in to one vacancy and interviewing in to Bucks Coordinator role on 2/8/19. Reviewed role and delegated minor responsibilities to Rotational Operations Liaison Officers. Support requested from key nursing areas who have the skills to support a number of aspects relating to the role & discharge process- awaiting confirmation	Review of Datix incidents figures Superstranded patirnt data	4	4	16	HIGH	Additional funding to over recruit 1 WTE to for a 6 month period to cover the long term sickness	3	3	9	MOD	TREAT - above tolerable level - appropriate cost-effective control required		28/08/2019	No Change	New Risk	30/11/2019
2892			CEO	Noble, Deborah	Core Clinical & Support Services - Diagnostic & Screening	Imaging	The 10yr old mammography machine in BS2 could fail due to its age. The increased amount of unplanned downtime this year is consistent with aging equipment. With the introduction of new technologies the availability of replacement parts is a worry. A replacement part needed to be shipped from Chicago	Failure of the machine and unavailability of parts.	Failure of the machine would lead to a loss of service capacity for the 2ww clinics and NHSBSP programme which give have a detrimental effect on Trust metrics.	4	4	16	HIGH	Comprehensive service contract All faults reported immediately to external contractor / physicist for support. Robust QA systemin process to monitor system performance. This is reviewed weekly by medical physics.	QA monitored weekly by physicists.	4	4	16	HIGH	Availability of replacement parts.	3	1	3	VLOW	TREAT - above tolerable level - appropriate cost-effective control required		13/05/2021	Increased	Aging equipment	02/08/2021
2735			Deputy CEO	York, Craig	IT	Information Technology	IF the internal Trust telephone systems are not upgraded, THEN they will fall into a state where they cannot be supported by the Trust's IT Department or any third-party suppliers, LEADING TO potential loss of telephone systems either in small areas or across the Trust. This would have a significant impact upon operational procedures, especially during critical or busy periods.	Failure of the telephone system, communications being lost across critical areas.	As system versions get older, the likelihood of there being reliability issues increases, the cyber security threat increases, and the risk that telephone system suppliers stop supporting the system increases.	4	4	16	HIGH	Support in place, upgrade planned this year		4	4	16	HIGH	Upgrade planned this year	4	1	4	LOW	TREAT - above tolerable level - appropriate cost-effective control required		04/08/2021	No Change	No change - upgrade planned	30/11/2021
2055			Director of Corporate Affairs	Stamp, Mr Jamie	Core Clinical & Support Services - Clinical Support Services	Dietetics	The risk is that the trust is not providing suitable accommodation for the dietetic team, there are too many members of staff based in an inadequate space and also the portacabin is old and therefore is no longer suitable as an office environment. The trust is therefore failing in its statutory legal duty under the Health & Safety at Work etc. Act 1974, Management of Health & Safety at Work Regulations 1999, Workplace (Health, Safety & Welfare) Regulations 1992 and Display Screen Equipment Regulations 1992 to provide a safe and well maintained place of work including welfare facilities for staff	Health and Safety lead for the Trust has confirmed that the maximum number of staff by law would be 11 staff, this is exceeeded on a regular basis as staff are unable to write their notes on the wards due to a lack of WOWs.	1. Physical and mental wellbeing concerns in relation to staff welfare with potential for sickness absence and potential litigation claims 2. Multiple breaches of statutory and regulatory duties leading to interest from the Health & Safety Executive 3.Enforcement action including formal notices; potential criminal prosecution resulting in fines and/or imprisonment dependent upon the action pursued; loss of Trust reputation; adverse publicity	4	4	16	HIGH	Due to the number of staff within the area, increased number of staff are having to work from home (rota basis), however as all the team see inpatients this is limited. Mobile air conditioning units distributed during summer months. Plumbed in water cooler in situ. .	Number of staff in the portacabin at one time is limited to 12 (this is challenging and affects effectiveness of team) During hot weather the temperature in portacabin in monitored	4	4	16	HIGH	The portacabins continues to provide insufficient space for the staff using this base, this has been further compromised by the social distancing requirements for COVID-19.	2	3	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Risk to be reviewed by the Trust when office staff move to into MK Centre resolve short term issues - drinking water / flooring / window latches / changing facilities / secure path Upkeep of the portacabin including drinking water facilities, flooring and windown seals	03/08/2021	No Change	No change	05/10/2021

940	16	21/09/2021	Director of Finance	Hotchkin, Karan	Finance	Financial Management	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.	Increase in operational expenditure in order to manage COVID-19	1.Uncertaintly around the funding streams post Sept 21 2.Reductions in non-NHS income streams as a direct result of COVID-19.3.Impaired operating productivity leading to costs for extended working days and/or outsourcing. 4.Potential for material increase in efficiency requirement from NHS funding regime to support DHSC budget affordability.	4	5	20	HIGH	1. Cost and volume contracts replaced with block contracts (set nationally) for clinical income;2. Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until September 2021); 3. Budgets to be reset for FY22 based on financial regime; financial controls and oversight to be reintroduced to manage financial performance.4. Cost efficiency programme to be reset to target focus on areas of greatest opportunity to deliver	Monthly financial performance monitoring information by the F&I Committee and the Trust Board Cost efficiency reporting BLMK ICS finance performance reporting	4	4	16	HIGH	Financial regime for FY22 only valid for first half of the year. Trust has minimal ability to influence	4	2	8	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Maintain dialogue with CCG re Contract Raise risk of dispute over interpretation of Contract with Monitor	21/07/2021	No Change	no change	09/09/2021
1472	2	24/03/2021	Director of Corporate Affairs	Ewers, Mr Paul	Corporate Affairs	Risk Management	There is a risk that not all known incidents, accidents and near misses are reported onto Trust Incident Reporting System (Datix) and that they will not be robustly investigated within the required timescales	Failure to comply with the Incident Reporting Policy; Poor incident reporting culture; Lack of understanding of the necessity and importance of reporting incidents; Lack of incentives to report incidents due to lack of feedback or poor quality investigation outcomes; Lack of consequences for failing to report; Lack of consequences for poor quality investigations; Lack of computer access to report incidents; Conflicting priorities and lack of time to report; Perceived difficulty in completing the online incident reporting form	The Trust will not have a complete list of incidents occurring in the Trust; Inability to learn from incidents, accidents and near-misses; Inability to stop potentially preventable incidents occurring; Potential failure to comply with Duty of Candour legislation requiring the Trust to report all known incidents where the severity was moderate or higher; Potential under reporting to the National Reporting & Learning System (NRLS); Potential failure to meet Trust Key Performance	4	5	20	HIGH	1. Incident Reporting Policy 2. Incident Reporting Mandatory/Induction Training 3. Incident Reporting Training Guide and adhoc training as required 4. Datix Incident Investigation Training sessions 5. Daily review of incidents by Risk Management Team to identify potential Serious Incidents and appropriate escalation 6. Serious Incident Review Group (SIRG) ensure quality of Serious Incident Investigations 7. SIRG ensure appropriate reporting of Serious Incidents to Commissioners 8. Staff able to have automatic feedback following investigation approval 9. Incident Reporting Awareness Campaign - September 2017 10. Standard Operating Procedure re Risk & Governance Team supporting the closure of incident investigations during unprecedented demand on service (e.g. Covid-19 Pandemic) approved February 2021 11. Patient Safety Framework	1. Risk Management Dashboard monitoring trends 2. Weekly overdue incident reporting 3. Routine and exception reports to Risk & Compliance Board 4. Weekly Compliance Report to Executive Team 5. Incident reporting rate and overdue incidents monitored through Trust KPIs 6. Regular reporting to Divisions through Clinical Governance reports 7. Divisional Dashboards to monitor trends 8. Bi-monthly National Reporting & Learning System reports 9. Serious Incident Review Group upward reports 10. Monitoring of Serious Incident Investigations by MKCCG 11. Escalation to Patient Safety Board for scrutiny 12. Escalation to TEC	4	4	16	HIGH	1. Lack of a high incident reporting culture 2. Lack of robust investigations for non-Serious Incidents 3. Lack of feedback to reporters/staff following incident investigations 4. Staff lack access to a computer to report incidents 5. Staff lack time during shift to report incidents 6. More intuitive incident reporting system - procurement scoping exercise on going for Datix Cloud/new system (since agreed move to Radar from October 2020). Ongoing implementation plan	4	3	12	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Comms initiative being developed to coincide with launch of simpler incident reporting form and enhanced Incident reporting training at Induction/Mandatory Training - Complete Quality Improvement Project to be undertaken - Ongoing through Learning From Incidents Focus Group Recruitment of two new band 7 facilitators - complete Launch the 'SHARE' Incident Reporting Campaign with Comms Team - Complete Letter re-iterating the importance of incident reporting to be sent from CEO via wage slips - Decision made not to undertake - Complete Incident Reporting Handbook for staff to coincide with 'SHARE' launch to be developed - Decision made not to undertake - Complete Consider the increase of accessibility to computers in order to report incidents at Risk & Compliance Board - Complete Datix Manager to speak to higher reporting Trusts to see how they have developed an effective reporting culture - Complete	06/07/2021	No Change	No change since last review	31/08/2021
767	3-2	30/03/2021	Director of Clinical Services	James, Mr Andrew	Surgical - Musculoskeletal	Trauma & Orthopaedics	There is a risk to head injury patients not being appropriately cared for as they are not being treated in accordance with NICE guidance (CG176: Head injury: assessment and early management, updated September 2019)	1. NICE guidance sets out very specific recommendations for where and how patients should be managed and treated 2. Clinicians may have to wait for an opinion from the Tertiary Centre at Oxford 3. Head injuries frequently fall under the remit of the T&O Team or be nursed on a surgical ward(patients should be under neurological team).	- Potential reduction in patient safety - T&O surgeons and nursing teams may be unaware of how to care for patients with moderate to severe head injuries especially patient who are anticoagulated. - Clinicians may have to wait for an opinion from the Tertiary Centre. - Staff training, competency and experience - Serious incidents. - Reduced patient experience	4	3	12	MOD	1, 2 & 3. Preventive controls - On going discussions with Senior Medical Team - CSU Lead to escalate via trauma network - Alert process is in place for escalation within T&O & externally. - Resources available at tertiary site for advice/support 1, 2 c& 3. mitigating controls - Policy for management of head injuries has been developed - Awaiting appointment of head injury liaison Nurse - Long term plan for observation block to be built.	25/03/2021 Team continue to express concerns around the allocation of head injury patients to T&O. - Monitoring of Datix reported incidents by CGL for Surgery and CSU Lead - Team discussion of incidents/mortalities at CIG and M&M meetings.	4	4	16	HIGH	- 29/03/2021 T&O continues to received referral for complex head injury patients. - 23/09/2020 T&O continues to receive referrals for complex head injury patients under their speciality. - 28/01/2020 despite agreed pathway for admitting head injury patients under T&O team - non complex/ significant co-morbidities/ or anticoagulated the team are still having to care for these patient. - Trust is not in line with other trauma units - Regional trauma centre advises head injury should not be managed by trauma and orthopaedics and after 24 hours the patient should be referred to neurosurgery. - Potential delay in opinion from Tertiary Centre	4	2	8	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Monitoring of incidents where tertiary advice/support was not available Monitor incidents where delay in tertiary opinion has occurred	21/07/2021	No Change	Ongoing risk	30/09/2021
2570	18	30/03/2021	Director of Clinical Services	Gawlowski, Dr Zuzanna	Women's & Children's Health - Children's Health	Neonatal	Overcrowding and insufficient space in the Neonatal Unit, exacerbated by need for social distancing due to COVID-19. The milk kitchen was condemned due to this.	Cot spacing does not comply with BAPM guidance or the latest PHE guidance for COVID-19. The Unit is seeking to increase both total cot spacing and cot numbers by 4 HDU/ITU cots in line with Network 5 year projections of acuity and demand, and spacing in line with National Recommendations.	Without the increase in cot numbers and corresponding cot spacing we will be unable to meet patient needs or network requirements. We will now also be unable to meet PHE recommendations for social distancing This may result in a removal of Level 2 status if we continue to have insufficient space to adequately fulfil our Network responsibilities and deliver care in line with national requirements. This may also impact on our ability to protect babies and their families during COVID	5	5	25	HIGH	1. Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards 2. Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID 3. Added to capital plan 4. Feasibility study completed	1. NNU Feasibility study in progress awaiting decision of the Board as to whether to proceed with major reconfiguaration and increased cots to meet TVN demand. 2.Planning for a specific W&C build is being discussed	5	4	20	HIGH	1. Outline business case for NNU rebuild has been developed by Trust and estates department and submitted to CCG/STP partners for consideration. Awaiting final decisions	3	3	9	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Approval of business case - Complete Business Case for Refurnishing Milk Kitchen and Sluice	02/08/2021	No Change	No change	30/11/2021
2920		05/05/2021	Director of Clinical Services	Biggs, Adam	Operations	Emergency Planning	The risk of capabilities in responding to a Novel Coronavirus (COVID-19) impacting on patient care within clinical and non-clinical services, with the inability to maintain safety for staff and patients due to national pressures on supplies and infrastructure.	Surge of COVID-19 patients impacting on Trust ability to maintain patient care and clinical services. Loss of staff to support clinical and non-clinical services due to high levels of absence. Loss of national stockpile in PPE or medical devices (ventilators) resulting in the Trust not receiving deliveries to preserve the safety of patients and staff.	Loss of clinical and non-clinical services Financial impacts Risk to patient care Risk to staff wellbeing	5	5	25	HIGH	COVID-19 operational and contingency plans in place reviewed through Silver and Gold command structure, with meeting recorded through action logs PPE logged daily covering delivery and current stock		5	4	20	HIGH	Trust has no control over national stockpile of PPE and medical devices required for response. This is monitored and reported daily.	5	3	15	HIGH	TREAT - above tolerable level - appropriate cost-effective control required		21/10/2020	No Change	National oversight	09/11/2020

2928			Director of Corporate Affairs	Evans, Ms Joanne (Inactive User)	Core Clinical & Support Services - Diagnostic & Screening	Imaging	Lack of capacity for appropriate management of CT and MRI within KPI and DM01 timescales	The issue is increasing demand at upto 14% annually with a requirement to reduce turnaround times. Covid has added to the burden with covid recovery posing a significant risk to the service. Workload is increasing significantly but both CT and MRI are working at caqpacity and have no flexibility to increase capacity without additional staff and equipment.	Financial due to missed targets Reputation due to long waiting times Reputation and financial due to increased infection rates Staff leaving due to poor working conditions. This is delaying patient management and causing issues with meeting the diagnostic waiting times. Inability to manage patients privacy and dignity also increased risk of infection due to overcrowding of faciliities.	4	5	20	HIGH	Extended working hours and days, some scans sent off site to manage demand. Reduced appointment times to optimise service. 1.12.20 no change to risk rating services remain challenged due to lack of basic capacity made worse by Covid social distancing and cleaning issues. 1.6.21 Ongoing capacity issues, situation deteriorating as post covid activity builds up. Case approved for mobile MRI capacity which should be implemented in June Case for additional CT declined by Trust to be revisited in July 2021. IS provider approached to provide more MRI capacity	Future plans will increase MRI capacity and support through to Dec 21 at which point the modular units should be operational. CT capacity plan still unresolved.	4	5	20	HIGH	Currently still capacity gaps with increasing numbers of patients waiting over 42 days for routine scanning, breaching DM01 requirements	2	2	4	LOW	TREAT - above tolerable level - appropriate cost-effective control required		01/12/2020	Increased	INcreased risk	30/06/2021
2796			Director of Clinical Services	Chadwick, Ms Helen	Core Clinical & Support Services - Pharmacy	Pharmacy	The risk is there will be insuffient staff in pharmacy to meet demands of the organisation and ensure patient safety in the use of medicines.	High turnover of staff due to: work pressure, not having the opportunity to work at the top of their licence, lack of capacity for development, lack of capacity for supervision / support. Also difficulty in recruiting particuarly to 8a posts. Loss of staff to primary care which offers more attractive working hours.	1. increased length of stay due to TTO delay 2. increase in prescribing errors not corrected 3. increase in dispensing errors 4. increase in missed doses 5. failure to meet legal requirements for safe and secure use of medicines All resulting in adverse patient outcomes. Lack of financial control on medicines expenditure Breach of CQC regulations	4	5	20	HIGH	Actively recruiting, listening events with staff, implementing 1-1 system to support staff, reviewing work activities of 8a's and above to identify what could stop for a period of time. Recruitment of additional Pharmacy technicians requested Aug19. Approved end of 2020. 3 appointed and in training.	Staff feedback HR metrics eg turnover Medicines reconciliation rate Datix rate	4	5	20	HIGH	Use of senior staff to support not viable long term - 28/5/21 This action has resulted in further deterioration in morale and ability to make change, increased losses Maternity leave returners leaving for more flexible / family friendly working hours	2	3	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Bc to execes Internal review of Clinical service Undertake workforce analysis Develop a business case for the clinical pharmacy servcie Implement changes recommended in review	28/05/2021	No Change	No change - capacity	31/07/2021
3062			Director of Clinical Services	Barton-Young, Mr Phillip	Surgical - Head & Neck	Ophthalmology	Clinical data stored on visual field machine hard drives for Ophthalmology Department patients will not be transferred between two machines (visual field analysers & Windows XP computer). There is a risk of irretrievable loss of patient data when manually transferring data using USB sticks.	Both of the two Humphrey HFA 2i machines within Ophthalmology Department are outdated and there is no backup. The visual field machines are not connected to the server and currently rely on a Windows XP computer to transfer data between the two machines. The Windows XP system is no longer supported by the IT department at MKUH or by Zeiss, the manufacturer of the machines	Machines accurately calculate decline in vision therefore assessment, diagnosis and monitoring could be significantly compromised. Consultant Ophthalmologists and other clinical staff would not be able to accurately compare between tests meaning that patient treatment could be negatively impacted as there is a risk of missing progressive disease.	4	4	16	HIGH	Data is currently stored on visual machine hard drives and Windows XP computer. It has been recommended that Data is exchanged using unencrypted USB drives.	Monitoring of incidents in relation to patient data and functionality of both machines. 19/07/2021 two new machines have been purchased awaiting items to be in situ and then risk can be closed. 17/05/2021 full business case needs to be submitted as previous business case not approved.	4	5	20	HIGH	N/A	4	1	4	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Business case to purchase replacement visual field analysers	19/07/2021	No Change	New risk	20/09/2021
2945		30/03/2021	Director of Clinical Services	Philpott, Ms Katy	Women's & Children's Health - Women's Health	Obstetrics & Maternity	Risk of insufficient scanning capacity to meet criteria of Saving Babies Lives (SBL) version 2	Small for Gestational age not being identified in a timely manner as per the Saving Babies Lives pathway SBL version 2. Lack of capacity resulting in decreased frequency of obstetric scanning which is in contrast to saving babies life bundle (SBLB). SBL bundle version 2. Decreased frequency of obstetric scanning which is in contrast to saving babies life bundle (SBLB).	Potential poor outcomes on non-identification of risks in pregnancy	4	4	16	HIGH	We do serial scanning on women fulfilling the criteria of SBLB	Monitoring SBL v1 KPIs Incident reporting SBL action plan	4	5	20	HIGH	Increased capacity within Imaging	2	2	4	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Imaging Business Care to increase capacity - Outside of Women's Health's control	11/08/2021	Increased	new risk	21/09/2021
3105			Director of Corporate Affairs	Ewers, Mr Paul	Corporate Affairs	Risk Management	There is a risk that the Trust will not be able to access the old (legacy) incident, complaint, claims, safety alert data once the current annual license expires at the end of November 2021	The Trust is moving to a new Risk Management System (RMS) Inability to electronically transfer the legacy data to the new RMS provider. The vast volume of complex data recorded on Datix.	Inability for the Trust to defend itself against future claims/litigation leading to potential financial penalties, improvement notices etc. Inability to evidence compliance with CQC regulations and freedom of information requests. Inability to run benchmarking / trend reports if access to the old data is not maintained. Potential increase in incidents, complaints and claims due to lack of learning from incidents. Difficulty and delay in obtaining reports where the required data spans both Datix and Radar. Manual transfer of data exposes the Trust to significant risk of data quality issues impacting on the Trust's ability to defend itself in relation to claims and litigation.	5	5	25	HIGH	Current Datix License in place until 30th November 2021 Plan in place for extension of Datix Client read-only license for key staff (x14)	Business Case included the need for read-only access to Datix Client for at least 1 year post current Datix license	5	4	20	HIGH	Long-term solution in place for the ongoing access to old Datix (legacy) data	5	1	5	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Develop options paper for long term access to legacy data	13/08/2021	No Change	New Risk	30/09/2021

Meeting Title	Trust Board	**Date:** September 2021
Report Title	Board Assurance Framework	**Agenda Item: 15**
Lead Director	**Name:** Kate Jarman	**Title:** Director of Corporate Affairs and Communication
Report Author	**Name: Kwame Mensa-Bonsu**	**Title: Trust Secretary**

Key Highlights/ Summary	Board Assurance Framework containing the principal risks against the Trust's objectives. 1. The risk score for the following risk entry has been revised downwards: a. Risk Entry 22 – From 12 to 8 (page 50). (NB: This risk has been removed from the Health Education England-Thames Valley Risk Register and will be removed from the Trust Risk Register after September 2021). 2. The risk score for the following risk entry has been revised upwards: a. Risk Entry 1 – From 12 to 16 (Page 6)			
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Noting** [ ]	**For Review** [ ]

Strategic Objectives Links	All
Board Assurance Framework (BAF)/ Risk Register Links	All

Report History	Board Committees and Trust Executive Group
Next Steps	N/A
Appendices/Attachments	Board Assurance Framework

The Board Assurance Framework – Summary of Activity in August 2021

COVID-19 Risks

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

The Board Assurance Framework

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

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

Strategic Objectives

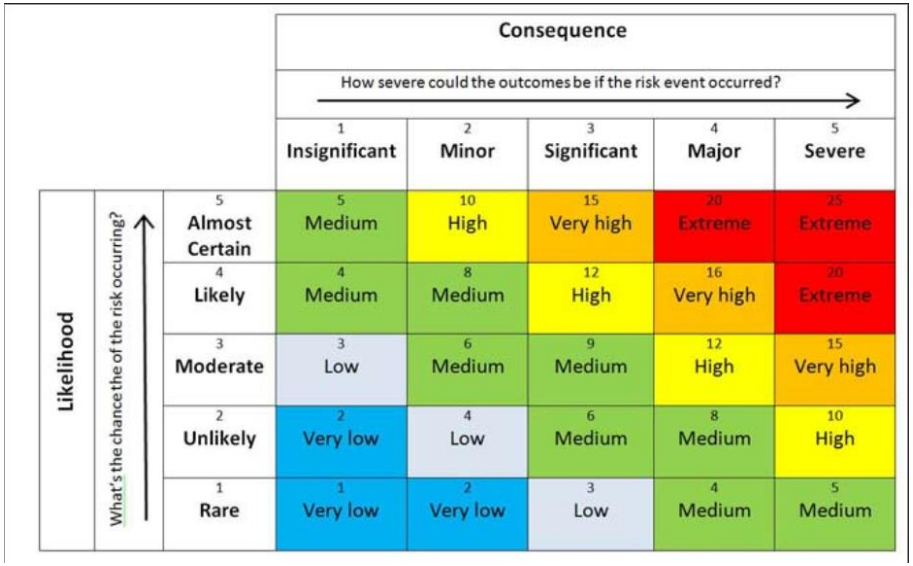
1. Improving patient safety
2. Improving patient experience
3. Improving clinical effectiveness
4. Delivering key performance targets
5. Developing MK at place
6. Developing teaching and research
7. Being well governed and financially viable
8. Investing in our people
9. Developing our estate
10. Being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

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

Assurance ratings:

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

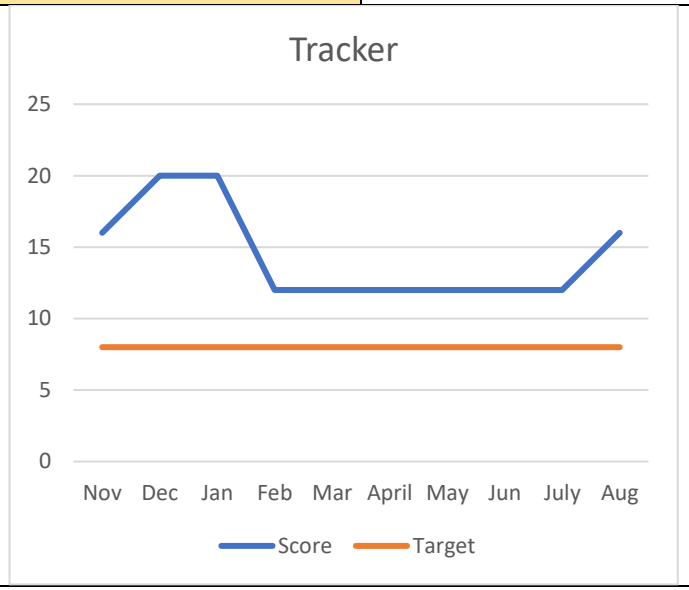
5X5 Risk Matrix:



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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust's ED does not have adequate staffing and estate capacity, and effective escalation plans, it will not be able to maintain patient safety during periods of overwhelming demand.				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Operations	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	03/08/21	**Risk Rating**	16	8		



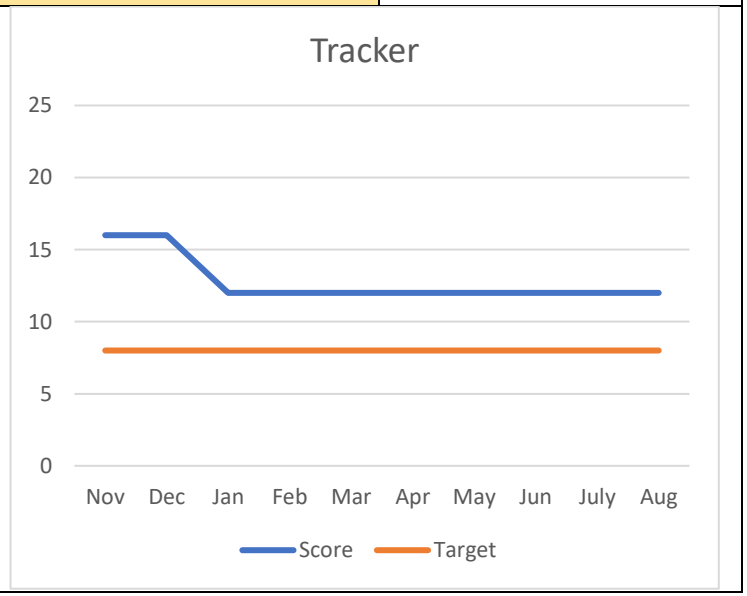
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Significant increase in activity and	Clinically and operationally	ED staffing levels -	Ongoing recruitment drive and	Daily huddle / silver command and hospital	Short term sickness or unexpected	Appropriate escalation.	

number of patients through the ED Significantly higher acuity of patients through the ED Major incident/ pandemic – constraints on space and adherence to IPC measures.	agreed escalation plan Adherence to national OPEL escalation management system Clinically risk assessed escalation areas available. Surge plans, COVID-specific SOPs and protocols have been developed. Emergency admission avoidance pathways, SDEC and ambulatory care services.	vacancies in nurse staffing, higher than normal staff absences and sickness Increased volume of ambulance conveyances and handover delays. Over-crowding in waiting areas at peak times. Admission areas and flow management issues. Reduction in bed capacity / configuration issues through estates work.	review of staffing models and skill mix. Redeployment of staff from other areas to the ED at critical times of need. Enhanced clinical staff numbers on current rotas Services and escalation plans under continuous review in response to shrinking pandemic numbers and related non covid pressures	site meetings in hours. Out of hours on call management structure. ED dashboard on Trust information portal. System-wide (MK/BLMK/ICS) Partnership Board, Alliance & Weekly Health Cell. Daily system resilience report (BLMK) Regional and National reporting requirements - Daily COVID sitrep.	staffing levels / surges Details of Winter Plan not yet complete.	Director of Operations oversight delivering the Winter Plan.	

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If an effective reporting, investigation and learning loop is not established and maintained, the Trust will fail to embed learning and preventative measures following serious incidents/ Never Events.				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	16/08/21	**Risk Rating**	12	8		



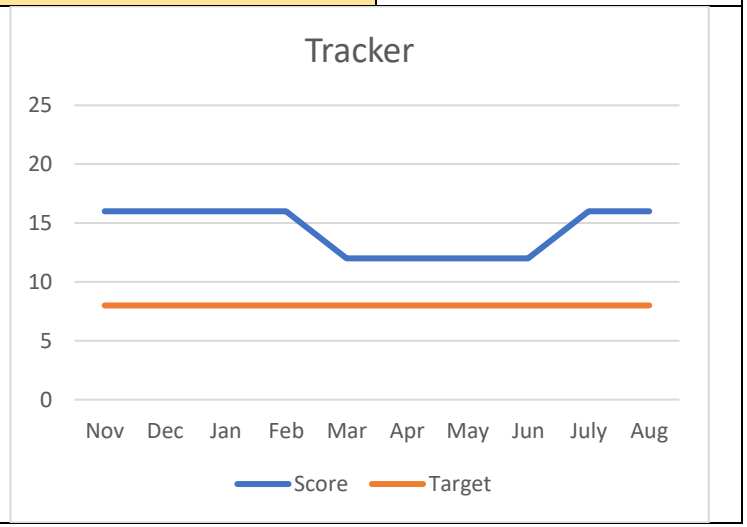
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Not appropriately reporting, investigating or	Improvement in incident reporting rates	Establishing Learning and Improvement Board	October 2020 - ongoing	NRLS data SIRG	None Currently	None Currently	

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

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust is unable to accurately predict demand (for example, relating to the COVID-19 pandemic) and re-purpose its resources (physical, human and financial) with agility, the Trust will fail to manage clinical risk during periods of sustained or rapid change in the level or type of demand.				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	16/08/21	**Risk Rating**	16	8		



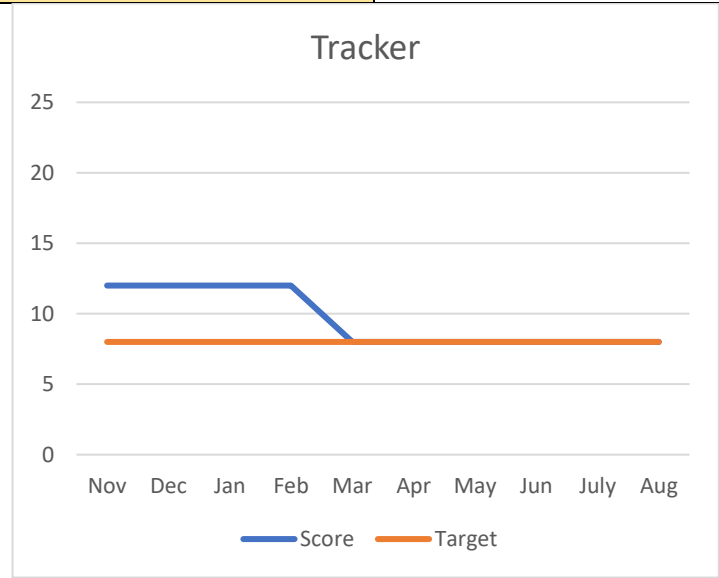
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Rapid or sustained period of upheaval and	Board approved major incident plan and procedures	Inability to accurately predict or	On going dialogue with	MK place-based and ICS-based planning	Incomplete oversight of OP delays	Enhanced visibility of OPD PTL	

change caused by the Covid-19 pandemic and need to respond and maintain clinical safety and quality Risks have increased (since May 2021) in view of the combination of planned and emergency demand which exceeds pre-pandemic levels, coupled with a resurgence in COVID cases is placing the Trust under significant pressure. Number of vacant beds fewer / inpatient density higher.	Rigorous monitoring of capacity, performance and quality indicators Established command and control governance mechanisms Gold (Daily) Level 3/4 Incident management	forecast levels of activity and risk	community partners	and resilience fora Regional and national data and forecasting COVID MARC Meeting (Data, Intelligence, Collaboration with partners)		and non RTT pathways	

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust does not carefully manage its significant digital change programme, then the delivery of clinical services may be impaired				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Deputy CEO	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	19/08/21	**Risk Rating**	8	8		



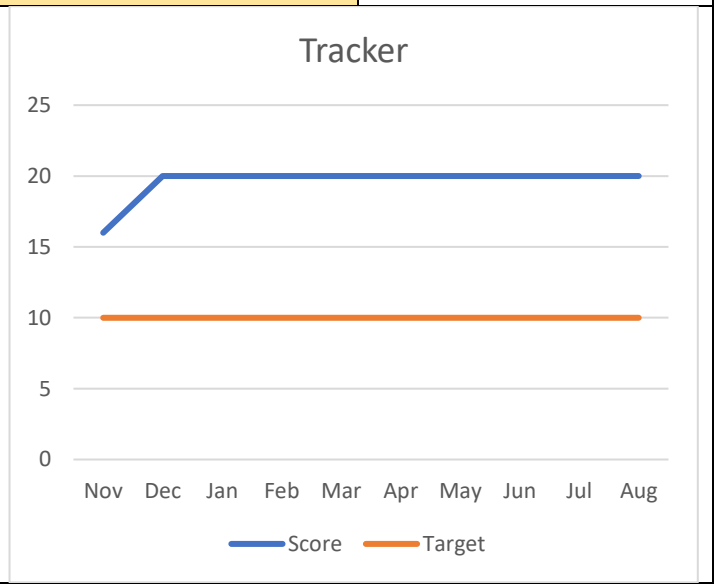
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Inadequate assessment of clinical risk/ impact on clinical services or practices	Robust governance structures in place with programme management at all levels	None currently	Continue to maintain programme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

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

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust is unable to provide capacity to match demand for elective care, (such as for cancer and screening programmes), there is a risk that this could lead to patient harm.				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Operations	**Consequence**	5	5	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	03/08/21	**Risk Rating**	20	10		



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

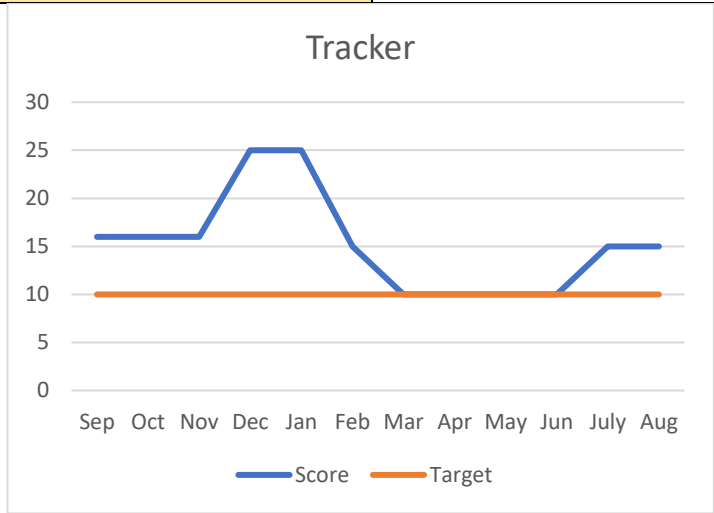
and other pathways, during the peaks of the Covid-19 pandemic Inability to match capacity with demand	Granular understanding of demand and capacity requirements with use of national tools. Robust oversight at Board, and sub committees. Divisional and CSU management of WL. Agreement of local standards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

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

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust does not establish and maintain effective capacity management processes it will be unable to cope with high demand for ITU and inpatient care during a public health crisis (or due to the Covid-19 pandemic)				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	5	5	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	19/08/21	**Risk Rating**	15	10		



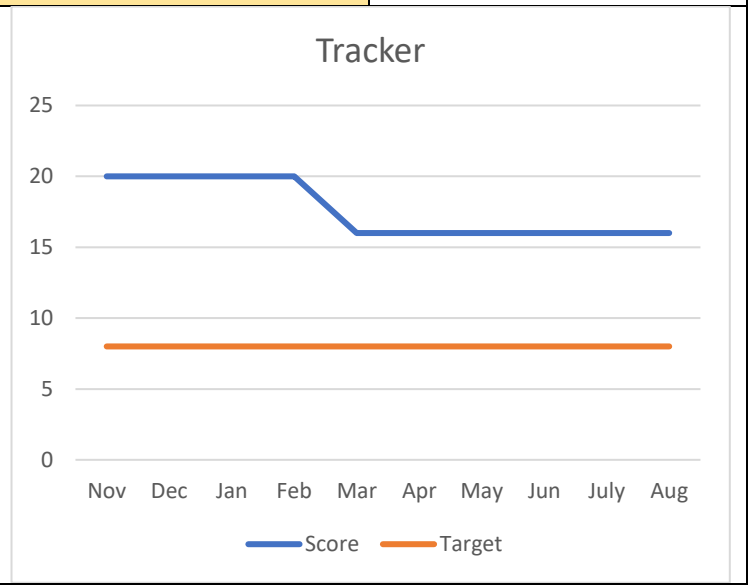
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Demand for ITU and inpatient beds exceeds capacity, including	Increased capacity across the hospital	Inability to accurately forecast demand	On going dialogue with	Tested escalation plans	None currently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

escalation capacity within the hospital and regionally. Risks have increased (since May 2021) in view of the combination of planned and emergency demand which exceeds pre-pandemic levels, coupled with a resurgence in COVID cases is placing the Trust under significant pressure.	Increased capacity for ITU Clear escalation plans Real time visibility of regional demand/ capacity		community partners	Active part of regional networks Clear view of CPAP support for COVID-19 patients Medical Director and Chief Nurse liaising with teams			

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

Strategic Objective 2: Improving Patient Experience

Strategic Risk	If the radiotherapy pathway provided until 2019/20 in Milton Keynes by Genesis Care (under contract with OUH) is not replaced, the access and experience of patients on clinical oncology (radiotherapy) pathways will continue to be negatively impacted.				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	19/08/21	**Risk Rating**	16	8		



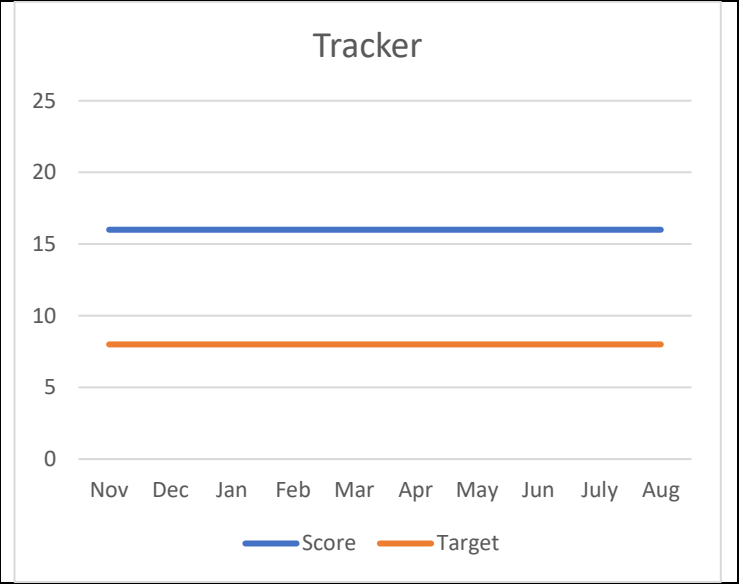
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Break down in the established relationship (subcontract) between Oxford	Contingency for the provision of treatment to patients in Oxford and the ongoing provision of palliative	Contracting and commissioning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

University Hospitals and the private Genesis Care facility (Linford Wood, Milton Keynes) which has provided local radiotherapy to MK residents for the last six years. This breakdown results in less choice and longer travel distances for patients requiring radiotherapy. Patients tend not to differentiate between the different NHS provider organisations. This risk materialised 16.12.2019 when the contract expired and no extension was agreed.	and prostate radiotherapy at Linford Wood or in Northampton Promotion of agreement between OUH and Northampton General Hospital to facilitate access to facilities at Northampton for those who prefer treatment in this location. Proactive communications strategy in relation to current service delivery issues.	control or management Specific issues with the ICS CDEL limits			Impact of ICS capital control limits		

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

Strategic Objective 2: Improving Patient Experience

Strategic Risk	If the Trust does not effectively work with patients and families in delivering care and positive patient experience the national patient surveys may not demonstrate improvement.				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Chief Nurse	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	20/08/21	**Risk Rating**	16	8		



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

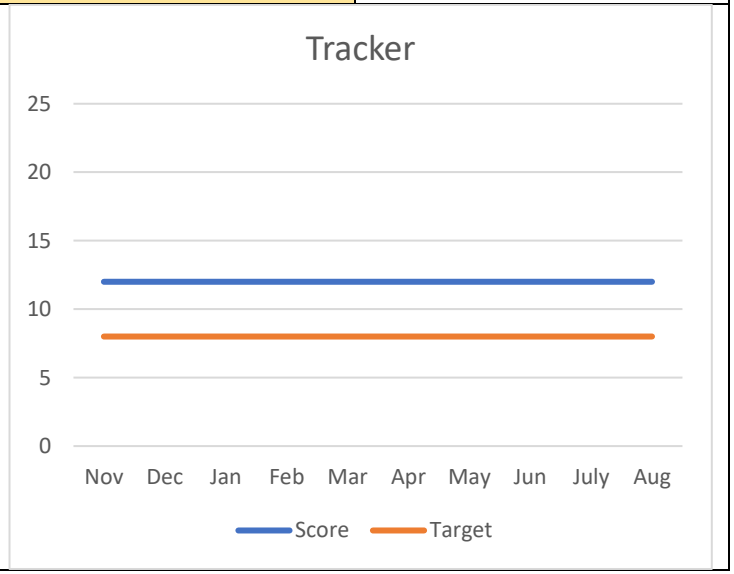
(measured through the national surveys). Children and Young People Survey Adult Inpatient Survey Urgent and Emergency Care Survey Maternity Survey Cancer Patient Experience Survey	governance arrangements in place at Trust, division and department levels, including but not limited to: • Patent Experience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

	operational meetings and supporting substructure of steering groups.			**External Reviews:** Healthwatch Maternity Voices partnership (MVP) Cancer Patient Partnership **Website:** 'You said we did'			

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

Strategic Objective 2: Improving Patient Experience

Strategic Risk	If the Trust does not effectively work to use feedback from complaints and PALS contacts to inform learning and embed related changes patient experience will not be improved.				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Chief Nurse	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	20/08/21	**Risk Rating**	12	8		



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

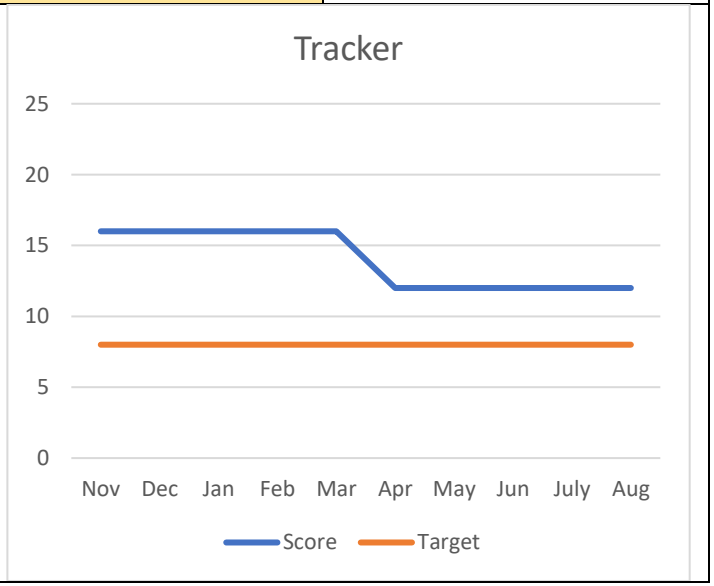
of complaints and PALS contacts.	division and department levels, including but not limited to: • Patent Experience Strategy • Learning Disabilities Strategy • Dementia Strategy • Nutrition steering group • Catering steering group • Domestic planning group • Discharge steering group • Induction training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

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

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

Strategic Objective 3: Improving Clinical Effectiveness

Strategic Risk	If clinical audit requirements are not completed the Trust will fail to meet the requirements of clinical compliance regimes including NICE				**Strategic Objective**	Improving Clinical Effectiveness
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Corporate Affairs	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	20/08/21	**Risk Rating**	12	8		

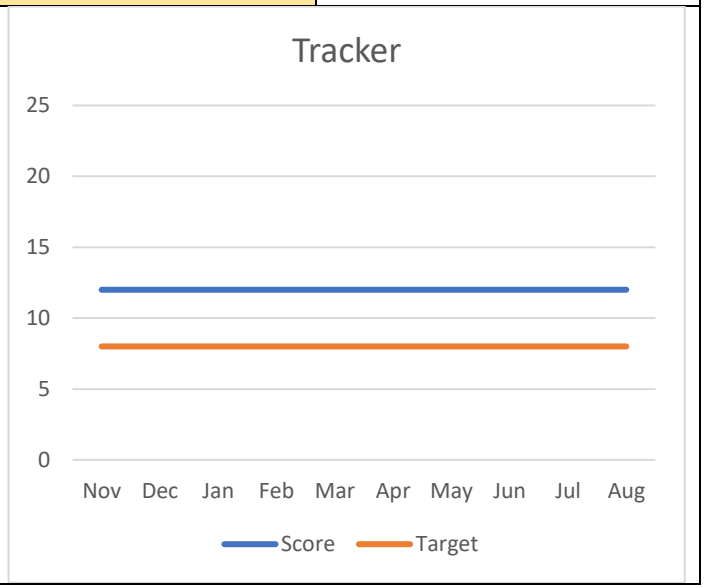


Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
1. Lack of understanding/ awareness of audit requirements by	1. Designated audit leads in CSUs/ divisions 2. Clinical governance and administrative	1. Resource to complete audits 2. Audit policy out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

clinical audit leads 2. Resources not adequate to support data collection/ interpretation/ input 3. Audit programme poorly communicated 4. Lack of engagement in audit programme 5. Compliance expectations not understood/ overly complex	support - allocated by division 3. Recruited additional clinical governance post to medicine to support audit function (highest volume of audits) 3. Audit programme being simplified, with increased collaboration and work through the QI programme 4. Audit compliance criteria being segmented to enable focus on compliance with data returns; opportunity for learning/ changing practice and communication/ engagement 5. Monthly review of all compliance requirements, including NICE and policies		2. Audit policy being reviewed and re-written (advanced first draft commented on for further review April 21)	External benchmarking			

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

Strategic Objective 3: Improving Clinical Effectiveness

Strategic Risk	If the Trust is unable to establish robust governance around data quality processes, there is the risk that this could lead to patient harm, reputational damage and regulatory failure.						**Strategic Objective**	Improving Clinical Effectiveness
Lead Committee	Audit	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm		
Executive Lead	Director of Operations	**Consequence**	4	4	**Risk Appetite**	Minimal		
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat		
Date of Review	03/08/21	**Risk Rating**	12	8				

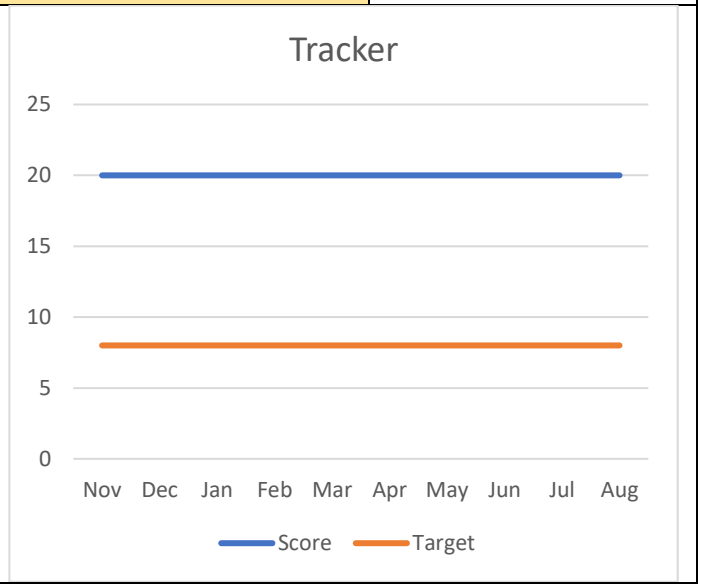
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Failure to ensure adequate data quality leading to patient harm, reputational risk	Robust governance around data quality processes including executive ownership	RPAS will reduce the numbers of manual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

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

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

Strategic Objective 4: Meeting Key Targets

Strategic Risk	If the Trust does not establish and maintain effective capacity management processes it will be unable to achieve waiting time targets due to seasonal emergency pressure (or further Covid-19 surges).				**Strategic Objective**	Meeting Key Targets
Lead Committee	TEG	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Operations	**Consequence**	5	5	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	03/08/21	**Risk Rating**	20	10		



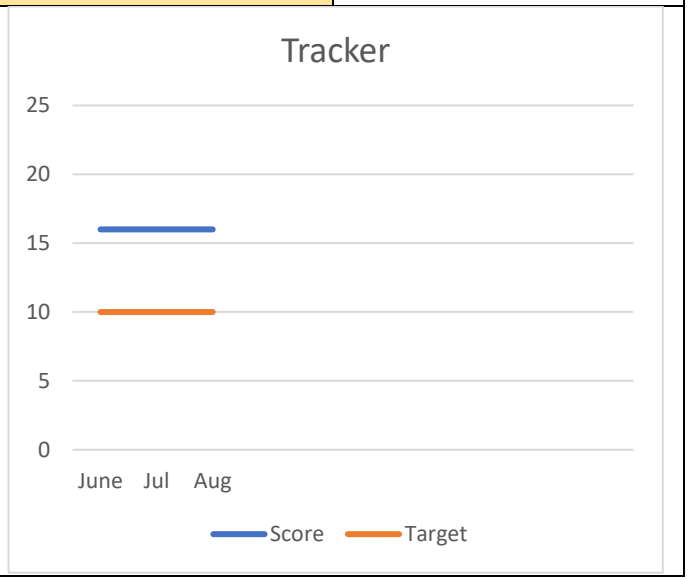
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Elective activity is suspended (locally or by national directive) to enable the Trust to	Winter escalation plans to flex demand and capacity	Unpredictable nature of both emergency demand and the	Continued planning and daily reviews (depending	Emergency Care Board (external partners)	None Currently	None Currently	

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

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

Strategic Objective 7: Being Well Governed and Financially Viable

Strategic Risk	If the Trust does not have a sufficient capital expenditure limit (CDEL) then the Trust will not be able to complete the level of planned capital investment				**Strategic Objective**	Being Well Governed and Financially Viable
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	DoF	**Consequence**	4	5	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	16/08/21	**Risk Rating**	16	10		



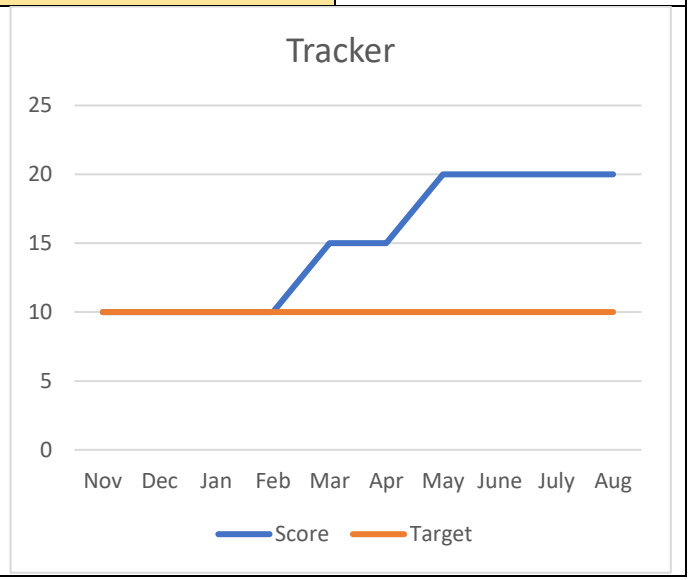
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Following the FY21 year end audit the Trust had to adjust misstated capital expenditure	The Trust is introducing enhanced in-year capital spend monitoring to proactively manage	The Trust has limited control over the availability and reassignment of	The Trust will report the capital expenditure position	Monthly capital report and BAF	CDEL reporting oversight at regional level	The Trust will engage with the NHSE/I	

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

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

Strategic Objective 7: Being Well Governed and Financially Viable

Strategic Risk	If the Trust does not maintain investment in its IT infrastructure and systems, then all operational systems will be severely affected by IT failures such infiltration by cyber criminals.				**Strategic Objective**	Being Well Governed and Financially Viable
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	Deputy CEO	**Consequence**	5	5	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	19/08//21	**Risk Rating**	20	10		



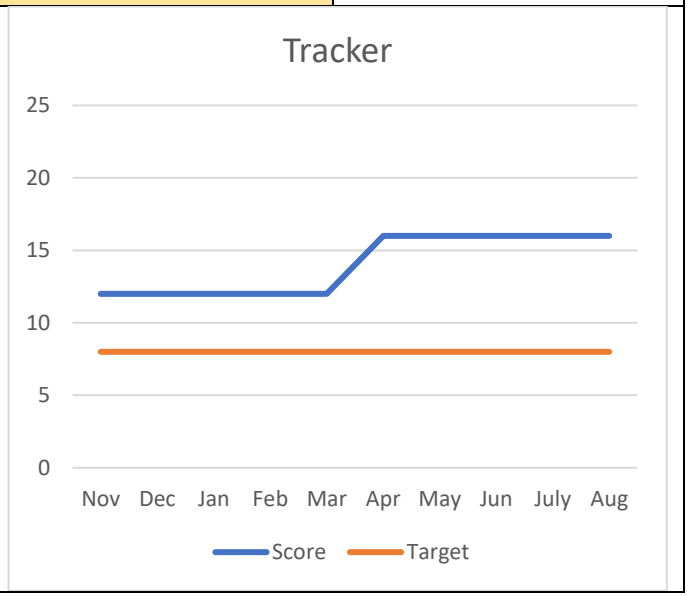
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Hardware failure due aged equipment	2 dedicated cyber security posts Good network protection from cyber	None identified	Continued review	External review and reporting	None currently	None currently	

Increasing Cyber-attacks across the world and in particular in Ireland	security breaches such as Advanced Threat Protection (ATP) – A part of the national programmes to protect the cyber security of the hospital All Trust PCs less than 4 years old Purchase new hardware – not implemented yet EPR investment			Purchases new equipment to install in 9 months			

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

Strategic Objective 7: Being Well Governed and Financially Viable

Strategic Risk	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.				**Strategic Objective**	Being Well Governed and Financially Viable
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	DoF	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	16/08/21	**Risk Rating**	16	8		



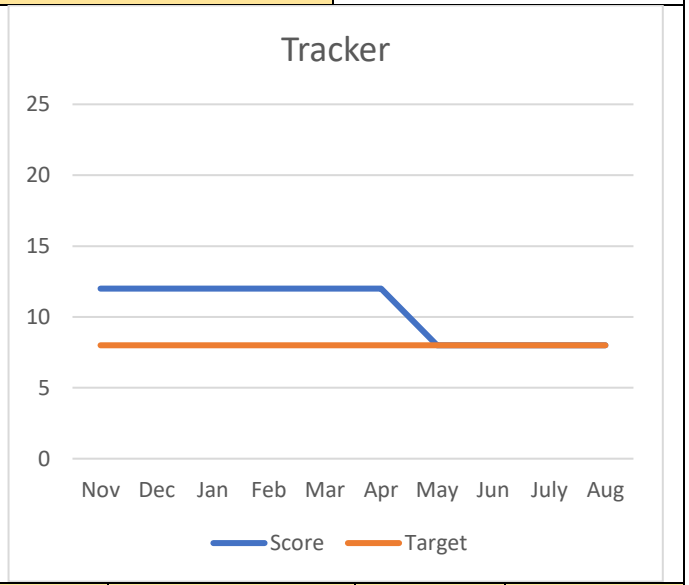
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Increase in operational expenditure in order to manage COVID-19	1. Cost and volume contracts replaced with block contracts (set nationally) for clinical income;	Financial regime for FY22 only valid for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

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

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

Strategic Objective 7: Being Well Governed and Financially Viable

Strategic Risk	Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care				**Strategic Objective**	Being Well Governed and Financially Viable/ Patient Safety
Lead Committee	Finance and Investment and Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	Deputy Chief Executive	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	19/08/21	**Risk Rating**	8	8		



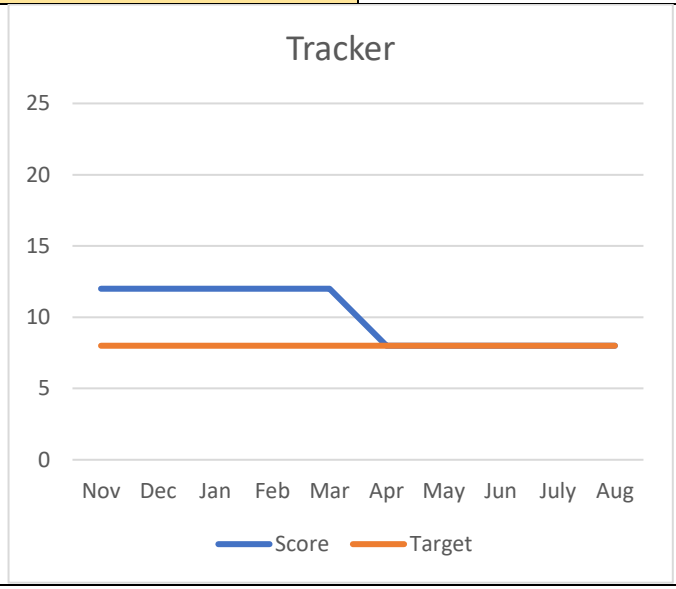
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
The current size of the Neonatal Unit does not meet the demands of the service. This risks high numbers of transfers of unwell	Reconfiguration of cots to create more space Additional cots to increase capacity	External timeframe and approval process for HIP2 funding	Continued review	External review and reporting. Whilst a technical risk the likelihood has been downgraded on	None Currently	None Currently	

babies and potential delayed repatriation of babies back to the hospital. There is a risk that if the Trust continues to have insufficient space in its NNU, the unit's current Level 2 status could be removed on the basis that the Trust is unable to fulfil its Network responsibilities and deliver care in line with national requirements.	Parents asked to leave NNU during interventional procedures, ward rounds, etc to increase available space. HIP2 funding for new Women and Children's Hospital announced.			the basis of actual reporting			

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

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust does not retain staff then posts will be vacant resulting in workforce shortages across the hospital or increased temporary staffing expenditure.				**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	17/08/21	**Risk Rating**	8	8		



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

development or opportunities for progression Benefits packages elsewhere Culture within isolated departments	Schwartz Rounds and coaching collaboratives Recruitment and retention premia We Care programme Onboarding and exit strategies/reporting Staff survey Learning and development programmes Health and wellbeing initiatives, including P2P and Care First Staff friends and family results/action plans Links to the University of Buckingham Staff recognition - staff awards, long service awards, GEM Leadership development and talent management Succession planning Enhancement and increased visibility of benefits package Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and deliver improvement to						

	working experience/ environment. Enhanced Benefits Package						

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

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust does not recruit to vacancies in the short term (0-18 months) then there will be workforce shortages across the hospital and/or increased temporary staffing expenditure.						**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff	At target level – no tracker	
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Cautious		
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Tolerate		
Date of Review	19/08/21	**Risk Rating**	8	8				

Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
National shortages of appropriately qualified staff in some clinical roles, particularly at consultant level for dermatology and acute medicine, and at middle grade level for urology and trauma and orthopaedics	Active monitoring of workforce key performance indicators Targeted overseas recruitment activity Apprenticeships and work experience opportunities Exploration and use of new roles to help bridge particular gaps	None Currently	Continued review	External review and reporting Vacancy Rates	None Currently	None Currently	

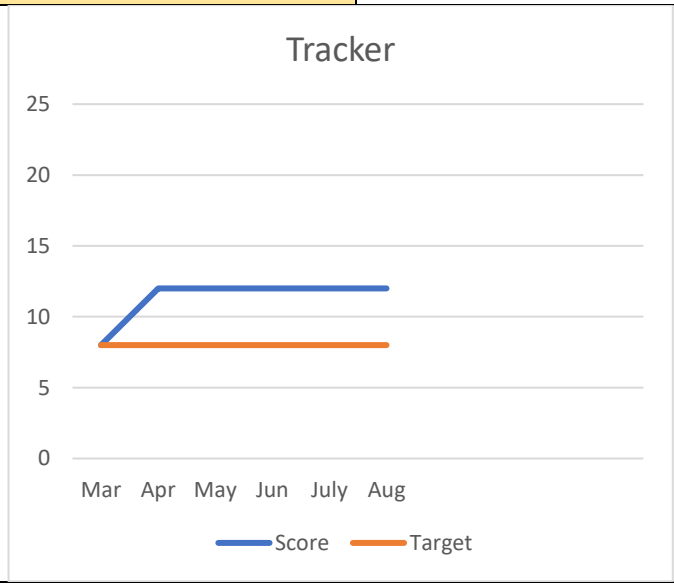
Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply)	Use of recruitment and retention premia as necessary Use of the Trac recruitment tool to reduce time to hire and candidate experience Rolling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

	Targeted recruitment to reduce hard to fill vacancies						

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

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust does not recruit to vacancies in the long term (19+ months) then there will be workforce shortages across the hospital and/or increased temporary staffing expenditure.				**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Tolerate
Date of Review	19/08/21	**Risk Rating**	12	8		



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

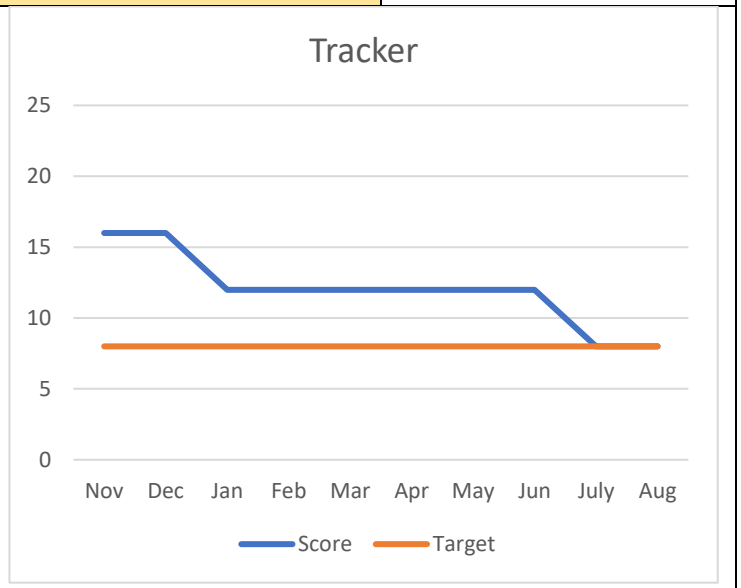
some clinical roles, particularly at consultant level Brexit may reduce overseas supply Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply) Large percentage of workforce predicted to retire over the next decade Large growth prediction for MK - outstripping supply Buoyant private sector market	Targeted overseas recruitment activity Apprenticeships and work experience opportunities Expansion and embedding of new roles across all areas Rolling programme to recruit pre-qualification students Use of enhanced adverts, social media and recruitment days Review of benefits offering and assessment against peers Development of MKUH training programmes Workforce Planning Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and						

creating competition for entry level roles New roles upskilling existing senior qualified staff creating a likely gap in key roles in future (e.g. band 6 nurses) Reducing potential international supply New longer training models	deliver improvement to working experience/environment International workplace plan Assisted EU staff to register for settled status and discussed plans to stay/leave with each to provide assurance that there will be no large scale loss of EU staff post-Brexit						

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

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust is unable to maintain a compliant training environment, 11 postgraduate training posts remain under threat of removal by HEE.				**Strategic Objective**	Investing in Our People/ Patient Safety
Lead Committee	Workforce/ Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	16/08/21	**Risk Rating**	8	8		



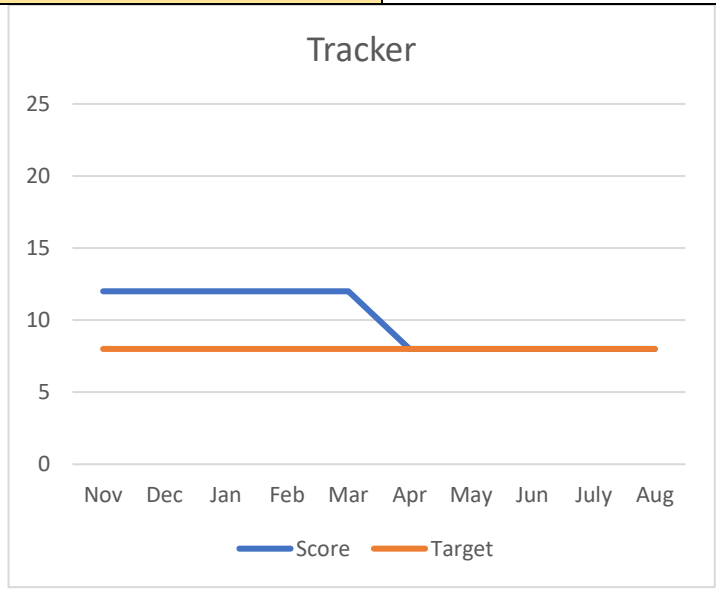
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Poor training environment: lack of standardisation of process;	Heavy involvement from clinical leaders outside the	To date, we have not recruited to the additional	Positive initial work with Professor	The output of a meeting of the HEE TV quality committee on 16	None Currently	None Currently	

variable levels of support; and, persistent concerns around behaviours by consultants perceived as belittling / inappropriate / bullying. Risk raised in November 2019 following HEE TV quality meeting.	department (DD, DME, MD). Change in clinical leadership model within the service. Formative external review (Berendt consulting). Close liaison with HEE TV Head of School. Developmental work with consultant body and other senior clinicians in relation to vision and agreement of an ambitious forward-looking programme of work. Agreement around further investments within the department to improve the working lives of trainees and the quality of the training environment.	posts approved in order to move away from a single tier middle grade rota 24/7. This currently sits in part with the Head of School as a rotation is envisaged. The COVID-19 situation has resulted in additional complexity (development work etc.)	Belinda Dewar (Wee Culture) across the maternity department, using appreciative inquiry. Recruitment in progress of additional middle grade doctors with anticipated start date August 2021.	June has been fed back to the Trust in writing. The risk has been closed from the HEE-TV risk register.			

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

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust does not maintain stocks of Personal Protective Equipment (PPE) and continue implementing the enhanced infection control measures it will be unable to maintain a safe working environment during the COVID-19 pandemic				**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	19/08/21	**Risk Rating**	8	8		



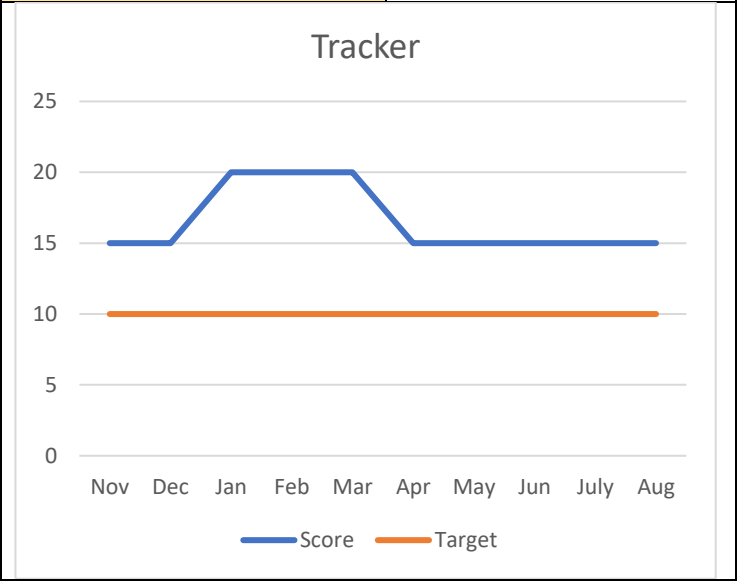
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Ability to maintain a safe working environment	Incident command structure in place	None currently – noted that this	None Currently	Completed Risk Assessments	None Currently	None Currently	

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

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

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust does not implement and progress staff health and wellbeing initiatives, there is the risk of staff burning out during or due to the COVID-19 pandemic				**Strategic Objective**	Investing in Our People	
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff	
Executive Lead	Director of Workforce	**Consequence**	5	5	**Risk Appetite**	Avoid	
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat	
Date of Review	19/08/21	**Risk Rating**	15	10			



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

down, recession and other social factors	health and support and advice available Staff Hub in use Remote working wellness centre in place 12 weeks of wellbeing focus January to March	and how it will affect staff	engagement with staff about support systems			remote workers	

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 3.2):

"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 Finance, Director of Operations 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 are 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:	August 2021~~October 2017~~
Date of Approval:	
Author:	Trust Secretary
To be Reviewed by:	Trust Board
To be Approved by:	Trust Board
Executive Responsibility:	Director of Corporate Affairs

Agenda Item 17
Public Board 09/09/2021

Meeting of the Audit Committee held on 19 July 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

a. The Committee approved the 2021-22 Internal Audit Strategy.
b. The Committee approved the 2021-22 Counter Fraud Annual Plan.
c. The Committee approved the write offs and losses, special payments and waivers.
d. The Committee formally approved the Information Governance Toolkit Return for 2021.

Summary of matters considered at the meeting:

Quarterly Health and Safety Report
The Committee reviewed the quarterly report and noted with concern the high rates of violence and abuse committed against staff by patients. The Committee agreed that awareness of the Trust Board's position on this issue was important if the culture of violence and abuse against staff can be changed.

Information Governance (IG) Toolkit Return - Recommendation
The Committee noted the management response to the recommendation by the IG Toolkit Return for investment to be made in an information asset system.

Public Procurement Regulations Following Brexit
The Committee reviewed and noted Public Procurement Regulations Following Brexit.

2021-22 Internal Audit Strategy
The Committee noted the Internal Auditors' focus on the rising profile of cyber security in the NHS and the on the Trust's cyber security arrangements.

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Agenda item 18.1
Public Board 19.09.21

Meeting of the Finance and Investment Committee held on 28 June 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:
N/A

Summary of matters considered at the meeting:

- Regarding the M02 Performance Dashboard, the Committee comprehensively reviewed the trajectories of all key performance indicators.

- Regarding the M02 Finance Report, the Committee noted that guidance had not yet been circulated on funding arrangements for the second half of the year.

- The Committee noted that the Trust's Capital Departmental Expenditure Limit (CDEL) allocation from the ICS capital financial envelope for 2021-22 was £14m, and that business cases for capital projects were being progressed for approval.

- The Committee noted the proposed approach to financial efficiency delivery by the Trust based on the efficiency requirements which will be factored into a government funding settlement for the second half of 2021/22.

Agenda item 18.2
Public Board 19.09.21

Meeting of the Finance and Investment Committee held on 03 August 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:
N/A

Summary of matters considered at the meeting:

- Regarding the M03 Performance Dashboard, the Committee comprehensively reviewed the trajectories of all key performance indicators.

- Regarding the M03 Finance Report, the Committee noted that there had been a in-month deficit which was driven in part by an increase in activity driven by non-pay and pay expenditure together with high-cost drugs.

- The Committee noted that business cases for capital projects, under the auspices of the Trust's Capital Programme, continued to be progressed for approval.

- The Committee noted that the Trust's project evaluation template had been revised to align with the requirements of the Treasury Green Book and the terminology and themes from the Treasury Magenta Book. The template would be utilised six months post the completion of a scheme/project and reviewed by the Trust Executive Group for cases between £500k and £1m, and by the Trust Board for cases above the £1m threshold.

- The Committee supported the funding application for the Community Diagnostic Hub initiative.

Agenda item 19
Public Board 09/09/2021

Meeting of the Charitable Funds Committee held on 15 July 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- The Charity Fundraising Plan 2021-24.

Matters referred to the Trust Board for final approval:

There were no matters referred to the Trust Board for final approval.

Summary of matters considered at the meeting:

Fundraising Update –

a. The 3 Draeger BabyLeo incubators, which were procured with funding from the Charitable Funds, was delivered in May 2021 and were being utilised in the Neonatal Unit;
b. The Meaningful Activities Facilitator, a post funded by the Charity, took up their post in July 2021. The Facilitator and the Head of Charity would meet every month to evaluate the impact of the post;
c. A pastoral support worker, also funded through the Charity, started in post in July 2021.

Arts for Health – The Committee noted that the Charity's positive links with MK Arts for Health continued to develop.

Agenda item 20
Public Board 09/09/2021

Workforce & Development Assurance Committee Meeting held on 21 July 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

a. The Committee approved the Gender Pay Gap Report for publication on the Trust website.
b. The Committee approved the Workforce Race Equality Standard (WRES) Report for submission and publication on the Trust website.
c. The Committee approved the Workforce Disability Equality Standard (WDES) Report for submission and publication on the Trust website.

Matters referred to the Board for final approval:

There were no matters referred to the Board for final approval.

Summary of matters considered at the meeting:

Staff Story – The Committee received a presentation from a Senior HR Business Partner who had been instrumental in setting up the inclusion and pride networks. The Senior HR Business Partner updated the Committee on their significant progress and contributions since they joined the Trust in 2006.

2021/22 Objectives – The Committee was updated on the Workforce-related ambitions of the Trust in 2021/22.

Workforce Strategy – The Committee noted that a project plan which would help track progress against the Strategy would be developed for the Workforce Team.

Living Our Values Programme – The 'Leading With Values Programme', which had the remit of creating conditions to enable positive change across the Trust, continued to be implemented.

Freedom To Speak Up Strategy – The Committee noted the completion of Freedom To Speak Up Strategy which had an objective of encouraging people to come forward.

Fair and Just Culture update – Disciplinary Process Improvement (Suspensions) – The Committee received and reviewed a report which outlined the proposed changes which would be made to HR practices following a review of how the Trust managed employee suspensions.

Staff Survey – The Committee noted the establishment of two working groups to separately explore the issues around staff hours and to undertake a deep dive into violence and

aggression against staff. It was also noted that resolving the issue of ‘violence and aggression against staff’, was of the highest priority for the Workforce Team.