Board of Directors

Public Meeting Agenda

Meeting to be held at 10.00 on Friday 6 July 2018 in Room 6, Postgraduate Education Centre, Milton Keynes University Hospital.

Item No.	Title	Purpose	Type and Ref.	Lead
1. Introduction and Administration				
1.1	Apologies	Receive	Verbal	Chairman
1.2	Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda	Noting	Verbal	Chairman
1.3	Minutes of the meeting held in Public on 4 May 2018	Approve	Pages 5-14	Chairman
1.4	Matters Arising/ Action Log	Receive	Pages 15-16	Chairman
2. Chair and Chief Executive Strategic Updates				
2.1	Draft Minutes of the Council of Governors Meeting held on 22 May 2018	Receive	Pages 17-26	Chairman
2.3	Chairman's Report	Receive and Discuss	Verbal	Chairman
2.4	Chief Executive's Report	Receive and discuss	Verbal	Chief Executive
2.5	Sustainability and Transformation Partnership	Note	Verbal	Chief Executive
3. Quality				
3.1	Patient Story	Receive and Discuss	Verbal	Director of Patient Care and Chief Nurse
3.2	Mortality update report	Receive and Discuss	Pages 27-34	Medical Director
3.3	Nursing staffing update	Receive and Discuss	Pages 35-42	Director of Patient Care and Chief Nurse
3.4	Approach to Safety Checklists within the Trust	Receive and Discuss	Pages 43-52	Medical Director
4. Strategy				
4.1	Vision and Strategy update	Receive and Discuss	Pages 53-62	Chief Executive
4.2	Outpatients Transformation Programme Board update	Note	Pages 63-66	Director of Corporate Affairs
4.3	Revised corporate governance structure	Note	Pages 67-72	Director of Corporate Affairs
4.4	Research and Development update	Note	*To follow*	Medical Director
5. Performance and Finance				
5.1	Performance report Month	Note	Pages 73-86	Deputy Chief

Item No.	Title	Purpose	Type and Ref.	Lead
	2			Executive
5.2	Finance update report Month 2	Receive and Discuss	Pages 87-94	Director of Finance
5.3	Workforce update report Month 2	Receive and Discuss	Pages 95-98	Director of Workforce
6. Assurance and Statutory Items				
6.1	Board Assurance Framework	Receive and Discuss	Pages 99-112	Director of Corporate Affairs
6.2	Medical Revalidation Annual Report	Approve	Pages 113-128	Medical Director
6.3	Management Board upwards report	Note	Pages 129-132	Chief Executive
6.4	Annual Complaints Report 2017/18	Note	Pages 133-150	Director of Patient Care and Chief Nurse
6.5	Annual Safeguarding Report 2017/18	Note	Pages 151-184	Director of Patient Care and Chief Nurse
6.6	Annual Infection Control Report 2017/18	Note	Pages 185-210	Director of Patient Care and Chief Nurse
6.7	Health and Safety Update	Note	Pages 211-214	Director of Corporate Affairs
6.8	(Summary Report) Finance and Investment Committee – 30 April and 25 May 2018	Note	Pages 215-218	Chair of Committee
6.9	(Summary Report) Workforce and Development Assurance Committee – 30 April 2018	Note	Pages 219-222	Chair of Committee
6.10	(Summary Report) Charitable Funds Committee – 30 April 2018	Note	Page 223	Chair of Committee
7. Administration and closing				
7.1	Questions from Members of the Public	Receive and Respond	Verbal	Chair
7.2	Motion to Close the Meeting	Receive	Verbal	Chair
7.3	Resolution to Exclude the Press and Public	Approve	The Chair to request the Board pass the following resolution to exclude the press and public and move into private session to consider private	Chair

Item No.	Title	Purpose	Type and Ref.	Lead
			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."*	

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors meeting held in PUBLIC on Friday 4 May 2018 in Room 6, Postgraduate Education Centre, Milton Keynes University Hospital

Present:

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

In Attendance:

Kate Jarman	Director of Corporate Affairs
Joyce Elliot	ST7 Doctor, Obstetrics & Gynaecology
Kate Laszlo	Rotational Midwife (item 3.1)
Julie Cooper	Head of Midwifery (item 3.1)
Ade Kadiri	Company Secretary

2018/05/01	**Welcome**
1.1	The Chairman welcomed all present to the meeting.
2018/05/02	**Apologies**
2.1	Apologies for this meeting were received from Bob Green
2018/05/03	**Declarations of interest**
3.1	No new interests had been declared and no interests were declared in relation to the open items on the agenda.

2018/05/04	**Minutes of the meeting held on 9 March 2018**
4.1	The minutes of the public Board meeting held on 5 January 2018 were accepted as an accurate record, with the exception of the following issues: • Paragraph 12.3 – the 3rd sentence should read: "It was noted that it was not clear from the Nursing and Midwifery Council how nursing associates would be able to give medication". • Paragraph 15.2 – the reference in the first sentence should read month 10 rather than month 6.
2018/05/05	**Matters Arising/ Action Log**
5.1	There were no matters arising in addition to those included on the agenda.
5.2	The action log was reviewed in turn: <u>352 Nursing Staffing update</u> The Birthrate Plus analysis has been included in the Nursing Staffing Report on the agenda. Closed. <u>355 Nursing Staffing update</u> Detailed proposals around the recruitment of nurses and allied health professionals are to be taken to the next meeting of the Workforce and Development Assurance Committee. Closed.
2018/05/06	**Draft Minutes of the Council of Governors' Meeting held on 20 March 2018**
6.1	The draft minutes of the Council of Governors' meeting held on 20 March 2018 were received and noted.
2018/05/07	**Membership and Engagement Strategy**
7.1	The Chairman introduced this draft strategy and action plan which had been produced by the Council of Governors. He commended it to the Board as a good piece of work that had been led by Alan Hastings. **Resolved**: The Board **approved** the Membership and Engagement Strategy and Action Plan.
2017/05/08	**Chairman's Report**
7.1	The Chairman informed the Board that he and Parmjit Dhanda had attended and given out awards at a supporters of the charity event, attended by 60 people. He had been heartened by the positive comments about patient care that were shared, and was impressed by the range of activities that are being undertaken on the charity's behalf.
7.2	The NEDs had visited the Emergency Department this morning, and had been struck by the teamwork ethos that runs throughout the hospital. They had also attended the stand set up in the main entrance to mark World Hand Hygiene Day. It

	is important that the focus on infection control is retained, and that MKUH maintains its good record in this area.
7.3	The Chairman had attended the most recent NHS Improvement regional event at which Baroness Dido Harding had spoken. Her speech had focused on what NHSI does, emphasising their determination to drive out inappropriate clinical variations. She was engaging and spoke forthrightly, noting the need to improve on talent management across the NHS to ensure that it is deployed in an appropriate manner.
7.4	The Chairman reminded the Board that this year's Event in the Tent will be held during the course of next week, and he encouraged all to attend. It was noted that each of the 3 days has a different theme – for the first day it is learning, the second staff and patient experience, and the third innovation and the future. Fantastic speakers have been lined up for each day and there will be a live link to Witan Gate House. **Resolved**: The Board **noted** the Chairman's report.
2018/05/08	**Chief Executive's Report**
8.1	The Chief Executive informed the Board that the executives had held a useful discussion on patient experience, with a view to determining what ought to be in place at the beginning of July. This had led to the identification of 3 areas oif focus: • Food – the Director of Patient Care and Chief Nurse is chairing a Catering Steering Group, whose work has already led to a significant increase in the amount of choice that is available to patients. Work is also being done to address issues around the delivery of food and the management of patients at mealtimes. • Cleanliness – new 'modern mops' are now appearing across the hospital. These have a more of an impact on dirt, although it is yet to be seen whether this by itself will drive enough of a change, especially in ward and toilet areas. • Noise at night – The Chief Nurse did a ward round earlier in the week. One of the proposals being considered to address this issue is to see whether some bay areas could be segregated, to help avoid the situation whereby some patients are keeping others up. The Trust does not have segregation areas, and there will therefore be a cost implication to this. It was also noted that eCARE gives the Trust the opportunity to change the way the admission process works. Patients are to be re-surveyed in July.
8.2	The currently draft patient experience strategy has already been approved by Management Board and the Quality and Clinical Risk Committee will consider it in June and it should then come to the Board for approval in July. Andrew Blakeman made the point that although the QCRC is tracking a number of initiatives, but having a project plan would provide the Committee with assurance. It was noted that the highest number of complaints received are to do with outpatient processes. The Zesty system has now been launched in orthopaedics, giving patients the

	ability to look at process letters online. 7000 texts have also been sent reminding patients of their appointments – there has been a 32% take up thus far. It was noted that in addition to improving the experience of patients, these new processes would also save the Trust money as every letter that the Trust sends in hard copy costs £1. The intention is to roll the system out across the organisation. There has also been significant interest from other parts of the NHS.
8.3	A&E performance thus far has been superb. For the first time, the Trust has ranked third in the country on this measure. The Chief Executive extended his thanks to the Director of Patient Care and Chief Nurse, who has taken over the operational management of the site. The Trust's intention would be to sustain this performance for as long as possible. On the other hand, the Trust's big risk area is the length of time that patients spend waiting for planned care. Over winter there had been an increase of 600 patient interactions, and the Trust is trying to reduce the number of patients waiting for follow up. The Trust has fallen outside the top quartile on RTT. It is imperative that the Trust gets to grip with this situation.
8.4	In response to a question from Tony Nolan as to the factors that have led to this improvement in performance, the Chief Executive explained that demand has been relatively stable, but that when there is a smooth flow of patients through the hospital, the Emergency Department can perform well. He made the point that most hospitals have reported a temporary improvement in performance in recent months, but that this has since dropped off. Although Mondays are always difficult at MKUH, the hospital has had a good April.
8.5	The Medical Director made reference to the recent controversy around breast screening, in which a computer glitch nationally may have led or contributed to the deaths of between 137 and 270 patients. It is not yet clear what this might mean for MKUH, although an additional 400 additional screens would need to be performed by the end of October. This equates to between 25 and 30 clinics. The Medical Director confirmed that the Trust does not send out the invitations for these screens – this is done by Public Health England, although it was acknowledged that the Trust should have noticed a rise in the number of older women presenting with breast cancer.
8.6	The Chief Executive had attended a round table meeting with the Secretary of State for Health and Social Care to consider what any additional funding might be spent on. The ideas that had emerged included out of hospital and social care, technology, a credible workforce strategy taking account of Brexit and the need to be clear about the success of the NHS, and using the 70th anniversary to celebrate this. Parmjit Dhanda confirmed, in relation to the issue of clinicians from overseas, that the NHS would not be able to sustain the current workforce without the establishment of proper connections with the Home Office. In response to a question from Andrew Blakeman, the Chief Executive confirmed that the issue of capital funding did also come up at the round table, but that the focus had been on investment in technology and out of hospital care rather than bricks and mortar, although it was acknowledged that this approach potentially ignores the needs of areas that are facing significant population growth. **Resolved**: The Board **noted** the Chief Executive's Report.

2018/05/09	**Sustainability and Transformation Partnership**
9.1	The Chief Executive presented this update, remarking that the very clear devolution within BLMK into locally driven health and care settings is to continue. He announced that Sophia Aldridge has agreed to take on the role of STP finance lead, while the Deputy Chief Executive has agreed to become estates lead. The Director of Corporate Affairs is to be the communications lead, while Emma Goddard continues as Programme Director. There is an emerging acceptance of the 2 different health systems – Bedfordshire/Luton and Milton Keynes, but joint working will continue where there are opportunities for savings to be made. It was also noted that requests for development funding has to go through the STP.
9.2	Andrew Blakeman was concerned about the extent to which the STP work could be a drain on executive capacity, but the Chief Executive explained that this is now part of business as usual, and that it is helpful for the Trust to be able to be able to contribute to development of strategic priorities across the footprint. **Resolved**: The Board **noted** the Sustainability and Transformation Partnership update.
2018/05/10	**Patient's Story**
10.1	The Director of Patient Care and Chief Nurse introduced Kate Laszlo, one of the Trust's midwifes, who attended with Julie Cooper, the Head of Midwifery. Ms Laszlo had been nominated for the award by a mother that she had worked with. The mother had had a difficult time during the birth of her first child, and for her second pregnancy, Ms Laszlo had taken on the role of advocate. This had helped the mother gain more confidence in the delivery room, and contributed to a much better experience overall. Ms Laszlo had attended the awards ceremony in London at which all midwives were celebrated.
10.2	Tony Nolan made reference to the difficulties that the Trust's maternity service has had previously, and asked Ms Laszlo how it now is as a place to work. In response, Ms Laszlo explained that she had worked at the Trust since 2005 and in the community since 2008. She regarded it as a very positive place sat the moment, with all colleagues working well together as a team. **Resolved**: The Board resolved to **note** the Patient's Story.
2018/05/11	**Mortality update report**
11.1	The Medical Director provided this regular monthly update. He confirmed that on the Hospital Standardised Mortality Rate (HSMR) measure, the Trust's 12 month relative risk score over the latest 12 month period to January 2018 is 86.6, which is in the lower than expected range. There is one significant outlier for this period – 'other perinatal conditions. There is nothing to suggest that deaths under this category are to do with quality of care. Deaths are now being reviewed, and no concerns have been raised.
11.2	With regard to the Summary Hospital-level Mortality Indicator (SHMI), it was noted

	that a score below 1.00 is better than average – the Trust's score is now 0.935, within the as expected range. However, the Medical Director confirmed that these favourable scores should give the Trust no reason for complacency.
11.3	The Medical Director made reference to the qualitative work that the Trust is now doing in response to the requirement to review deaths. It is estimated that between 3 and 4% of all deaths in hospital are avoidable, but no hospital is yet reporting such rates. The Trust's aim is to get to the point where 25% of all deaths are reviewed. In Q3 of 2017/18, 19% of deaths were reviewed. Most deaths occur in the Medicine division, and Q3 is a very busy time, exacerbated by the absence through maternity leave of their clinical governance facilitator.
11.4	In response to a question from Helen Smart about how long it would take to get the process back on track, the Medical Director made the point that the focus is on getting the multidisciplinary teams to discuss all aspects of care, and as such the outstanding Q3 deaths will not be pursued. In response to a question from Tony Nolan about the number of deaths that could be avoided as part of this review process, the Deputy Chief Executive stated that this could be around 1 in 2000. Andrew Blakeman also made the point hospitals often have a number of opportunities to delay deaths, but they do not often look broadly enough for examples of things that could have been done differently. Heidi Travis enquired whether the Trust would same issues around capacity in Q3 of this year. In response, the Medical Director made the point that Medicine continues to be stretched, but that some of the staffing issues have now been resolved.
11.5	With regard to what it would take to get the Trust to the point where it is identifying 30 to 40% of cases, the Medical Director stated that there is a balance to be struck between building teams and embedding the right culture, on the one hand, and focusing on issues that are less positive on the other. Clinicians are being trained as reviewers, and the point was made that the MKUH figures would be similar to other hospitals. The issue is to be revisited in a year's time.
11.6	While Parmjit Dhanda found the statistics impressive, he was concerned about the extent to which resources are diverted away from patient care towards these issues. The Medical Director stressed that activities of this nature do help to improve patient care, but he also made the point that both NHS improvement and the CQC have emphasised the importance of the work. At is recent visit to the Trust, Professor Ted Baker, the Chief Inspector of Hospitals, had been impressed with the systems that the Trust has in place. **Resolved**: The Board resolved to **note** the mortality update report.
2018/05/12	**Nursing Staffing Report**
12.1	The Chief Nurse presented the routine update on nurse staffing. She drew the Board's attention to the in the number of care hours per patient day, noting the impact that eCARE training has had in this regard. This had been planned in advance.
12.2	The Trust has signed up to NHDS Improvement's retention, taking into account the higher rate of leavers within nursing, although this is now improving (dropping). It

	was noted that NED involvement in this programme may be required. The Chief Nurse presented the findings from the Birthrate Plus analysis of the Trust's midwifery staffing requirements. She explained that the system is run by an external company, and during September and October last year, they had conducted a large retrospective exercise assessing the mix of births within the service. Although the case mix findings were broadly within the expected range, she was nevertheless surprised by some of the findings. The Trust's overall ratio is 26 births to 1 wte, which is correct for the current case mix, although it was recommended that further maternity support staffing be provided. The Head of Midwifery is to have reassuring conversations with the Trust's midwives on the basis of these findings. They are also to be used in the Trust's recruitment literature. The Trust will seek clear instructions from Birthrate Plus on how to make the calculations in the future.
12.3	In response to a broader question from Helen Smart as to why staff are leaving, the Chief Nurse made the point that nationally the highest turnover of nursing staff occurs between 12 and 18 months of their qualifying, and the principal reason is for relocation. The Trust is looking to make more use of internal transfers to seek to retain more staff within the hospital. It is expected that the greater use of onboarding and exit questionnaires will also help in this regard. The Director of Finance enquired whether the lack of a midwife-led service was a factor in terms of recruitment and retention. It was noted that some mothers do attend a unit that is based in Northampton, but the numbers are small. On the question where staff go when they leave MKUH, this is on the agenda of the Workforce and Development Assurance Committee. **Resolved**: The Board resolved to **note** the nursing staffing report.
2018/05/13	**Patient Experience Strategy update**
13.1	It was noted that most of the work in preparing the Patient Experience Strategy is now complete. The document will be formally presented for approval at the July Board meeting.
2018/05/14	**Performance Report Month 12**
14.1	The Deputy Chief Executive introduced the Month 12 Performance Report. He made the point that the rules around the cancer treatment target are constantly changing, but there is now some more clarity about how breaches are calculated. There is the possibility, as a result of this, that the Trust's performance going forward may appear as impressive as previously. Discussions are ongoing as to how pathways are constructed with a view to maintaining better relationships with tertiary centres. With regard to the recent concerns around missed breast scans, it was noted that the Trust treats around 220 cases of breast cancer each year – the view is that it would have been difficult to notice on this basis that a small number of scans had not been performed.
14.2	With regard to the RTT position, the Deputy Chief Executive indicated that performance on the non-admitted pathway is now back up to the 95% level, and accounts for 25% of 18 week breaches. However, performance is under some

	pressure with regard to the admitted pathway, with the Trust cancelling 150 patients a month over winter, mostly due to a lack of beds. The Trust will need to catch up. He made the point that in 2018/19, the Trust will be measured on the number of open pathways, and catching up with 600 elective patients will be difficult. Detailed recovery plans are being produced and including for work to be carried out away from this hospital, for example at Blakelands, Ramsey and the Horton. The Trust is seeking to develop a better relationship with BMI, and a regular supply of outside slots is likely to make a difference. The Medical Director made the point that the requirement is that the Trust has fewer open pathways at the end of the year than it did at the beginning, and that this means the Trust needs to get its waiting list better under control. This is a productivity issue.
14.3	In response to a question from Helen Smart about the Trust's DNA rate and Access Policy, it was noted that the rate is relatively low. The Trust has mobile phone numbers for 85% of its patients and sends them reminders by text. In addition, take up of the new Zesty electronic management system is quite good. There is also good adherence to the Access Policy. With regard to outpatient processes, the Director of Corporate Affairs indicated that a new central management structure is now being put into place, a training 'passport' has been developed, and audit is being carried out against compliance.
14.4	The Director of Clinical Services made reference to risks associated with the implementation of eCARE, noting that there will be a major challenge in getting staff to become comfortable with the system. There is a high likelihood that the Trust's performance would be affected in the short term. It was confirmed that 17 May remains as the proposed go live date, and that systems are in place to ensure as smooth a transition as possible.
14.5	In response to a question about the pressure ulcer on ward 23, the Chief Nurse made the point that this is a 40 bedded ward whose clinical caseload had changed last year, and they have encountered difficulties since. Additional support and resources are being allocated, but there is a need for additional substantive staffing. There is also a need to re-review the ward's caseload mix, noting the difficulties of managing a ward with more than 30 patients.
14.6	The Director of Corporate Affairs indicated that incident reporting within the Trust remains low compared to peers. A visit is to be paid to Guys and St Thomas with a view to learning from what they do.
14.7	The Deputy Chief Executive highlighted proposals for changes to the performance dashboard to make it more helpful in preparation for next winter. It was suggested that the glossary be updated. New measures for MRSA, C Difficile and e-coli have been added and national guidance has now been received. NHS Improvement expects boards to discuss rates of these infections at their public meetings, and not to focus only on e-coli. It was confirmed that the Trust is tackling e-coli, but the Trust has limited control over these infections which are largely contracted out ain the community. Andrew Blakeman made the point that in this area, the Trust is required to work as part of the wider system. It was agreed that the infection control team would be asked to attend the next meeting of the Quality and Clinical Risk Committee and then report back to the Board. **Action: Director of Patient Care and Chief Nurse**

	Resolved: The Board **noted** the Month 12 Performance Report.
2018/05/15	**Finance Update Report Month 12**
15.1	The Director of Finance presented the Month 12 position. The Trust is reporting a £16.1m deficit position at year end, which is £261k better than control total, excluding STF. As the Trust did not achieve the required 95% performance on the 4 hour A&E target there was a £768k adverse variance. However, this was more than offset by STF incentive funding of 3.6m – this was unplanned but expected income, as the Trust had expected pound for pound funding, but was also hoping for a bonus. This turned out to be the case for all trusts that agreed their control total. The Trust's £16.1m year-end deficit position is a significant improvement on £20.1m in 2016/17 and £32m in 2015/16.
15.2	In terms of specifics, the Director of Finance noted that non-pay costs were overspent – this relates to the impact of high cost drugs and how busy the hospital has been. The performance around pay costs is a real achievement for the organisation. In month, it was noted that there has been an £8.5m (6.5%) increase in the value of the hospital estate, which has led to a £0.5m cost pressure.
15.3	The Board commended the Trust's good financial performance **Resolved**: The Board **noted** the Month 12 Finance update report.
2018/05/16	**Corporate Workforce Information Monthly Report**
16.1	The Director of Workforce introduced this report, a summary of a more detailed report. It was noted that headcount had increased significantly, and that the Trust had done some good work around hard to recruit posts. The downward trend of agency spending has continued. However, sickness absence remains higher than at other trusts, and the reporting of the reasons for absences remains poor. It was also noted that the time that would normally be devoted to statutory and mandatory training is currently being taken up with eCARE training. **Resolved:** The Board **noted** the Workforce information monthly report.
2018/05/17	**Freedom to Speak Up Annual Report**
17.1	The Trust Secretary introduced this report, which is the first annual report to be presented by the Trust's Freedom to Speak Up Guardians. He provided some background to the role of the Guardian's making reference to the work of Sir Robert Francis QC and his recommendation that every Trust must have a Guardian, who is independent of the Executive Team, and is able to support staff who might feel unable or unwilling to raise concerns that that they might have.
17.2	The Trust Secretary made reference to the range of issues that had been brought to his and the Deputy Chief Nurse's attention, noting that half of all the concerns raised contained elements of bullying and harassment, although he acknowledged that in cases of this nature it is often difficult to distinguish behaviour that is inappropriate

	from robust management. He also made the point that although it was initially envisaged that the Guardian's role would mainly deal with disclosures that potentially raise patient safety issues, staff are in fact raising a range of concerns including bullying and harassment, but also relationships with colleagues. Often, the Guardian's role is to help signpost colleagues to more appropriate forums.
17.3	It was noted that the establishment and operation of an FTSU Guardian scheme is a key component of the CQC Well Led inspection, and the inspectors would often meet with the Guardian(s) at the start of the process. In the course of the discussion, the Board agreed that steps should be taken by the FTSU Guardians to: • Target difficult to reach staff • Encourage medical staff (particularly juniors) to raise concerns, either through the Guardians, or the Deanery, and • Guardians should work closely with staff groups.
17.4	It was also agreed that the assistance of the Communications team would be sought to help further publicise the role, but also that other routes for raising concerns or seeking assistance would be highlighted. **Resolved**: The Board **noted** the content of the Freedom to Speak Up annual report.
2018/05/18	**Board Assurance Framework**
18.1	The Director of Corporate Affairs presented the latest iteration of the Board Assurance Framework. The Board noted the contents of the Framework and the movements that had occurred in the risks The Director of Corporate Affairs indicated that a plenary session would be held with the Board at the July meeting. **Resolved**: The Board **noted** the Board Assurance Framework.
2018/05/19	**Board Committee Summary Reports**
19.1	The Board noted the contents of the summary reports of recent Board Committee meetings as follows: • Quality and Clinical Risk Committee meeting held on 22 March 2018 • Finance and Investment Committee meeting held on 6 April 2018 • Audit Committee held on 22 March 2018.
2018/05/20	**Questions from Members of the Public**
20.1	There were no questions from members of the public.
2018/05/21	**Any other business**
21.1	The Chief Executive announced that the Director of Workforce would be leaving the Trust to take up a role at another hospital. The whole Board congratulated her and wished her well for the future. The Chief Executive indicated that the process of identifying her replacement had already begun.

	All					**Action log – All items**				
	Public/ Private	**Action item**	**Mtg date**	**Agenda item**		**Action**	**Owner**	**Due date**	**Status**	**Comments/Update**
Board of Directors	Public	353	5 Jan 2018	12.2	Approach to Safety Checklists within the Trust	The process of completing the safety checklists in theatres is to be reviewed at the Quality and Clinical Risk Committee and an update is to be presented at the Board in six months' time	Ian Reckless	6 Jul 2018	Closing	On agenda
Board of Directors	Public	354	2 Feb 2018 (private)	10.7	Research and Development Strategy	A Board update on research and development activity is to be presented at the July meeting	Ian Reckless	6 Jul 2018	Closing	On agenda
Board of Directors	Public	356	4 May 2018	14.7	Performance Report Month 12	The Infection Control team would be asked to attend the next meeting of the Quality and Clinical Risk Committee and then report back to the Board	Lisa Knight	7 Sept 2018	Open	The Infection Control team attended the 21 June meeting of the Quality and Clinical Risk Committee. An update will be presented at the next Board meeting

Milton Keynes University Hospital NHS Foundation Trust

MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST COUNCIL OF GOVERNORS' MEETING

DRAFT minutes of a meeting of the Council of Governors' of the Milton Keynes University Hospital NHS Foundation Trust, held in public at 5.00pm on Tuesday the 22 May 2018, in room 6 of the Education Centre at Milton Keynes University Hospital, Milton Keynes

Present:
Simon Lloyd - Chairman

Public Constituency Members:
Amanda Anderson (AA)
Amanda Jopson (AJ)
Carolyn Peirson (CP)
Peter Skingley (PS)
Akin Soetan(AS)

Appointed Members:
Maxine Taffetani - Healthwatch Milton Keynes
Matt Webb - Milton Keynes CCG

Staff Constituency Members:
John Ekpa (JE)
Lesley Sutton (LS)
Kim Weston(KW)

In Attendance:
Nicky Burns-Muir (Item 3.3) - Deputy Chief Nurse
Michaela Tait (Item 3.3) - Patient Experience Manager

Executive Directors
Joe Harrison (JH) - Chief Executive
Kate Jarman (KJ) - Director of Corporate Affairs

Non Executive Directors
Andrew Blakeman (AB)
Bob Green(BG)
Heidi Travis (HT)

Adewale Kadiri (AK) - Company Secretary
Carol Duffy (CD) - Governor and Membership Manager

There was one member of the public in attendance.

1.	**WELCOME & ANNOUNCEMENTS**
	The Chairman extended a warm welcome to everyone present at the meeting and welcomed newly elected Governor Amanda Anderson to her first meeting of the Council of Governors.
1.1	**APOLOGIES**
	Apologies for absence were received from Andrew Buckley, William Butler, Douglas Campbell, John Clapham, Alan Hancock, Alan Hastings, Clare Hill, Robert Johnson-Taylor, Tony Nolan, Carolyn Peirson, Helen Smart, Clare Walton, Marc Yerrell.
1.2	**DECLARATIONS OF INTEREST**
	There were no new declarations of interest received and no interests received in relation to any other open items on the agenda.
1.3	**MINUTES**
(a)	**Minutes from the Council of Governors meeting held on the 20 March 2018.** The draft minutes of the meeting held on the 20 March 2018 were considered. **<u>Resolved:</u> That the draft minutes of the meeting held on the 20 March 2018 be agreed as a correct record of the meeting.**
(b)	**MATTERS ARISING / ACTION LOG**
	Action Log There were no outstanding action log items. **<u>Resolved:</u> That the action log as updated at the meeting was received.**
2	**CHAIRMAN AND CHIEF EXECUTIVE REPORTS**
(a)	**Chairman's Report**
	The Chairman reported that he had attended the most recent NHS Improvement regional event at which Baroness Dido Harding had spoken. Her speech had focused on what NHSI does, emphasising their determination to drive out inappropriate clinical variations. Baroness Harding was engaging and spoke forthrightly, noting the need to improve on talent management across the NHS to ensure that it is deployed in an appropriate manner. She also spoke of NHS Improvements' focus to "engage more actively with the work of NHS Digital and NHS England" to speed up digital transformation in the NHS. The Non- Executive Directors had participated in World Hand Hygiene Day and attended the stand set up in the main entrance. It is important that the focus on infection control is retained, and that MKUH maintains its good record in this area. The NEDs had also visited the Emergency Department, and had been struck by the teamwork ethos and noted the continuing improvements particularly the children's area.

	The Event in the Tent 2018, activities had been very successful. Liz Wogan whose public governor tenure came to an end on the 11th May was presented with a trophy by The Director of Patient Care and Chief Nurse Lisa Knight and Jenni Middleton Editor of the Nursing Times in recognition of her outstanding contribution to the Trust as a Non Executive Director and Governor. **Non Executive Director Parmjit Dhanda arrived at the meeting** **<u>Resolved:</u> That the Chairman's report be received and accepted.**
(b)	**Chief Executives Report,**
	The Chief Executive drew the Council of Governors attention to the written summary, of the outcome of discussions at the 18th April 2018 Management Board. The Chief Executive reported that A&E performance thus far has been superb. For the first time, the Trust has ranked third in the country on this measure. The Electronic Patient Record eCARE went live over the weekend of 19 - 20 May. eCARE will allow our staff to treat patients at MKUH more effectively by providing them with easier access to up-to-date information, which can be shared in real-time across all departments. The system will be capable of suggesting plans of care, supporting clinical decision-making and acting as a double-check to ensure that patients are receiving the treatment they require. There has been a massive amount of training, with super users, floor walkers and a help desk, on hand to support staff during the implantation period and there are a number of tools including quick reference guides to assist staff in being eCARE ready. The process of switching over to eCARE has been a very significant undertaking and a big change to the way we work across the hospital – particularly in inpatient wards and in the ED. With any big change, we expect to encounter problems and frustrations, and that has been the case throughout the week as people get used to new ways of working and accessing records. But overwhelmingly, the feedback on the new system has been positive and the way in which staff have approached and managed the change has been nothing short of remarkable. The second year of our Event in the Tent, staff engagement event took place between the 8 to 10 May, there were many more people and a significantly higher diversity of staff in attendance. The exceptional range of external and internal speakers delivered sessions that were variously innovative, thought-provoking, interactive, always interesting – and in some cases packed an emotional punch. All in all, the event covered improvements, staff and patient experience and importantly, innovation, as we look to the future to help make our hospital and the services we offer the best they can possibly be. In response to a question from Public Governor Peter Skingley, The Chief Executive reported that eCARE had increased significantly the ability of a richer source of clinical information.

	In response to a question from Appointed Governor Maxine Taffetani, The Chief Executive agreed that when there are extreme weather conditions, it can increase patient volumes at the Trust. In response to a question from Appointed Governor Maxine Taffetani, The Director of Corporate Affairs reported that there had been a massive focus, with all specialities being challenged to prioritise the clearance of the backlog for non RTT (patients waiting for treatments not covered by the Referral to Treatment 18 week target) and good progress had been made in some areas, with those who have been waiting over 6 months seeing the largest reductions. In response to a question received by Public Governor Peter Skingley, The Chief Executive reported that there had been a massive take up from patients for the opportunity to book appointments live from phones and tablets, enabling information to be exchanged immediately. **Resolved: That the Chief Executive's report be received and accepted.**
3.	**Sustainability and Transformation Partnerships (STP)**
	The Chief Executive provided a verbal update and highlighted the following:- • Further to the timeline of the 1st April now delayed to deliver the merger of Luton and Dunstable and Bedford Hospitals. There was no further news of the date of when the merger is to take place. • Conversations are ongoing with Oxford University Hospitals FT and Bucks Healthcare NHS Trust about partnership opportunities with a view to securing cost reductions. **Resolved: That the Sustainability and Transformation Partnership update be received.**
3.1	**Update on Estate Development**
	The Chief Executive provided a verbal update and reported that the new multi storey car build was now complete. The car park is for staff only, to compensate for the spaces that will be lost to allow for the start of construction work on the new Cancer Centre. Once exiting on foot, staff should follow the directions in place which will designate the appropriate walking route to the hospital. **Resolved: That the Update on Estate Development be received.**
3.2	**Cancer Centre Appeal Update**
	The Director of Corporate Affairs reported that the official launch of the Cancer Centre Appeal is to take place on the 7th June, at the INTU shopping centre in Central Milton Keynes. Volunteers are required for the day to help, anyone wishing to take part are to contact Kate Jarman or Vanessa Holmes. There are various awareness and fundraising initiatives planned to take place in the Community and a briefing pack is being prepared that will be available for Governors use.

	Resolved: That the Cancer Centre Appeal Update be Received.
3.3	**Patient Experience Strategy Update**
	A presentation was given by the Deputy Chief Nurse Nicky Burns Muir and Michaela Tait, the Patient Experience Manager, providing an update on the Patient Experience Strategy. The following was highlighted:- • The strategies aims are to:- o Ensure patients and carers are involved in their own care, supporting them to make informed decisions. o Ensure we use feedback from patients to understand what is important to them o Facilitate improvements in processes and overall care by listening to feedback including improvements in environment & food o Ensure public involvement and engagement are embedded within our strategic direction • Contributors & co-design partners are:- o MKUH Directors & Governors o Patient Experience Board o MKUH staff o HealthwatchMK o Milton Keynes CCG o Patient groups including Maternity MK and MKCPP • Next steps o Draft was taken to Patient experience Board in April and agreed to be taken to next stage o Next stage will be an approval at Management Board in June o Final approval and sign off at Trust Board o Once the Strategy is completely signed off it will be printed and shared with staff , governors and stakeholders o Presentations & workshops will take place with staff to ensure staff feel involved and engaged with it's delivery The Chief Executive reported on the identification of 3 areas of focus that aim to be in place in July:- • **Nutrition and hygiene**, the Director of Patient Care and Chief Nurse is chairing a Catering Steering Group, whose work has already led to a significant increase in the amount of choice that is available to patients. Work is also being done to address issues around the delivery of food and the management of patients at mealtimes. • **Cleanliness** – new ‘modern mops’ are now appearing across the hospital. These have a more of an impact on dirt, although it is yet to be seen whether this by itself will drive enough of a change, especially in ward and toilet areas. • **Noise at night** – The Chief Nurse did a ward round earlier in the week. One of the proposals being considered to address this issue is to see whether some bay areas could be segregated, to help avoid the situation whereby some patients are keeping others up. The Trust does not have segregation areas, and there will therefore be a cost implication to this. It was also noted that eCARE gives the Trust

	the opportunity to change the way the admission process works. **<u>Resolved:</u> That the Patient Experience Strategy Update be received.**
4.1	**Summary Report from the Finance and Investment Committee**
	The written summary report for the Finance and Investment Committee Meeting held on the 6th April was considered. **<u>Resolved:</u> That the Summary Report from the Finance and Investment Committee be noted.** **Staff Governor John Ekpa, left the meeting**
4.2	**Summary Report from the Audit Committee**
	Bob Green Non-Executive Director and Chairman of the Audit Committee, presented the summary report for the meeting held on the 22 March. The following was highlighted:- • Significant improvement had been seen due to work being done to address the issues around data quality, with confirmation from the internal auditors that there was now good governance oversight of the processes. • A Cyber Security presentation given to the Audit Committee will also be presented to Governors at the July meeting. • The Internal Auditor update had indicated that the work programme had been broadly completed with ratings of marked improvement in relation to data quality, particularly with the creation of the Data Quality Compliance Board. Partial assurance was awarded for the clinical audit review, although the work was being done, it was not being monitored for quality of progress and there was no evidence of learning being derived from the programme. The Chairman further reported that the Internal Auditor contract was currently out to tender. **<u>Resolved:</u> That the Summary Report from the Audit Committee**
4.3	**Summary Report from the Quality and Clinical Risk Committee** Andrew Blakeman, Non Executive Director and Chairman of the Quality and Clinical Risk Committee presented the summary report for the meeting held on the 22 March. The following was highlighted:-

	• In relation to the Quarterly Patient Experience Report, the Committee had acknowledged that the report demonstrates that the Trust has a good complaints policy, but made the point this does not reflect the broader picture around patient experience. • The committee was assured that the hospital remains safe and commended the engaged professional executive team.
	Resolved: That the Summary Report from the Quality and Clinical Risk Committee
5.1	**Healthwatch Milton Keynes Update**
	The written report for the Healthwatch Milton Keynes Update was considered. **Resolved: That the Healthwatch Milton Keynes Update be noted**
5.2	**Engagement Group Update**
	The written report for the Engagement Group Update was considered. **Resolved: That the Engagement Group Update be noted**
6.	**Integrated Performance Report Month 12**
	The Integrated Performance Report for Month12 was considered. **Resolved: That the Integrated Performance Report Month 12 be received**
6.1	**Finance Report Month 12**
	The Finance Report for the Month 12 was considered. **Resolved: That the Finance Report Month 12 be received.**
7.1	**Lead Governor**
	The process for appointing the Lead Governor of the Council of Governors was reported and approved by the Council of Governors at its meeting on the 23rd January 2018. The deadline for Nominations was 5pm on the 14th May and submission of candidates supporting statement by the 18th May at 12.00 Noon. Alan Hastings was the sole nomination received by the deadline. The tenure of the Lead Governor is 18 months. **Resolved**: **That Alan Hastings be approved as the Lead Governor from 22 May 2018 – 21 November 2019**
7.2	**Trust Self Certification**
	It is a Foundation Trust requirement, to self-certify compliance with the conditions of the NHS provider licence. The Company Secretary reported that a report would be made to Governors following Board discussions for the 2017/18 self-certification submission.

	<u>Resolved:</u> That the Trust Self Certification be received.
7.3	**Draft Quality Account 2017/18**
	The Company Secretary presented the 2017/18 draft Quality Account document and reported that the documents had also been presented at the respective Councils for Milton Keynes and Bedfordshire at their recent meetings. **<u>Resolved:</u> That the Draft Quality Account 2017/18 be received**
7.4	**Annual Members Meeting Minutes 2017**
	The draft minutes of the Annual Members Meeting held on the 27 September 2017 were considered. **<u>Resolved:</u> That the draft minutes of the Annual Members Meeting held on the 27 September 2018 be received.**
7.5	**Constitution Clarification**
	The Company Secretary stated the following:- 1. For clarification purposes it is recommended that Paragraph 14.4 (page 8) of the Trust Constitution should read **An** *elected Governor shall hold office for a maximum of six years, and shall not be eligible for re-election if his re-election would result in him holding office for more than six years'.* This is consistent with the relevant provisions of Schedule 7 to the NHS Act 2006 2. It is recommended that for clarification purposes Paragraph 6.3 (page 64) is to read ' *may hold office for a maximum of six years, and shall not be eligible for re-appointment if his re-appointment would result in him holding office for more than six years'.* It is also proposed that for clarification and to bring about consistency of tenure between elected and appointed governors that Paragraph 6.3 (page 64) be moved to the main body of the document to become part of paragraph 14. **<u>Resolved:</u> That the Constitution Clarification be approved.**
7.6	**Motions and Questions from Council of Governors**
	There was none
7.7	**Annual Work plan**
	The Annual Work Plan was considered and any items pertaining to this meeting are to be

	added. **<u>Resolved:</u> That the Annual Work Plan be noted.**
7.8	**Any other Business** Staff Governor Lesley Sutton, reminded all of the date of the 2018 Annual Members Meeting, which is taking place on the **12th September and will be held on site at the Academic Centre.**
7.9	**Date and Time of next meeting** The date of the next meeting of the Council of Governors is on the 17th July at 5.00pm in room 6 at the Education Centre.
7.10	**RESOLUTION TO EXCLUDE THE PRESS AND PUBLIC** **<u>Resolved:</u> that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted.**

Carol Duffy
Governor and Membership Manager
23 May 2018

Meeting title	**Public Board**	**Date: 06 July 2018**
Report title:	**Mortality update report**	**Agenda item: 3.2**
Lead director **Report author** **Sponsor(s)**	**Dr Ian Reckless** **Dr James Bursell**	**Medical Director** **Associate Medical Director**
FoI status:	**Publicly disclosable**	

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

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

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

Executive Summary

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

Definitions

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

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

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

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

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

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

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

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

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

HSMR

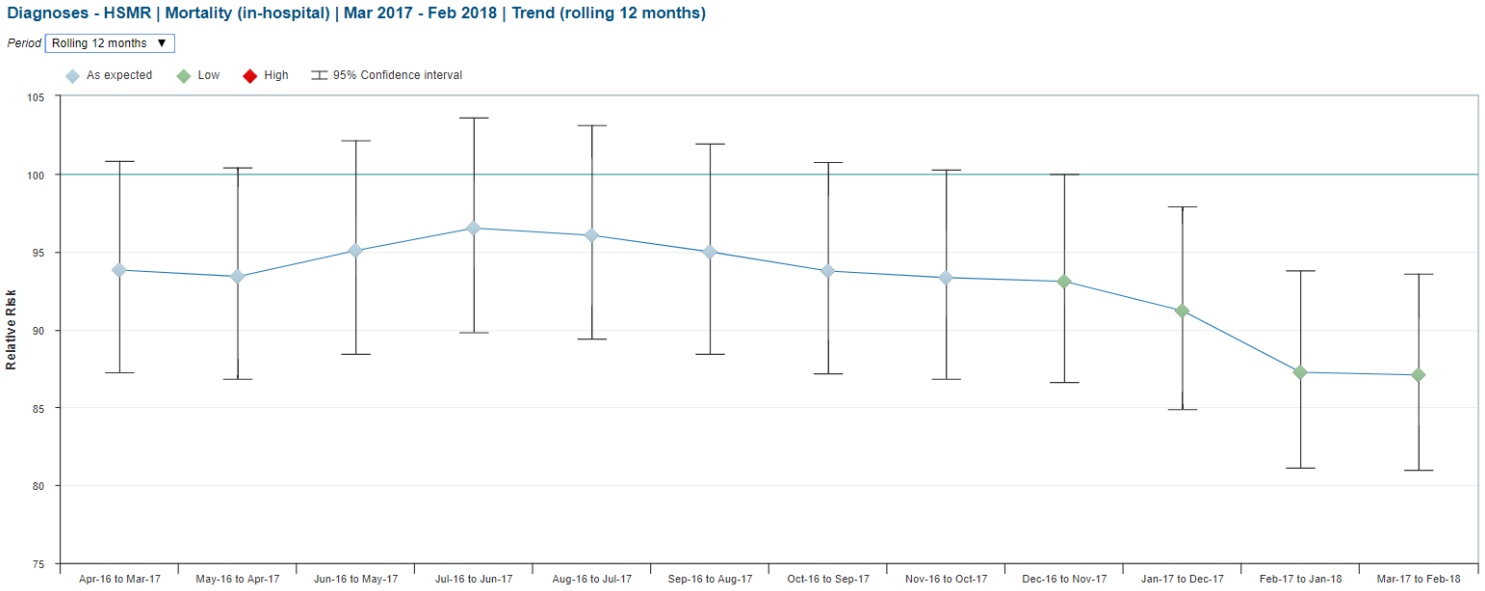
Data period: March 2017 – February 2018

Key Highlights:

- HSMR relative risk for 12 month period = **87.1** 'lower than expected' range
- Crude mortality rate within HSMR basket = **3.2%** (MKUH local acute peer group rate = 3.9%, national crude rate 3.9%)
- **1 significant outlier** was identified within the HSMR basket for this period – 'other perinatal conditions'.

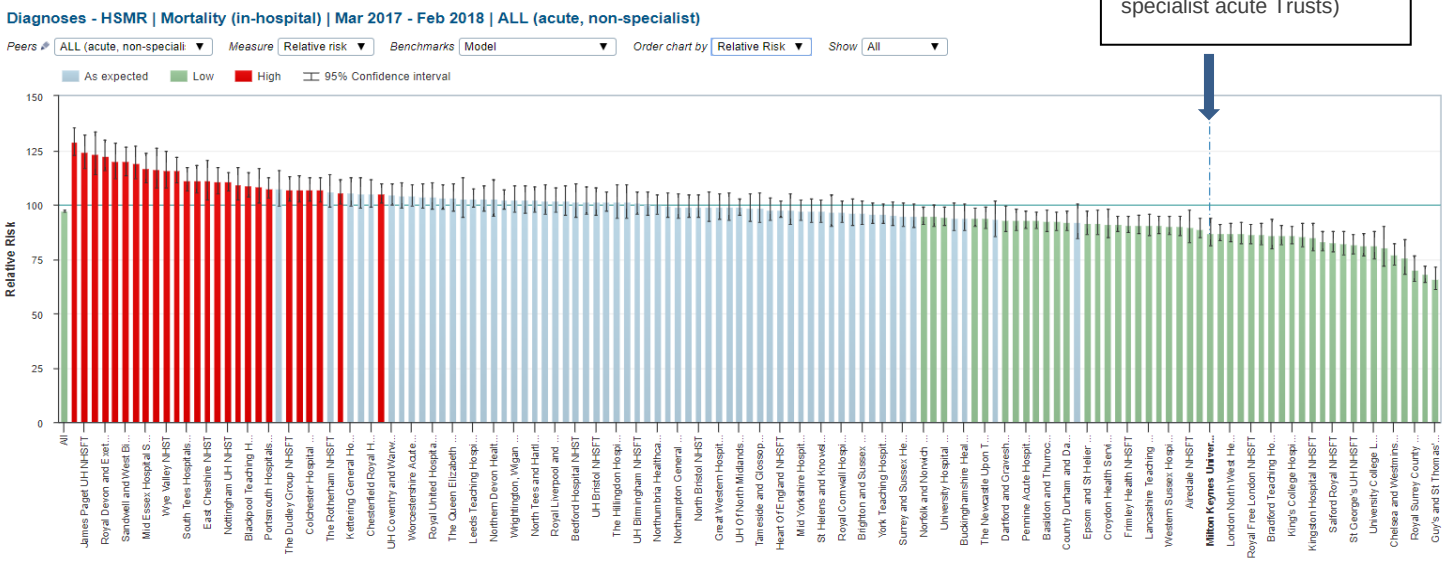
The Trust currently ranks 2nd (2nd lowest HSMR relative risk value) against its MKUH peer group and 19th lowest (best) against 136 national peers. The Trust is one of only 3 Trusts from 21 within the peer group with an HSMR which is statistically 'lower than expected'.

Trust level HSMR monthly performance Trend rolling 12 months (March 2017 – February 2018)



HSMR position vs. national acute peers: March 2017 – February 2018

HSMR = 87.1 'lower than expected'
(23rd lowest out of 136 non specialist acute Trusts)



HSMR relative risk = 87.1 'lower than expected' (23rd lowest out of 136 non-specialist acute). 1st lowest ranking indicates the trust with the lowest (best) HSMR relative risk.

SHMI

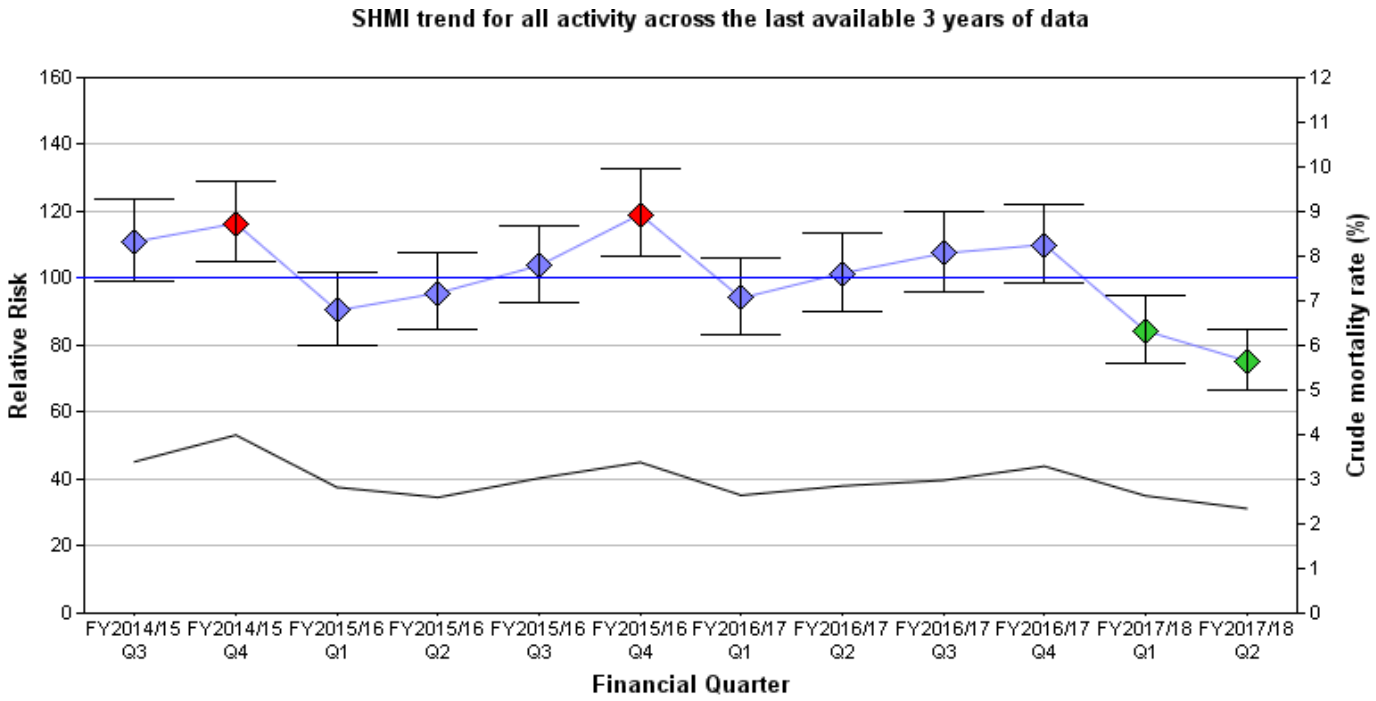
Data period: October 2016 – September 2017 (most up to date data available)

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

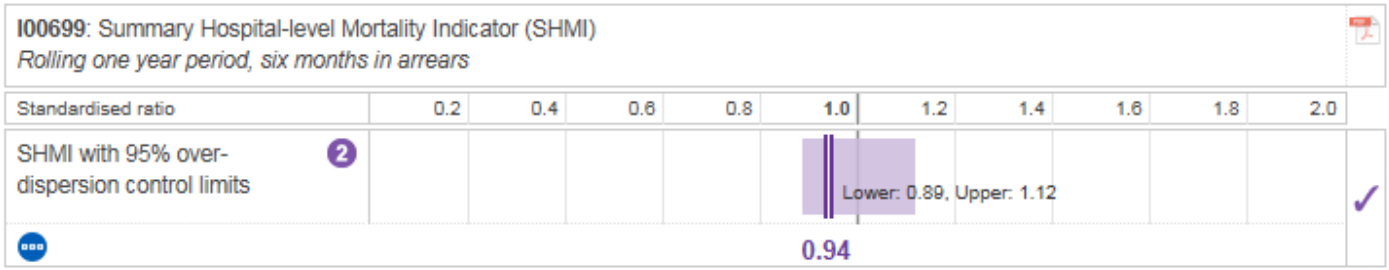
Key Highlights:

The latest SHMI published in March 2017 by HSCIC for the rolling 12 months to September 2017 = **0.935** '**as expected'** range.

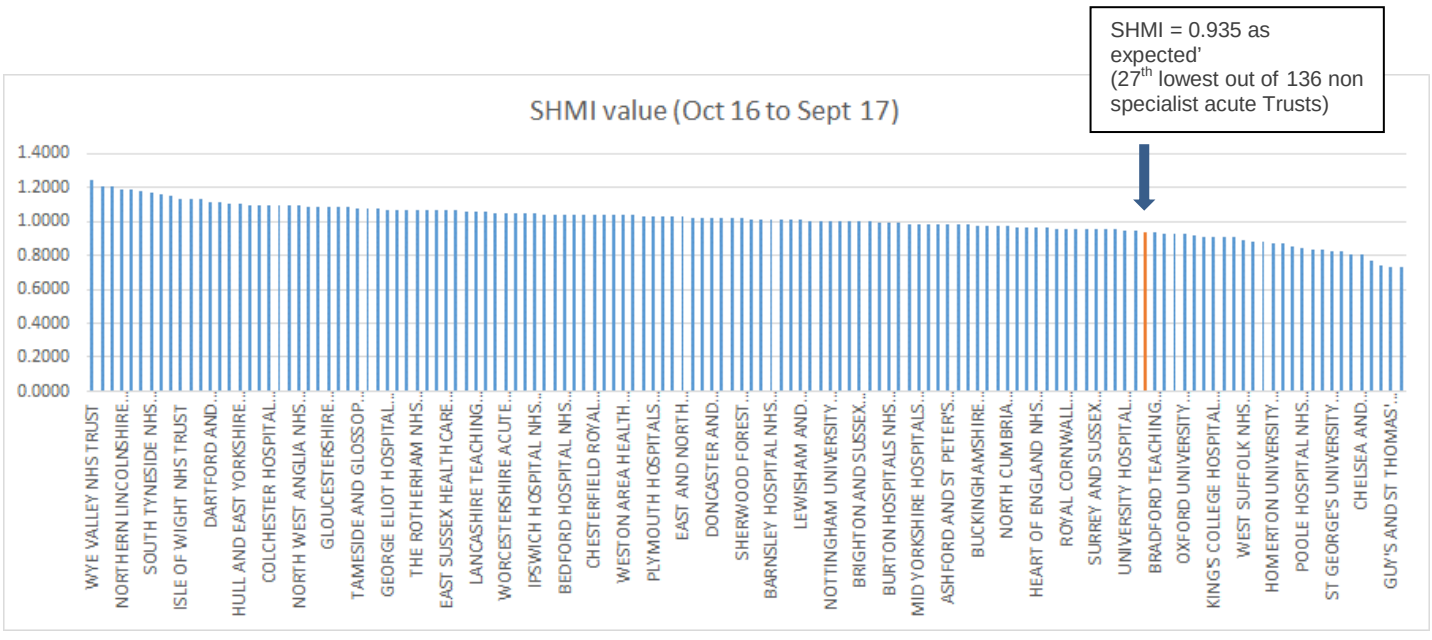
The Trust is currently ranked 27th in SHMI performers among the 136 non-specialist acute trusts in England (ranking 1 = lowest or 'best' SHMI) on 12 month data to September 2017. The Trust previously ranked 90th in SHMI on 12 month data to September 2016, 66th on 12 month data to March 2017 and 53rd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



Summary Hospital-level Mortality Indicator (SHMI) • October 2016 - September 2017



SHMI position vs. national acute peers: October 2016 – September 2017



Investigations of Deaths

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

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

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

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

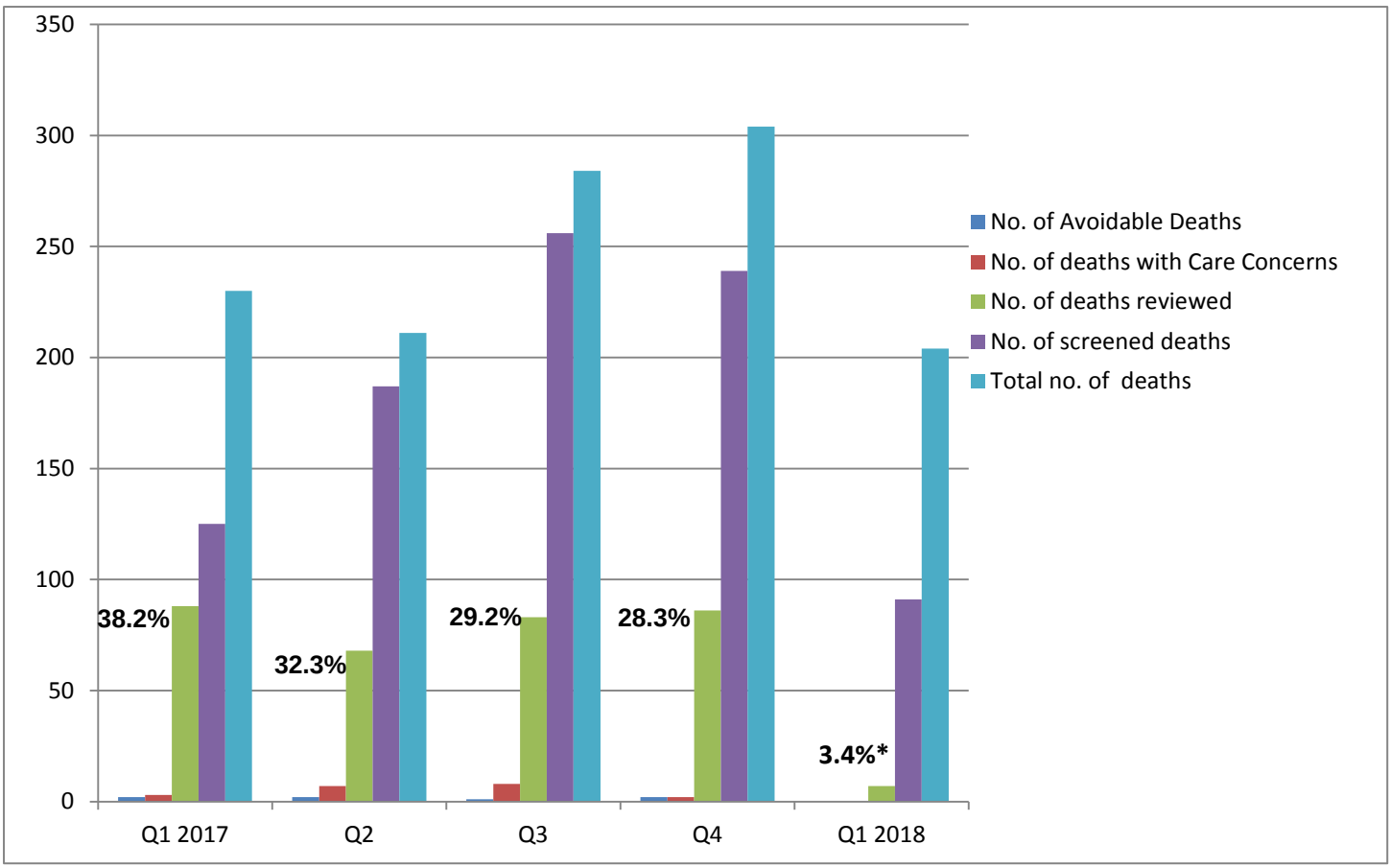
4. Judged as 'non-avoidable' but where there have been Care Quality concerns identified. This includes 'suboptimal care where different management WOULD NOT have changed outcome'.

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

	Q1 2017	Q2	Q3	Q4	Q1 2018
No. of deaths	**230**	**211**	**284**	**304**	**204**
No. of deaths reviewed by responsible consultant (% of total)	**125 (54%)**	**187 (89%)**	**256 (90%)**	**239 (79%)**	**91 (44.6%)***
No. of investigations (% of total)†	**88 (38.2%)**	**68 (32.3%)**	**83 (29.2%)**	**86 (28.3%)**	**7 (3.4%)***
No. of deaths with Care Quality concerns (%)	**3 (1.3%)**	**7 (3.3%)**	**8 (2.8%)**	**2 (0.6%)**	**0***
No. of potentially avoidable deaths (%)	**2 (0.8%)**	**2 (0.5%)**	**1 (0.5%)**	**2 (0.6%)**	**0***

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

* Q1 data are provisional and are still subject to further modification (as formal review processes occur within the Trust's clinical divisions).



Qualitative information on deaths (whilst maintaining patient anonymity)

Cases not previously published at Public Board meetings

Q3 Avoidable deaths or deaths where suboptimal care where different management MIGHT have changed outcome care – 1 case - published in May Public Board report

Q3 deaths – Care Quality concerns that would not have changed outcome – outstanding deaths not reported in May Public Board report

1. Poor documentation in initial clerking notes.
2. Concerns regarding appropriate means of transporting patient to radiology department and delay in X-ray taking place
3. To restrict bed moves out of possible when possible
4. Delay in ordering of investigations that delayed End Of Life decisions
5. Inadequate end of life discussions between Oncology team and patient and relatives

Q4 Avoidable deaths or deaths where suboptimal care where different management MIGHT have changed outcome care

1. A man in his 10th decade with palliative bladder and renal cancer, other multiple pathologies and a urinary catheter in situ was admitted with worsening blood in his urine (haematuria). He required repeated blood transfusions for anaemia. He was noted on

admission to have a chest infection associated with known underlying lung pathology. There was suboptimal treatment and recording of fluid balance in a patient receiving blood transfusions and at risk of fluid overload worsening his respiratory status. Sub optimal nursing records and incomplete resuscitation documentation were also highlighted as concerns. These issues have been discussed with the appropriate nursing and medical teams.

2. A man in his 8th decade was admitted with shortness of breath and abdominal pain. He was initially treated for pneumonia and influenza (positive Flu swab). He was subsequently found on CT scan to have evidence of bowel perforation. Surgery was agreed with family despite high associated risks of morbidity and mortality. A perforated ulcer with peritonitis was identified at laparoscopy and the patient subsequently died postoperatively of multi-organ failure. A delay in performing the CT scan and identification of the perforated ulcer was identified. Consideration was given at to the patient's suitability for surgery however it was recognised that the family wished for the operation to take place.

Q4 - Care Quality concerns that would not have changed outcome

1. Earlier escalation to Level 1 pathway identified as potential issue in management
2. Need for improved communication between medical staff and family
3. Suboptimal medical management of hyponatraemia

Meeting title	Board Of Directors	**Date: 6** July 2018
Report title:	Nursing Staffing Report	**Agenda item: 3.3**
Lead director **Report author Sponsor(s)**	**Name:** Lisa Knight **Name:** Matthew Sandham	**Title:** Director Of Patient Care/Chief Nurse **Title:** Associate Chief Nurse
FoI status:		

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

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

Report history	To every Public Board
Next steps	
Appendices	Appendix A,B

Board of Directors Report on Nursing and Midwifery staffing levels Amalgamated report for April 2018 and May 2018

1. Purpose

To provide Board with:-

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

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

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

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

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
April	14768	4.5	3.2	7.7
May	14381	4.8	3.5	8.3

Hospital Monthly Average Fill Rates for October and November 2017

Month	RN/RM Day % Fill Rate	HCA/MCA Day % Fill Rate	RN/RM Night % Fill Rate	HCA/MCA Night % Fill Rate
April	82.2%	107.5%	96.8%	134.7%
May	87.5%	114.2%	99.3%	137.4%

The CHPPD hours in May increased due to fill rates in Registered Nurses following the implementation of E-Care and the reduction in annual leave allowed.

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

3. Recruitment

Our estimated vacancies in May 2018 are:

44.6 wte Band 5 residual and 9.3 wte Band 2 vacancies in Medicine, most of these are on the elderly care wards. Medicine has seen a reduction of 20 wte Band 5's following a successful rolling advert campaign; they also have had an excellent HCA recruitment day with 20 HCA's recruited.

17 wte band 5 and 11 wte Band 2 residual vacancies in Surgery – Surgery continues to recruit on a rolling advert which has been successful in recruiting both Band 5's and 2's. Theatre staff with experience at Band 6 level continues to be an area hard to recruit to with 9

wte vacancies which is a reduction from the last report due to a successful recruitment campaign for Operating Department Practitioners.

4.9 wte band 5/6 residual vacancies in Maternity.

6 wte band 5 residual vacancies in Paediatrics which includes 4 wte in NNU, this is following the successful recruitment of 8 wte Paediatric Nurses.

4. NHSI Retention Programme

There is a national focus on retention and the Trust is in Cohort 3 of the Retention Direct Support Programme with NHS Improvement (NHSI), which launched on 05 April 2018; attended by the trust's Associate Chief Nurse and Deputy Director of Workforce.

National Health Service improvement (NHSI) has committed support from their clinical and workforce leads for planning and implementation, with the overall aim being to gain greater benefit locally. Initial focus at Milton Keynes University Hospital will be Band 5 nurses however, it is intended its principles will be transferrable across professions and staff groups. The overall aim is to reduce turnover in Surgery by 2% by the end of June 2019. This has been agreed as realistic prospect with NHSI.

Following analysis of Band 5 staff nurse turnover; three key areas of focus have been identified:

1. Healthroster:
    a) Increase Healthroster finalisation period from 6 to 8 weeks by *Q3 2018/19.*To improve work/life balance.
    b) Introduce a Matron's accountability framework including rostering KPIs & challenge meetings – in *Q3 2018/19*.
2. Introduce an internal transfer market to support July and November turnover hotspots – make it easy for colleagues to stay at MKUH – *August 2018.* This process will enable staff to move internally without going through a lengthy recruitment process and will support talent management.
3. Refine on-boarding and exit questionnaire process – follow up welfare & wellbeing and exit phone calls – *July 2018.* This will ensure the Trust support all new starters and has a clear understanding of why staff leaves the organisation, which will support future planning in retention.

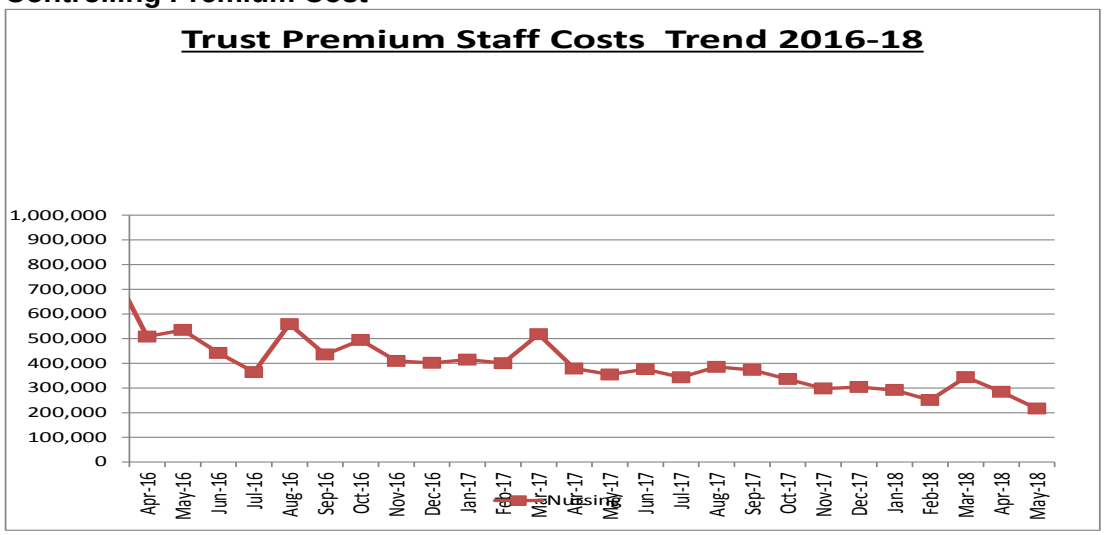
Programme timeline:

Introductory call with NHSI – 16 May 2018
NHSI Retention Direct Support Programme visit – 13 June 2018 (including Ward 8 visit)
Submit full improvement plan – by 04 July 2018

Initial feedback from NHSI from the 13 June visit was positive; the Clinical Lead, Siobhan Heafield, Regional Nursing Director NHSI, was reassured that the trust had a good understanding of its data, its plans and had a good governance structure to support the work.

Working through task and finish subgroups, this work will report to the quarterly workforce board with updates to Nursing and Midwifery Board.

5. Controlling Premium Cost



Agency nursing expenditure continued to fall both in April and May being the lowest in 2 years. This was due to implementation of E-Care and staff not on training and a reduction in annual leave.

6. Student Recruitment

Predicted Student Numbers- September 2018 Nursing and Midwifery

Numbers are volatile until enrolment, late August 2018. Offered places do not translate into actual numbers until this point, as grades may not be achieved and applicants will be offered places at multiple universities.

Initial scoping suggests that we may be short about 8 adult branch student nurses across both of our provider universities, although we continue to work with them to fill the spaces. In addition we are supporting one of the Universities to bring overseas student nurses to begin training, of which their clinical placements would be at MKUH

Midwifery training is on track to recruit a full enrolment at both universities, with offers of additional students from both, which we are hoping to accommodate.

Children's Nurse training has full complements of students starting in September., as does Operating Department Practitioners.

Overall- September intake remains broadly on track at this point in time, March cohorts and Adult Nursing seem to have taken the largest reduction in applicants.

7. Nursing Associates Trainees(NAT,s)

In December 2015 it was announced that a new nursing support role was to be introduced to the NHS. Nursing Associates once qualified will provide care and support for patients and address the skills gap between health care assistants and registered nurses.

Nursing associate is a stand-alone role in its own right and will also provide a progression route into graduate level nursing with further training. This is part of the Government plan to provide an appropriate workforce to meet the future needs of the NHS.

In 2017 2000 Nursing Associate Trainees started a two-year training programme which commenced in 35 pilot sites across the UK. MKUH was chosen as part of a larger Thames Valley group to be a 'fast follower' site and started ten NATs (8 MKUH 2 CNWL) on a local training programme in April 2017. At this stage the academic part of the pilot courses is funded by Health Education England (HEE). In the future the training programme will be delivered as an apprenticeship with funding for university fees paid from our apprenticeship levy.

The pilot is run in collaboration with Bucks New University (BNU) and CNWL. BNU deliver the educational element onsite at MKUH. Placements were provided by both organisations across acute care and the community to provide the broad range of developmental experiences required by the course programme.

Plans are in progress to define a job description for a band 4 Nursing Associate and to determine how this role will be integrated into the current workforce. MKUH NAT's will qualify in April 2019 and be eligible to register with the Nursing and Midwifery Council (NMC). They will work to the Standards of Proficiency for Nursing Associates which sets out the expectations of skills and knowledge that a nursing associate will need to meet in order to be considered by the NMC as capable of safe and effective nursing associate practice.
Currently a business case has been developed and being considered to support the appointment of 20 NAT's for an October 2018 intake and will include 5 Central and North West London NHS Foundation Trust NAT's .

Fill rates for Nursing, Midwifery and Care Staff April 2018

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
MAU Ward 1	82.6%	142.8%	97.6%	169.3%	810	4.4	3.1	7.4
MAU Ward 2	80.0%	114.1%	99.4%	156.5%	781	3.2	3.4	6.5
Ward 3	76.6%	90.2%	104.1%	105.2%	840	2.9	3.3	6.2
Ward 5	77.3%	107.4%	110.6%	91.2%	578	6.4	1.4	7.8
DoCC	82.6%	73.8%	83.8%	-	183	24.8	1.5	26.3
Ward 7	77.8%	105.3%	103.3%	129.9%	735	3.4	4.5	7.8
Ward 8	75.7%	103.1%	100.0%	143.0%	733	3.3	3.3	6.6
Ward 9	94.6%	98.3%	86.7%	96.7%	434	6.4	1.7	8.2
Ward 10	91.7%	95.0%	95.0%	-	578	2.5	1.3	3.7
Ward 14	84.9%	95.1%	96.8%	109.6%	718	3.0	3.2	6.2
Ward 15	84.2%	111.9%	95.9%	148.4%	876	3.3	2.9	6.2
Ward 16	80.9%	99.1%	95.2%	124.5%	840	3.3	2.6	5.9
Ward 17	77.7%	102.5%	99.2%	122.6%	759	4.0	2.3	6.3
Ward 18	81.6%	91.0%	98.0%	126.9%	822	3.1	3.6	6.7
Ward 19	71.4%	103.7%	99.1%	138.9%	904	2.6	3.7	6.2
Ward 20	71.5%	122.9%	98.0%	124.6%	755	3.5	3.2	6.7
Ward 21	79.6%	147.9%	97.8%	162.9%	660	3.7	3.7	7.5
Ward 22	86.6%	141.3%	101.1%	164.2%	634	4.0	3.8	7.8
Ward 23	77.7%	129.5%	99.2%	149.2%	1059	3.3	4.2	7.5
Ward 24	88.1%	96.0%	97.2%	-	465	4.8	1.4	6.2
NNU	91.5%	91.3%	90.5%	96.4%	414	9.0	1.6	10.6

Fill rates for Nursing, Midwifery and Care Staff May 2018

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
MAU Ward 1	86.9%	107.7%	102.0%	124.1%	733	5.1	2.5	7.6
MAU Ward 2	83.3%	127.5%	104.3%	167.7%	737	3.5	3.9	7.4
Ward 3	82.1%	100.1%	99.9%	128.9%	820	3.1	3.9	6.9
Ward 5	76.4%	100.6%	96.8%	94.7%	522	6.7	1.5	8.2
DoCC	84.3%	52.4%	82.9%	-	160	21.0	0.5	21.5
Ward 7	89.6%	102.3%	108.7%	133.3%	640	4.3	5.1	9.4
Ward 8	81.7%	127.8%	102.0%	176.3%	713	3.6	4.2	7.8
Ward 9	79.7%	88.9%	96.2%	98.2%	637	4.4	1.1	5.5
Ward 10	86.7%	86.1%	95.9%	82.3%	388	3.7	3.4	7.1
Ward 14	89.1%	101.8%	100.0%	143.5%	695	3.2	3.8	7.0
Ward 15	94.9%	130.4%	97.6%	175.7%	868	3.6	3.5	7.0
Ward 16	89.2%	106.1%	100.0%	133.9%	826	3.6	2.9	6.5
Ward 17	86.8%	109.9%	99.2%	131.8%	730	4.4	2.6	7.0
Ward 18	91.1%	100.3%	102.2%	136.6%	818	3.3	4.0	7.3
Ward 19	80.1%	122.1%	99.2%	160.6%	843	3.0	4.6	7.5
Ward 20	86.7%	105.3%	104.7%	112.4%	722	4.4	2.9	7.4
Ward 21	86.5%	112.3%	101.1%	120.9%	708	3.7	2.6	6.3
Ward 22	90.5%	159.8%	100.0%	185.5%	601	4.3	4.6	8.9
Ward 23	91.2%	167.3%	112.8%	175.6%	1134	3.6	4.9	8.4
Ward 24	87.8%	92.5%	97.0%	-	495	4.5	1.0	5.5
NNU	98.3%	110.3%	99.4%	108.3%	465	8.7	1.7	10.3

Meeting title	**Trust Board**	**Date: 06 July 2018**
Report title:	**Approach to Safety Checklists within the Trust**	**Agenda item: 3.4**
Lead director **Report author** **Sponsor(s)**	**Dr Ian Reckless** **Dr Andrew Cooney**	**Medical Director** **Associate Medical Director**
FoI status:	**Publicly disclosable**	

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

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

Report history	This paper arises as an action from the Public Board meeting on 05 January 2018. Its contents have been reviewed within the organisation at the Clinical Quality Board (13 June 2018).
Next steps	
Appendices	Qualitative Analysis of Safety Culture in the surgical patient pathway and in the 5 Steps to Safer Surgery at Milton Keynes University Hospital NHS Foundation Trust.

1. Purpose of the Report

This report informs Trust Board about a programme of work being developed to progress safety culture along the surgical patient pathway at the Trust. This work includes a focus upon the World Health Organisation (WHO) surgical safety checklist.

2. Context

Following on from a Never Event at the Trust in late 2017 which involved the use of incompatible components in a hemiarthroplasty (replacement of the 'stem and ball' element of the 'ball and socket' hip joint), Trust Board considered the role of the WHO checklist in the prevention of such surgical errors.

It was noted that compliance with the WHO Checklist process at the Trust is reported to be good. A completed checklist existed in relation to this case. It was explained that whilst the presence of a completed checklist offers some evidence of a positive safety culture in theatre, it is not – in isolation – pathognomonic of such a culture.

Data sources in relation to the information on the WHO Checklist provided in the Trust quality dashboard were discussed, as were the pros and cons of quantitative and qualitative measurement of compliance with such processes.

Trust Board expressed a wish to gain a deeper understanding of this topic and it was agreed that a briefing paper would subsequently be provided outlining some of the work which was being conceived at that time in conjunction with Patient Safety Collaborative Partners. This was reflected as action item 353 at the January 2018 Public Board.

3. Body of the Report

The WHO checklist which is documented on the paper form represents three steps (sign in, time out, sign out) of a broader five step process which includes team briefing and debriefing ('5 steps to Safer Surgery'). Whilst the three steps documented on the paper form offer a convenient point from which to measure compliance with the process in a quantitative sense, they do not provide assurance about the other two steps – which may be more characteristic of effective teamwork and a positive safety culture.

The appended paper describes:

- The 5 Steps to Safer Surgery
- The audit tools currently in use at MKUH in respect of the WHO Checklist:
    - A data extract from the Trust's *Surginet* system assessing whether or not a single tick box has been selected, indicating (self-report) that the WHO Checklist has been completed for the specific theatre case.
    - A monthly process by which the physical WHO Checklists from sixty cases are identified and assessed against agreed criteria in the recovery room. This offers a more granular understanding of the different elements of Checklist completion.
- Work planned in collaboration with partners (academic and NHS peer organisations) to better understand safety culture in the theatre environment. This work is likely to include an element of peer review. It is hoped that this peer review will achieve a degree of objective observation and constructive feedback without having the disadvantages of structured external observation (when behaviours are often influenced temporarily) or a 'secret shopper' approach (where costs are significant, and trust within the team can be adversely impacted).

- It is hoped that this work may, in time, be rolled out beyond theatres to other areas of the Trust.

The paper describing this work was considered at the Trust's Clinical Quality Board on 13 June 2018 where it was well received.

4. Recommendations/ Actions

Trust Board is asked to note the current system of quantitative analysis of compliance with the WHO Checklist and the planned programme of qualitative analysis and cultural development.

Dr Andrew Cooney
Dr Ian Reckless

27 June 2018

Appendix

Paper – Qualitative Analysis of Safety Culture in the surgical patient pathway and in the 5 Steps to Safer Surgery at Milton Keynes University Hospital NHS Foundation Trust.

Qualitative Analysis of Safety culture in the surgical patient pathway and in the 5 Steps to Safer Surgery at Milton Keynes University Hospital NHS Foundation Trust

Project process map -

1. Definition of the 5 Steps to Safer Surgery

The Five Steps to Safer Surgery (5SSS) is a surgical safety checklist. The process involves team briefing, sign-in, timeout, sign-out and debriefing, and is advocated by the National Patient Safety Agency (NPSA) and the WHO for all patients in England and Wales undergoing surgical procedures.

In June 2008, the World Health Organization (WHO) launched a second Global Patient Safety Challenge, 'Safe Surgery Saves Lives', to reduce the number of surgical deaths across the world. The initiative was designed to strengthen the commitment of clinical staff to address safety issues within the surgical setting. This included improving anaesthetic safety practices, ensuring correct site surgery, avoiding surgical site infections and improving communication and teamwork within the team.

The WHO Surgical Safety Checklist is part of the 5SSS and is a core set of safety checks, identified for improving performance at safety critical time points within the patient's intraoperative care pathway. It is for use in any operating theatre environment, with the expectation that it can be adapted to fit local practice.

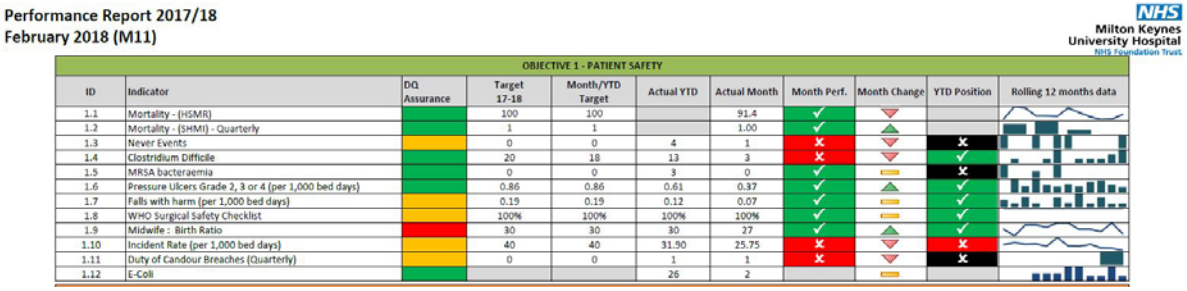
The three steps in the checklist (sign in, time out, sign out) are not intended as a tick box exercise, but as a tool to initiate meaningful and purposeful conversation between relevant members of the clinical team to improve the safety of surgery.

The additional briefing at the beginning of a list and a debriefing before members of the team depart the theatre or department are key in delivering the cultural change required.

2. Current Audit tools used at MKUH.

At MKUH, we currently undertake 2 audit processes looking at compliance with the WHO checklist specifically, rather than the whole 5SSS.

One audit involves an inputting of data into the patient's Surginet profile relating to whether the patient has had a WHO checklist performed. This merely answers the question "has the WHO process taken place for this patient?" It does not ask whether the form has been completed in totality, or whether all of the domains have been completed. This data is from where the Trust's performance dashboard is gathered.



Performance Report 2017/18
February 2018 (M11)

NHS Milton Keynes University Hospital NHS Foundation Trust

OBJECTIVE 1 - PATIENT SAFETY										
ID	Indicator	DQ Assurance	Target 17-18	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
1.1	Mortality - (HSMR)		100	100		91.4	✓	▽		
1.2	Mortality - (SHMI) - Quarterly		1	1		1.00	✓	△		
1.3	Never Events		0	0	4	1	✗	▽	✗	
1.4	Clostridium Difficile		20	18	13	3	✗	▽	✓	
1.5	MRSA bacteraemia		0	0	1	0	✓	▬	✗	
1.6	Pressure Ulcers Grade 2, 3 or 4 (per 1,000 bed days)		0.86	0.86	0.61	0.37	✓	△	✓	
1.7	Falls with harm (per 1,000 bed days)		0.19	0.19	0.12	0.07	✓	▬	✓	
1.8	WHO Surgical Safety Checklist		100%	100%	100%	100%	✓	▬	✓	
1.9	Midwife : Birth Ratio		30	30	30	27	✓	△	✓	
1.10	Incident Rate (per 1,000 bed days)		40	40	31.90	25.75	✗	▽	✗	
1.11	Duty of Candour Breaches (Quarterly)		0	0	1	1	✗	▽	✗	
1.12	E-Coli				26	2		▬		

A second internal audit is carried out each month, aiming to audit 60 forms across specialties, and across all 12 theatres. Patient's WHO forms are randomly selected each working day by Recovery ward staff and audited on the spot. If a form is incomplete, the audit will record it as such. The bleep holder is then notified and the WHO from taken back to the theatre and reported to the relevant staff for learning. The audit summary is sent to the Theatre CSU triumvirate for information. The audit focuses on completion of the form and, as such, the effectiveness of the WHO process is not audited.

We already know that the 'Sign Out' is the least well completed domain, and recent focus has been on improving the functioning of the 'Time Out' to prevent wrong site surgery. However, our adverse and never event occurrences suggest that the errors leading to these events have usually started earlier along the pathway, sometimes in the day surgery ward or at the patient check-in at the door to theatres. Usually there are human factor errors involved.

Another perception is that a significant obstacle to successful implementation is variable engagement of the surgical team.

In this proposed analysis model, we will use the data from the 2 audits to inform a qualitative analysis process will aim to evaluate stakeholders' opinions regarding the 5SSS and its implementation across the surgical patient pathway and specifically in theatres. This will provide an insight into culture and barriers and will help to uncover trends in thought and opinions, facilitating a deeper analysis into the implementation of the 5SSS.

We will use established tools such as a modified published questionnaire (An Exploration of the Factors that Influence the Successful Implementation of the World Health Organization Surgical Safety Checklist, Bill Robertson-Smith, Journal of Perioperative Care, Volume: 26 issue: 11, 243-249), as well as questionnaire and survey tools developed in collaboration with researchers and psychologists from the University of Buckingham Medical School.

3. Scope of this project

The project will be predominately undertaken at MKUH and with the University of Buckingham Medical School, in collaboration with the Oxford Academic Health Science Network (OAHSN) and Royal Berkshire Hospital NHS Foundation Trust (RBH). The project will aim to gain qualitative evidence about standardisation and safety culture in the operating theatres at Milton Keynes NHS Foundation Trust.
The multidisciplinary nature of the 5SSS and Surgical Safety Checklist necessitates that all relevant professions views on the subject will be obtained.

4. Partners

1. University of Buckingham Medical School
2. Patient Safety Collaborative (hosted by Oxford AHSN)
3. Royal Berkshire Hospital NHS Foundation Trust

5. The Milton Keynes Surgical Patient Pathway

We will look across the whole elective surgical patient pathway, analysing aspects of patient safety from outpatients and bookings administration through to pre-assessment, the admissions units, theatres, recovery and the ward.

We will seek the opinions of all staff members from across these domains, including nursing, orderlies, medical and admin.

6. Analysis tools

The project will aim to analyse the safety culture within the surgical patient pathway, and the 5SSS at Milton Keynes NHS Foundation Trust, through a combination of qualitative research techniques, including:

1. Staff surveys and questionnaires.
2. Staff interviews –
    i. Individual
    ii. Forum
3. Observational analysis –
    i. Peer-to-peer
    ii. Professional
4. Current audit process – trends and learning.
5. Incident review – trends and learning.

Initially, a survey regarding the 5SSS will be sent to all staff members working within the surgical division, in order to ascertain an understanding and overview of the surgical safety pathway at Milton Keynes Hospital.

We will then conduct a range of individual and staff forum interviews. Forums will aim to engage staff members in group discussions around the topic, in order to create an atmosphere of openness for participants to explore issues they perceive as important.

In addition, implementation of the 5SSS within the theatre environment will be observed, both by peers and professionally trained observers. There is scope for collaboration with the Royal Berkshire Hospital during this phase of the study. We would ask 5SSS champions, likely from a Theatres background, to visit each organisation and appraise the functionality of each system using a standardised review tool. The group will work co-productively to look for potential learning in each system, comparing what works well and what could be improved.

The current audit results will be analysed for trends and compared to the results from the interviews.

Finally, any safety incidents occurring in the surgical environment will be analysed in order to ascertain possible relation to the implementation of the 5SSS.

7. Interventions

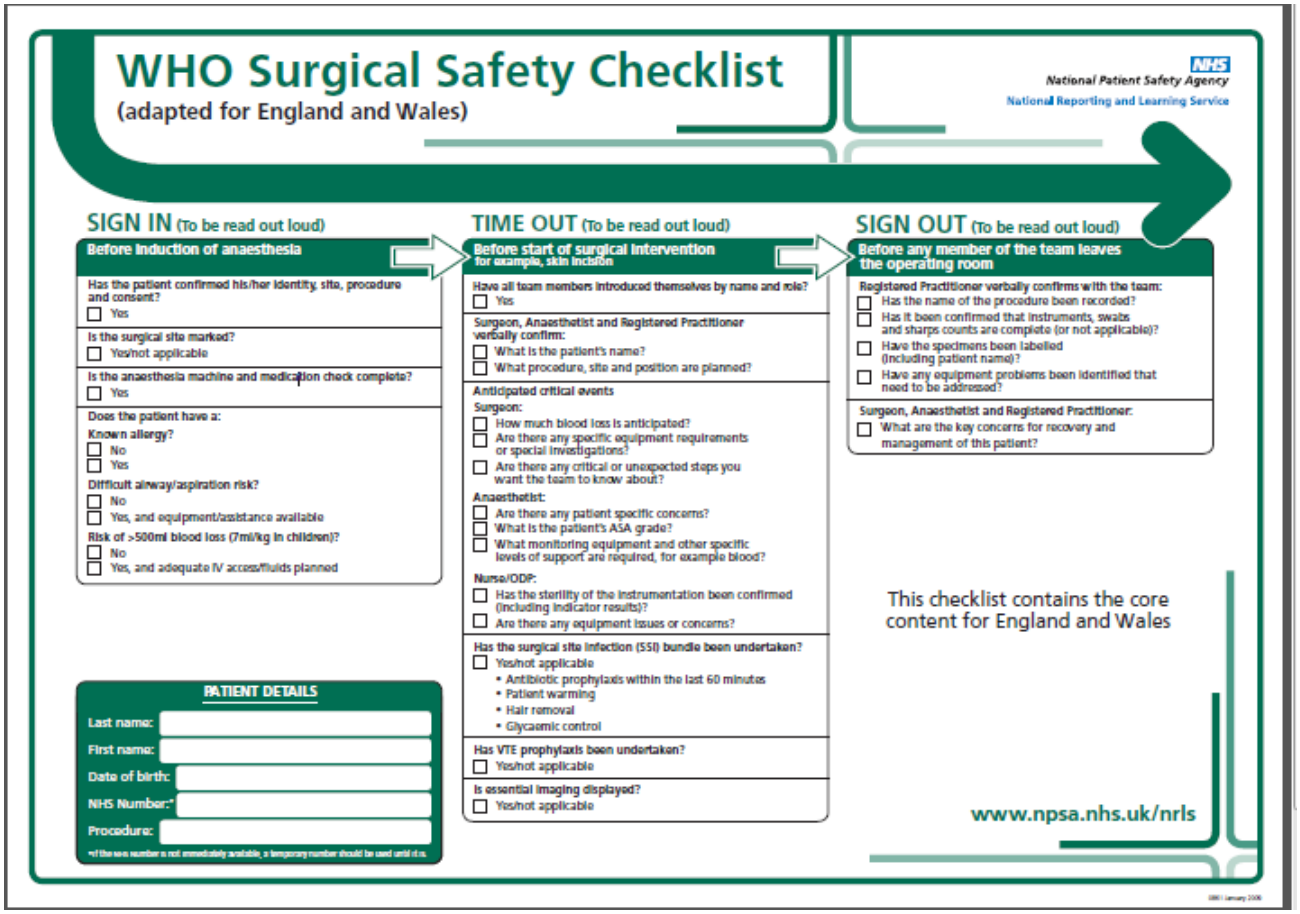
Simulation and team training can enhance non-technical skills and improve communication between staff. The Robertson-Smith study concludes that differing staff perceptions were found to create barriers to successful implementation of the checklist. Training of all staff is necessary for effective communication within the operating theatre.

Our interventions could include –
1. Internal learning.
2. External interventions, such as peer review, professional group eg Attrainability (https://atrainability.co.uk), shared learning, didactic training, simulation training.

8. Portability and regional relevance

It is anticipated that this study will be reproducible in other NHS Trusts.

9. Resources



10. References

1. NPSA - http://www.nrls.npsa.nhs.uk/resources/?entryid45=59860
2. An Exploration of the Factors that Influence the Successful Implementation of the World Health Organization Surgical Safety Checklist , Bill Robertson-Smith, Journal of Perioperative care, Volume: 26 issue: 11, 243-249
3. Implementation of the surgical safety checklist at a tertiary academic center: Impact on safety culture and patient outcomes. Am J Surg 2017 Aug 30;214(2):193-197. Epub 2016 Nov 30.
4. Changes in safety climate and teamwork in the operating room after implementation of a revised WHO checklist: a prospective interventional study. Patient Saf Surg 2017 31;11. Epub 2017 Jan 31.
5. Clinical motivation and the surgical safety checklist. Br J Surg 2017 Mar 3;104(4):472-479. Epub 2017 Feb 3.

11. Appendix

Example Questionnaire

1. What is your staff role?
   - o Surgical consultant
   - o Anaesthetic consultant
   - o Surgical Trainee
   - o Anaesthetist (non-consultant)
   - o Surgical Care Practitioner
   - o Non-surgical Trainee/Middle Grade
   - o Scrub Nurse
   - o Operating Department Practitioner
   - o Theatre Support Worker

2. How long have you worked within the theatre setting?
   - o Less than 5 years
   - o 5-10 years
   - o 10-20 years
   - o More than 20 years

3. Are you familiar with the WHO Surgical Check list?
   - o Yes
   - o No

4. In what format was the training that you received from this trust?
   - o Intranet
   - o Lecture
   - o No training received (proceed to question 9)

   Other (please specify

5. Were you formally trained in undertaking the WHO Surgical Checklist?
   - o Yes
   - o No

6. Did you feel the training was adequate?
   - o Yes
   - o No

7. What aspects of the training could be improved upon?

8. What aspects about the training were good?

9. Do any of the following components of the WHO Surgical Checklist need to be improved upon?
   - o Sign in (before induction of anaesthesia)
   - o Time out (before the start of surgical intervention)
   - o Sign out (before any member of the team leaves the operating theatre)

10. Why does this component need to be improved?

11. Does a team brief take place before every theatre list begins?
   - o Yes
   - o No

12. Are all team members present at the team brief?
   - o Yes
   - o No

13. If no, why are all team members not present in your opinion?

14. In your experience, which member of the team leads the WHO Surgical Checklist at Time out the majority of the time? (Time out takes place before the start of surgical intervention)
   - o Consultant Surgeon
   - o Consultant Anaesthetist
   - o Operating Surgeon
   - o Anaesthetist (non-consultant)
   - o Scrub Nurse
   - o Operating Department Practitioner
   - o Theatre Support Worker

15. Are all team members present when Time out occurs? (Before the start of surgical intervention)
   - o Yes
   - o No

16. Who do YOU think that the Time out should be led by and why?

17. Are all team members present when Sign out occurs? (This takes place after the operation has ended but before any members of the teal leaves theatre)
   - o Yes
   - o No

18. Does a team debrief take place after every list ends?
   - o Yes
   - o No
   - o Depends on consultant lead

19. If no, why does this not happen, in your opinion?

20. Are all team members present at the debrief?
   - o Yes
   - o No

21. If your answer is no, generally, who is absent?

22. How important do you think the team debrief is at the end of a theatre list?
   - o Very important
   - o Important
   - o Moderately important
   - o Of little importance
   - o Unimportant

23. Is feedback from the day's theatre list collected and how is this collected?

24. How is best practice shared with other theatre teams from this feedback?

25. Do you think that an electronic version, for example on the Sapphire system, of the WHO Surgical Checklist would be an appropriate use of resources rather than a paper version?
   - o Yes
   - o No

26. What reasons do you have for your answer to the above question?

27. What or whom do you feel is the biggest obstacle in the success of the WHO Surgical Checklist?

28. How would you improve the smooth running of the WHO Surgical Checklist?

29. How important is the WHO Surgical Checklist compared to your other priorities in a theatre list?
   - o Very important
   - o Important
   - o Moderately important
   - o Of little importance
   - o Unimportant

30. Do you think that the WHO Surgical Checklist is a useful tool that improves patient safety and team efficiency?
   - o Yes
   - o No

31. Any further comments?

Meeting title	Board of Directors	Date: 6 July 2018
Report title:	Vision, Values, Strategic Aims, Objectives – Summary Pack	Agenda item: 4.1
Lead director Report author Sponsor(s)	Joe Harrison	Chief Executive
FoI status:	Public Meeting	

Report summary	This paper summarises the trust's vision, purpose, values, strategic aims and objectives and is presented – following significant consultation and engagement in its development – to the Board for formal approval.			
Purpose *(tick one box only)*	Information ☐	Approval ☒	To note ☐	Decision ☐
Recommendation	The Board is asked to approve the contents of this summary paper			

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

Report history	Previous Board review and discussion.
Next steps	Approval and dissemination.
Appendices	Papers follow

Purpose, Vision, Values, Strategic Aims and Objectives

This paper summarises the trust's purpose, vision, values, strategic aims and objectives. It is designed to be accessible by all staff and members of the public, and to communicate these key foundations clearly and simply.

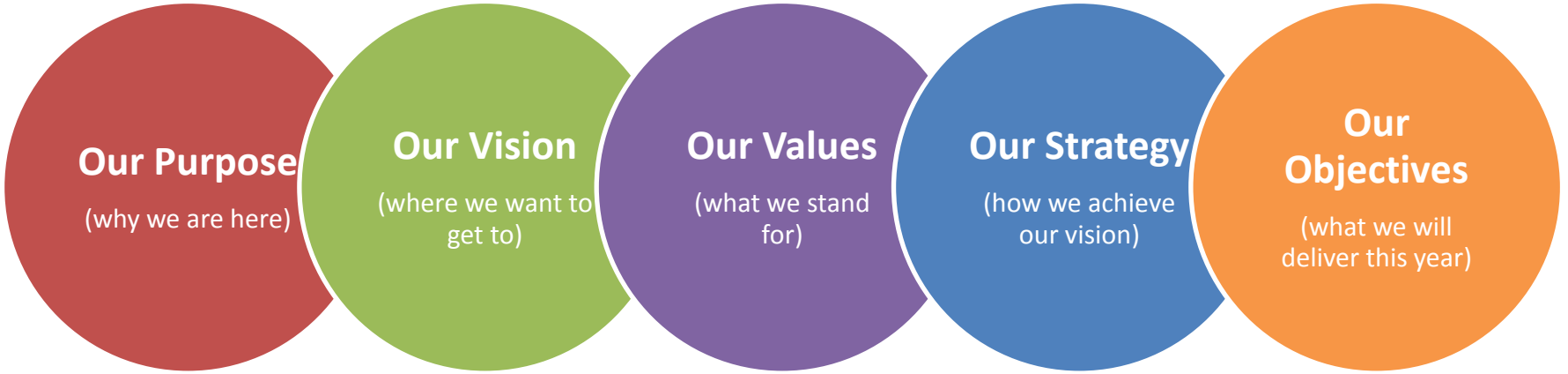
This summary has been developed with and through engagement with staff and the values particularly have been widely engaged with, amended and updated iteratively throughout the engagement process.

This paper presents the final, consolidated version and is presented to the Board for approval. Once approved, this summary will be widely disseminated to staff and made publicly available.

Recommendations to the Board

That the purpose, vision, values, strategic aims and objectives summary paper is approved.

Our Purpose, Vision, Values, Strategy and Objectives


Our Purpose
(why we are here)
Our Vision
(where we want to get to)
Our Values
(what we stand for)
Our Strategy
(how we achieve our vision)
Our Objectives
(what we will deliver this year)

Our Purpose

(why we are here)

High quality care for everyone we serve

To provide safe, effective acute hospital care and a positive experience of hospital services for the residents of Milton Keynes, Buckinghamshire and beyond.

Meeting the health and care needs of one of the fastest growing populations in the country.

Our Vision

(where we want to get to)

Our **vision** for Milton Keynes University Hospital NHS Foundation Trust is to be an **outstanding** acute hospital and part of a health and care system working well together and with care, communication, compassion and collaboration at its core.

Our Values

(what we stand for)

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

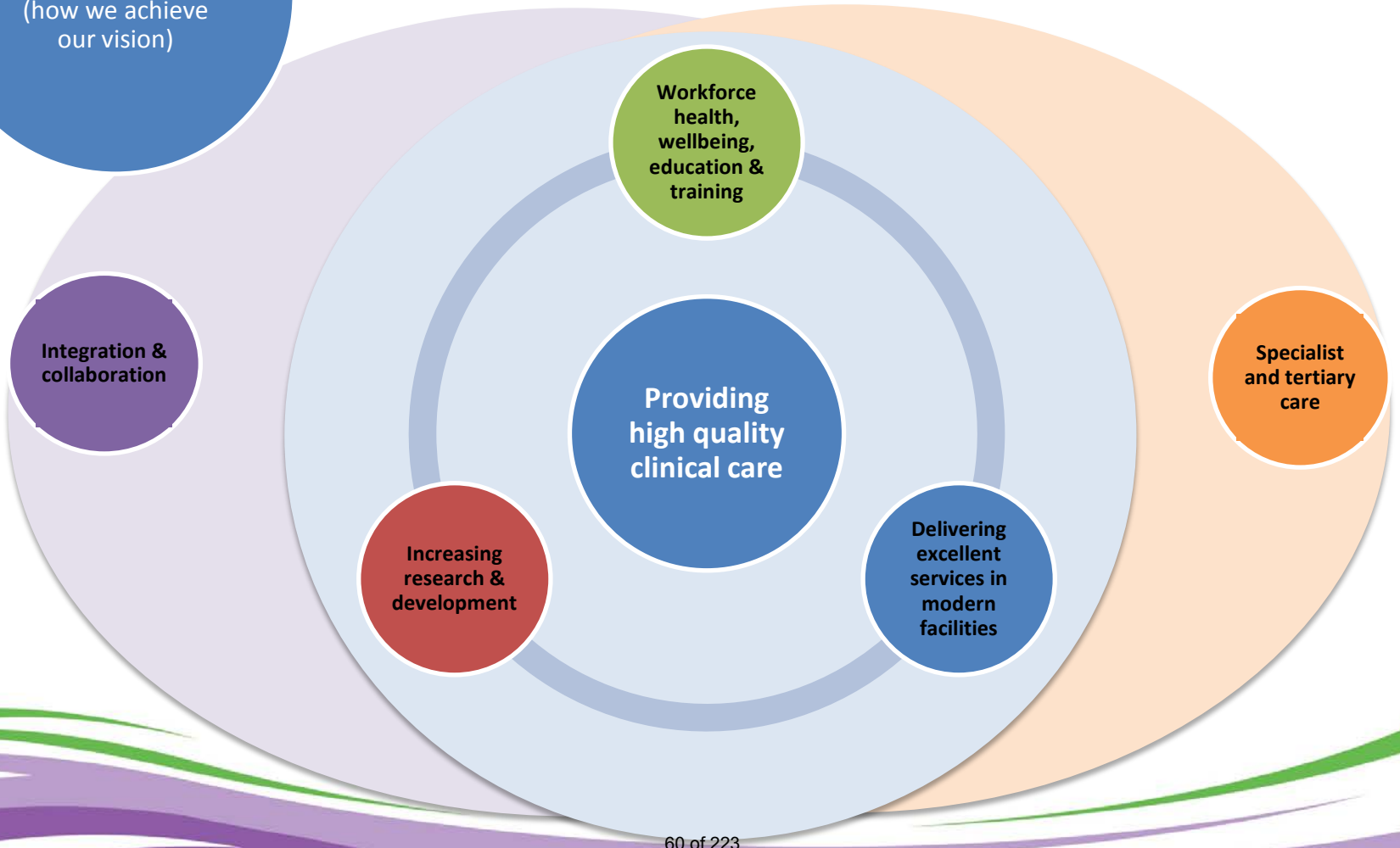
We communicate: We say #hellomynameis; we keep patients informed about and involved and engaged in their treatment and care; and each other informed about what's happening in our hospital. We know we can speak up to make sure our hospital is safe and our patients are well cared for.

We collaborate: We are **#TeamMKUH**. We work together and with GPs, primary care, community care, social care and mental health providers and other hospitals to deliver great care and services for people in Milton Keynes, Buckinghamshire and beyond.

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

Our Strategy

(how we achieve our vision)



Our Strategic Aims

(how we achieve our vision)

- To deliver **high quality clinical care and services** in the best possible facilities for every patient, every time
- To invest in our **workforce** and their **health and wellbeing**, **education and training** to recruit and retain great people in every profession
- To improve **research and development** to give patients in Milton Keynes and Buckinghamshire parity of access to clinical trials
- To lead **integration and collaboration** in the Milton Keynes health and care system to improve how residents access and experience services
- To ensure our patients can access the best **specialist and tertiary care** and working with neighbouring hospitals to make sure our clinical services meet the latest quality standards

Our Objectives

(what we will deliver this year)

Meeting title	Board of Directors	Date: 6 July 2018
Report title:	Outpatients Transformation Programme Update	Agenda item: 4.2
Lead director Report author Sponsor(s)	Kate Burke	Director of Corporate Affairs
FoI status:	Public meeting	

Report summary				
Purpose *(tick one box only)*	Information [x]	Approval [ ]	To note [ ]	Decision [ ]
Recommendation	The Board is asked to note the issues raised in the report and the summary action plan. This is for regualr reporting.			

Strategic objectives links	SO1: Patient Safety SO2: Patient Experience SO3: Clinical Effectiveness SO4: Key Targets SO7: Finance and Governance
Board Assurance Framework links	**4-1** Failure to manage scheduled care waiting lists appropriately
CQC regulations	All domains
Identified risks and risk management actions	**4-1** Failure to manage scheduled care waiting lists appropriately
Resource implications	Current re-organisation in budget Current likelihood of lost income
Legal implications including equality and diversity assessment	Failure to meet statutory waiting times

Report history	Previous reviews and actions reported to Board (last report March 2018)
Next steps	Regular reporting
Appendices	Papers follow

Outpatients Improvement Programme: Update to MAC (June 2018)

Outpatients – Safe Care and a Good Experience for Every Patient

Context

Milton Keynes University Hospital saw almost 360,000 outpatient attendances last year – almost 7,000 every calendar week.

This number includes patients being seen for the first time and those being seen in follow-up appointments. It also includes all type of appointment or patient 'pathway' – from urgent two-week cancer pathways and 18-week referral to treatment pathways, through to follow-up appointments three, six or even more months after any definitive treatment has begun.

Managing outpatient activity, including managing waiting lists, booking appointments, providing a call centre function, ensuring letters are typed and sent in a timely fashion, and acting as one of the main contact points for patients using the hospital way is complex, and relies on a skilled and professional administrative workforce and clinical staff who are trained and knowledgeable on the complexities of administrative pathway management.

Current Performance

There are focussed specialty-level plans to continue improving the Trust's RTT position.

The Trust has additionally been tackling a backlog of patients on non-RTT pathways, with significant additional capacity through waiting list initiatives (WLIs) and super Saturday clinics. This has seen the non-RTT waiting list backlog reduce from just over 13,000 to around 5,500 over the last six months.

All waiting lists are managed through operations and tracked at the weekly Patient Tracking List (PTL) meeting, chaired by the Deputy Chief Executive.

Outpatients Transformation Programme Plan

The Outpatients Transformation Programme is a significant programme of work, with the strategic aim of improving patient experience through standardised administrative processes and booking models, investment in and training for skilled administrative staff, use of digital platforms and technology. Additionally it is focussed on improving data quality.

Currently the programme is focussed on the following areas:

Programme Work Stream	Current Status	Next Steps
Administrative staffing and structures	• Consultation complete • Staff allocated into posts • Hotspot areas for staffing identified (PPCs and typists)	• Staff to move to centralised locations where agreed in the consultation (e.g. Admissions Hub to Goldfish Bowl now once vacated by eCARE Hub) • Solutions being identified to address staffing hotspot areas (e.g. risk summit held in orthodontics/ oral surgery) • Work with divisions to ensure full posts and funds released during the restructure to ensure appropriate staffing numbers
Staff training	• Training strategy developed • Training passport developed • Quality checked by NHS Improvement elective care intensive support team	• Roll out of strategy (reintroduction of classroom training for administrative staff) • Launch of training passport
Revised outcome forms (data quality)	• Updated forms and process rolled out across 7 specialties • Audits taking place to ensure efficacy of new format	• Accelerated roll out continuing, to be complete before end of July • Continue audits and retrain where necessary based on results • Review options for switching to electronic outcome forms
Digital dictation and transcription	• Current use of transcription service across the divisions to address backlogs	• Build of technical link between EDM and Scribetech Textflow system • Linking trust letter templates to new

	• Agreement received to pilot further use of Scribetech Textflow system which will 'top and tail' letters and feed directly into EDM system • IT server purchased to enable works	system • Testing of system with specialty areas • Complete pilot
Online patient portal (powered by Zesty)	• Current mixture of models available across specialties • Scoping full deployment of letters functionality (this would release significant income back into the Trust through eliminating postage costs)	• Map specialty list management and booking methods to portal model • Roll out standardised model (full and partial booking) • Identify support centre and train staff • Formalise letters module and roll out across specialties
Revised booking models	• 17 specialties identified to move to full booking • Remaining high volume specialties to retain partial booking model for the time being • Models being finalised	• Specialty by specialty roll-out plan • Reviewing list management processes for specialties remaining on partial booking

Recommendations

The Board is asked to note the current position.

Meeting title	Board of Directors	Date: 6 July 2018
Report title:	Corporate Governance Structure - Update	Agenda item: 4.3
Lead director Report author Sponsor(s)	Kate Jarman	Director of Corporate Affairs
FoI status:	Public Meeting	

Report summary	This paper provides a brief visual update to the Board on the Trust's corporate governance structure and quality governance structure, following updates to continue to strengthen reporting and oversight.			
Purpose *(tick one box only)*	Information ☐	Approval ☐	To note x	Decision ☐
Recommendation	The Board is asked to approve the contents of this summary paper			

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

Report history	None
Next steps	Approval and dissemination.
Appendices	Papers follow

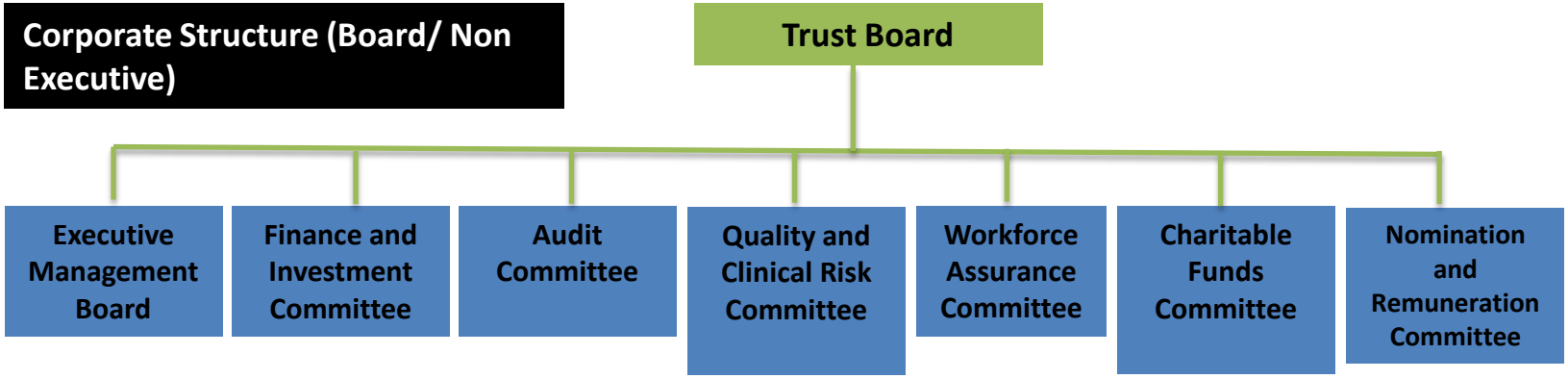
Updated Corporate and Quality Governance Structure

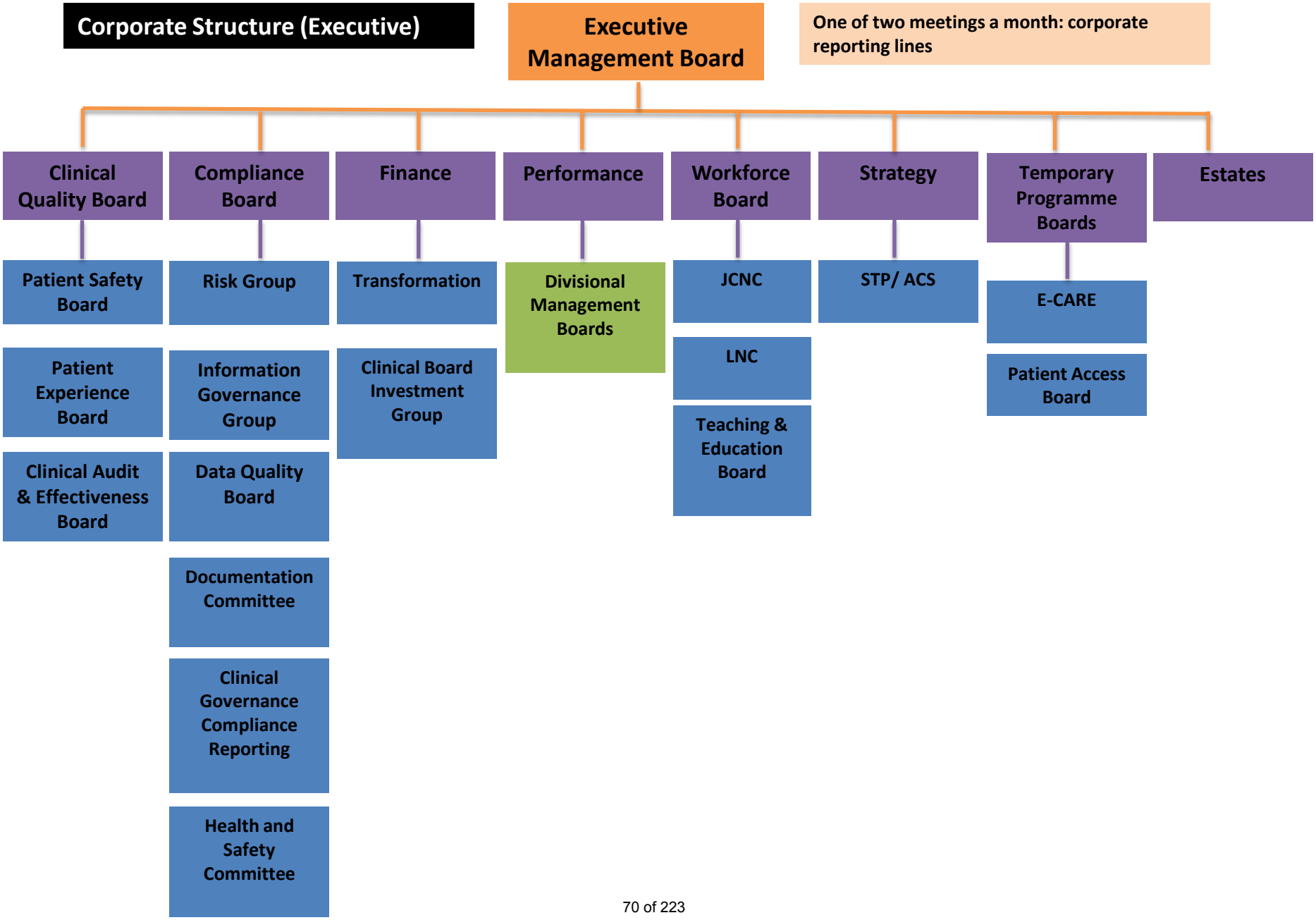
This paper is here to provide the Board with an updated version of the Trust's key corporate and quality governance structure and reporting boards.

This structure will continue to be revised and developed to ensure effective governance and oversight.

Recommendations to the Board

The Board is asked to note the paper.


Corporate Structure (Board/ Non Executive)
Trust Board
Executive Management Board
Finance and Investment Committee
Audit Committee
Quality and Clinical Risk Committee
Workforce Assurance Committee
Charitable Funds Committee
Nomination and Remuneration Committee


Corporate Structure (Executive)
Executive Management Board
One of two meetings a month: corporate reporting lines
Clinical Quality Board
Compliance Board
Finance
Performance
Workforce Board
Strategy
Temporary Programme Boards
Estates
Patient Safety Board
Patient Experience Board
Clinical Audit & Effectiveness Board
Risk Group
Information Governance Group
Data Quality Board
Documentation Committee
Clinical Governance Compliance Reporting
Health and Safety Committee
Transformation
Clinical Board Investment Group
Divisional Management Boards
JCNC
LNC
Teaching & Education Board
STP/ ACS
E-CARE
Patient Access Board

Divisional Reporting Structure

Executive Management Board

One of two meetings a month: divisional reporting lines

Divisional Management Boards

Divisional triumverate held to account for combined performance, business and quality agenda

Divisional Management Meetings

Chaired by DD, meets x10 a year, two way information flow (escalation and cascade)

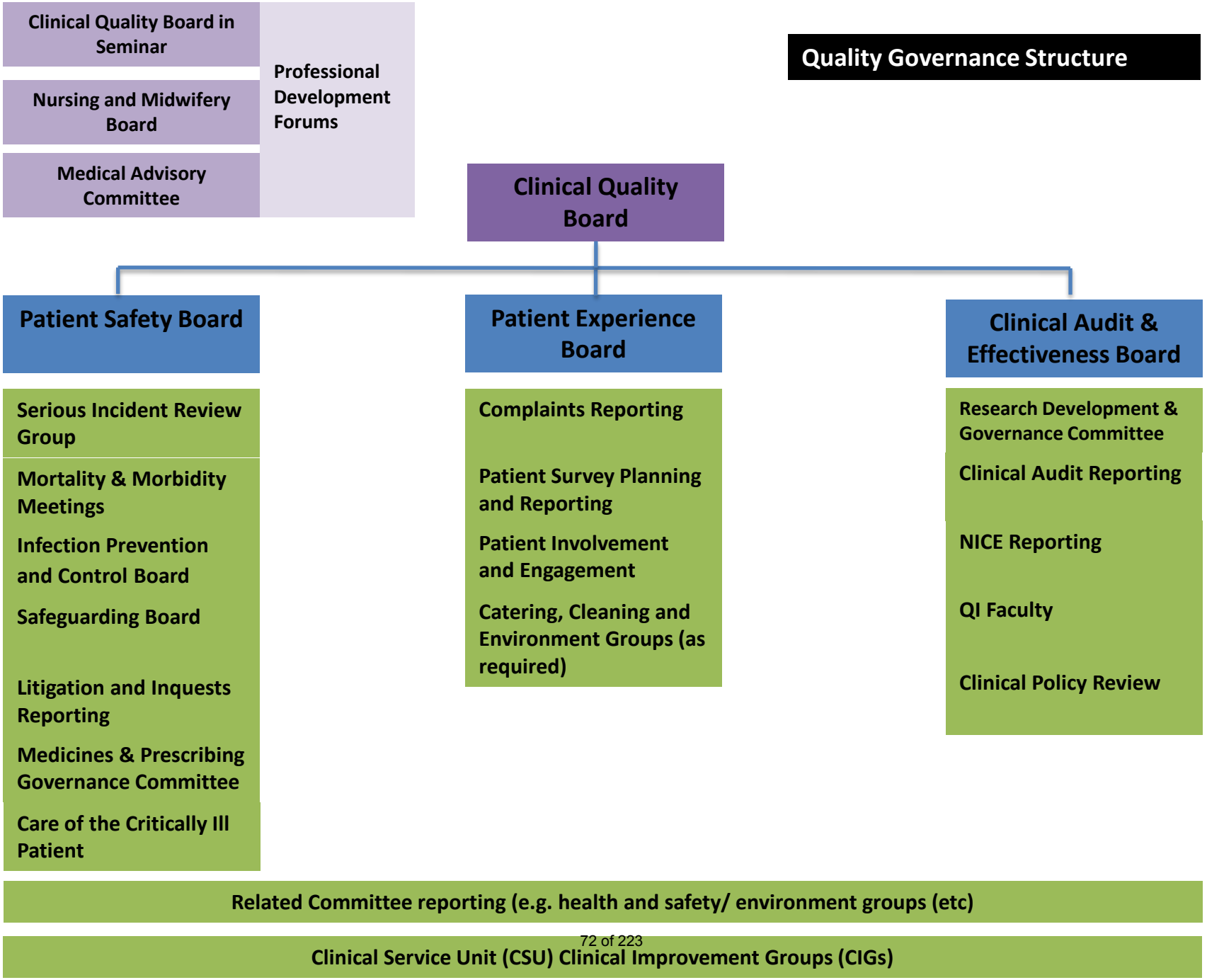
CSU leads all attend, trends and assurance, strategy, performance, finance, clinical governance and quality)

CSU Management Meetings

Chaired by CSU Lead, meets x10 a year, two way information flow (escalation and cascade)

CIGs (incidents, complaints, risks, audit, compliance, etc), mortality & morbidity, finance, performance, consultant meetings, specialty level information

Quality Governance Structure



Meeting title	Trust Board	Date: 6 July 2018
Report title:	Performance Report indicators for 2018/19 (Month 2)	Agenda item: 5.1
Lead director Report author Sponsor(s)	Name: John Blakesley Name: Hitesh Patel	Title: Deputy Chief Executive Title: Associate Director of Performance and Information
FoI status:	Disclosable	

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

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

Report history	None
Next steps	None
Appendices	None

Trust Performance Summary: M2 (May 2018)

1.0 Summary

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

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

2.0 Sustainability and Transformation Fund (STF)

Performance Improvement Trajectories

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

ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change
4.1	ED 4 hour target (includes UCS)		92.5%	91.9%	95.2%	94.5%	✓	▼
4.2	RTT Incomplete Pathways <18 weeks		90.1%	89.6%		84.0%	✗	▼
4.9	62 day standard (Quarterly)		82.4%	82.4%	Reported Quarterly			

After achieving a performance of 96% last month, ED performance dropped to 94.5% in May 2018, which was below the national standard of 95%. However, in the context of the Trust's NHS Improvement trajectory, it was ahead of the 91.9% commitment. NHS England national A&E performance in May 2018 was 90.4%.

The referral to treatment (RTT) national NHS operational standard (92%) for incomplete pathways was not achieved by the Trust in May 2018. At the end of May 2018, a performance of 84% was reported, which was the lowest since April 2012. The Trust's NHS Improvement target of 89.6% for RTT was also not met in May 2018.

The NHS England combined performance for the RTT standard at the end of April 2018 was 87.5%. May's national RTT performance will be published only on 12/07/2018.

Cancer waiting times are reported on a quarterly basis, usually six weeks after the close of a calendar quarter. The most recent confirmed position therefore was Q4 2017/18, when the Trust exceeded the 85% national standard, achieving 87.2%.The final validated figures for Q1 2018/19 will not be reported until early August 2018.

3.0 Urgent and Emergency Care

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

ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.6%	0.7%	✓	▼
3.2	Ward Discharges by Midday		30%	30%	20.1%	18.0%	✗	▼
3.4	30 day readmissions		6.4%	6.4%	8.2%	8.5%	✗	▼
3.7	Delayed Transfers of Care		25	25		23	✓	▲
4.1	ED 4 hour target (includes UCS)		92.5%	91.9%	95.2%	94.5%	✓	▼

Cancelled Operations on the Day

The number of elective operations cancelled on the day for non-clinical reasons increased from 16 in April 2018 to 21 in May 2018. This represented 0.7% of all planned operations during the month, which was still within the 1% tolerance.

Readmissions

The 30 day readmission rate continued above the threshold of 6.4% with a rate of 8.5% emergency readmission rate during May 2018. The Trust last met the threshold in August 2016.

At a divisional level, Women & Children reported 4%, an increase compared to April 2018 (3.9%). The readmission rate for Medicine remained high at 12.9% in May, whereas the rate in Surgery decreased to 5.1% from 5.2% in April 2018.

Delayed Transfers of Care (DTOC)

The Trust has seen a significant improvement in delayed transfers of care (DTOC) since April 2018. In May 2018, the Trust reported a decrease from 29 in April 2018 to 23 at midnight on the last Thursday of the calendar month. The cumulative number of days delayed for all patients throughout the month reduced to 803 days in May 2018 from 895 in April 2018.

Ambulance Handovers

After achieving a performance of 2.8% (the lowest level seen since August 2017) in April 2018, the Ambulance handovers taking longer than 30 minutes increased to 6.5% in May 2018. This was above the 5% tolerance. In addition, the number of ambulance handovers which took longer than 60 minutes increased to 10 in May 2018 from 3 in April 2018.

4.0 Elective Pathways

ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change
3.1	Overnight bed occupancy rate		93%	93%	94.2%	92.5%	✓	▲
3.5	Follow Up Ratio		1.50	1.50	1.48	1.46	✓	▲
4.2	RTT Incomplete Pathways <18 weeks		90.1%	89.6%		84.0%	✗	▼
4.6	Diagnostic Waits <6 weeks		99%	99%		98.5%	✗	▲
5.6	Outpatient DNA Rate		5%	5%	6.1%	6.3%	✗	▼

Overnight Bed Occupancy

In May 2018, the overnight bed occupancy was reduced to 92.5%, which was below the 93% internal threshold. This was the lowest reported since March 2017.

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

Follow up Ratio

Planning outpatient capacity to cope with new referrals is impacted by the demand for follow-ups. The follow up ratio for May 2018 improved significantly when compared to April 2018 and was within the threshold, with an average of 1.46 follow up attendances for every new attendance seen.

RTT Incomplete Pathways

As mentioned previously, the Trust 18 week RTT performance continued below the 92% RTT national standard and the NHS Improvement target (89.6%). The number of patients waiting more than 18 weeks increased to 2,405 in May from 2,156 in April 2018.

However, the number of patients waiting more than 52 weeks without being treated remained the same as last month (22) at the end of May 2018.

Diagnostic Waits <6 weeks

MKUH had a challenging month in terms of diagnostic waits, with the performance (98.5%) continuing below the 99% national standard in May 2018. However, this is an improvement in performance compared to April 2018 (98.2%).

At a Trust level, the number of breaches decreased from 83 in April to 49 in May 2018.

Outpatient DNA Rate

The outpatient DNA rate increased by 0.4% in May 2018 to 6.3%. This increase was evident across all divisions. DNAs represent clinic capacity that cannot be otherwise utilised. All services should ensure that they adhere to the Trust Access Policy to minimise DNA rates. The Policy is frequently discussed at the weekly RTT meetings, at which all services are represented.

5.0 Patient Safety

Infection Control

MKUH reported zero cases of E-coli, CDI, MRSA and MSSA infections in Month 2.

ENDS

Performance Report 2018/19
May 2018 (M02)

Milton Keynes University Hospital NHS Foundation Trust

OBJECTIVE 1 - PATIENT SAFETY										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
1.1	Mortality - (HSMR)		100	100		87.1	✓	▼		
1.2	Mortality - (SHMI) - Quarterly		1	1	Reported Quarterly					
1.3	Never Events		0	0	0	0	✓	▬	✓	
1.4	Clostridium Difficile		20	<4	1	0	✓	▲	✓	
1.5	MRSA bacteraemia (avoidable)		0	0	0	0	✓	▬	✓	
1.6	Pressure Ulcers Grade 2, 3 or 4 (per 1,000 bed days)		0.6	0.6	0.58	0.82	✗	▼	✓	
1.7	Falls with harm (per 1,000 bed days)		0.15	0.15	0.15	0.22	✗	▼	✓	
1.8	WHO Surgical Safety Checklist		100%	100%	100%	100%	✓	▬	✓	
1.9	Midwife : Birth Ratio		28	28	Not Available					
1.10	Incident Rate (per 1,000 bed days)		40	40	29.57	31.87	✗	▲	✗	
1.11	Duty of Candour Breaches (Quarterly)		0	0	Reported Quarterly					
1.12	E-Coli				3	0		▲		
1.13	MSSA				0	0		▬		

OBJECTIVE 2 - PATIENT EXPERIENCE										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
2.1	FFT Recommend Rate (Patients)		94%	94%	94.5%	95%	✓	▲	✓	
2.2	RED Complaints Received		8	1	0	0	✓	▬	✓	
2.3	Complaints response in agreed time		90%	90%	87.0%	92.9%	✓	▲	✗	
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.6%	0.7%	✓	▼	✓	
2.5	Over 75s Ward Moves at Night		2,554	426	406	229	✗	▼	✓	
2.6	Mixed Sex Breaches		0	0	0	0	✓	▬	✓	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
3.1	Overnight bed occupancy rate		93%	93%	94.2%	92.5%	✓	▲	✗	
3.2	Ward Discharges by Midday		30%	30%	20.1%	18.0%	✗	▼	✗	
3.3	Weekend Discharges		70%	70%	73.6%	80.8%	✓	▲	✓	
3.4	30 day readmissions		6.4%	6.4%	8.2%	8.5%	✗	▼	✗	
3.5	Follow Up Ratio		1.50	1.50	1.48	1.46	✓	▲	✓	
3.6.1	Number of Stranded Patients (LOS>=7 Days)		227	227		215	✓	▲		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		91	91		91	✓	▬		
3.7	Delayed Transfers of Care		25	25		23	✓	▲		
3.8	Discharges from PDU (%)		16%	16%	12.0%	10.8%	✗	▼	✗	
3.9	Ambulance Handovers >30 mins (%)		5%	5%	4.6%	6.5%	✗	▼	✓	

OBJECTIVE 4 - KEY TARGETS										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
4.1	ED 4 hour target (includes UCS)		92.5%	91.9%	95.2%	94.5%	✓	▼	✓	
4.2	RTT Incomplete Pathways <18 weeks		90.1%	89.6%		84.0%	✗	▼		
4.3	RTT Patients Waiting Over 18 Weeks		1,287	1,371		2,405	✗	▼		
4.4	RTT Total Open Pathways		12,999	13,181		15,003	✗	▼		
4.5	RTT Patients waiting over 52 weeks			10		22	✗	▬		
4.6	Diagnostic Waits <6 weeks		99%	99%		98.5%	✗	▲		
4.7	All 2 week wait all cancers (Quarterly)		93%	93%	Reported Quarterly					
4.8	31 days Diagnosis to Treatment (Quarterly)		96%	96%	Reported Quarterly					
4.9	62 day standard (Quarterly)		82.4%	82.4%	Reported Quarterly					

OBJECTIVE 5 - SUSTAINABILITY										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
5.1	GP Referrals Received		60,189	9,708	11,168	5,476	✓	▼	✓	
5.2	A&E Attendances		91,290	15,257	14,877	7,633	✗	▲	✗	
5.3	Elective Spells (PBR)		25,528	4,255	4,251	2,305	✓	▲	✗	
5.4	Non-Elective Spells (PBR)		35,287	5,897	6,076	3,169	✓	▲	✓	
5.5	OP Attendances / Procs (Total)		364,854	60,809	61,728	31,507	✗	▲	✓	
5.6	Outpatient DNA Rate		5%	5%	6.1%	6.3%	✗	▼	✗	
5.7	Number of babies delivered				549	270		▼		
5.8	Number of antenatal bookings				619	286		▼		

OBJECTIVE 7 - FINANCIAL PERFORMANCE										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
7.1	Income £'000		238,802	37,798	38,218	19,876	✓	▲	✓	
7.2	Pay £'000		(161,048)	(27,264)	(27,297)	(13,964)	✗	▼	✗	
7.3	Non-pay £'000		(72,791)	(12,199)	(12,791)	(6,376)	✗	▲	✗	
7.4	Non-operating costs £'000		(12,893)	(2,147)	(2,141)	(1,067)	✓	▲	✓	
7.5	I&E Total £'000		(7,930)	(3,812)	(4,011)	(1,531)	✗	▲	✗	
7.6	Cash Balance £'000		2,500	2,260		3,014	✓	▼		
7.7	Savings Delivered £'000		10,130	1,056	754	472	✗	▲	✗	
7.8	Capital Expenditure £'000		29,673	2,092	6,231	3,014	✗	▲	✗	

OBJECTIVE 8 - WORKFORCE PERFORMANCE										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
8.1	Staff Vacancies % of establishment		12%	12%		14.1%	✗	▼		
8.2	Agency Expenditure %		8%	8%	6.2%	5.7%	✓	▲	✓	
8.3	Staff sickness - % of days lost		4%	4%		4.1%	✗	▬		
8.4	Appraisals		90%	90%		82.0%	✗	▬		
8.5	Statutory Mandatory training		90%	90%		90.0%	✓	▬		
8.6	Substantive Staff Turnover		12%	12%		12.5%	✗	▼		
8.7	FFT Response Rate Staff (Quarterly)		15%	15%	Reported Quarterly					

OBJECTIVES - OTHER										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
O.1	Total Number of NICE Breaches		8	8		37	✗	▲		
O.2	Rebooked cancelled OPs - 28 day rule		95%	95%	77.6%	99.8%	✓	▲	✗	
O.3	Maternity Bookings <13 weeks		90%	90%	88.2%	86.0%	✗	▼	✗	
O.4	Overdue Datix Incidents >1 month		0	0		93	✗	▲		
O.5	Serious Incidents		45	<8	12	7	✗	▼	✗	
O.6	Dementia Measures Met		3	3		4	✓	▬		
O.7	Energy Consumption (GJ)		239,937	33,288	Not Available					
O.8	Completed Job Plans (Consultants)		90%	90%		87.5%	✗	▼		

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

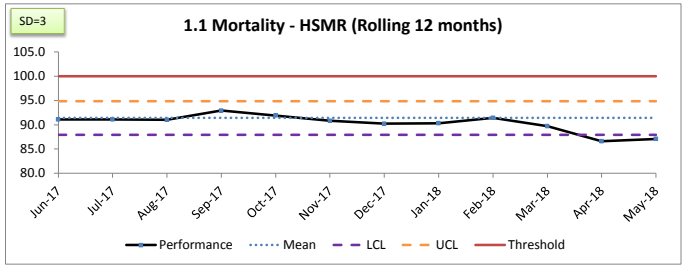
YTD Position

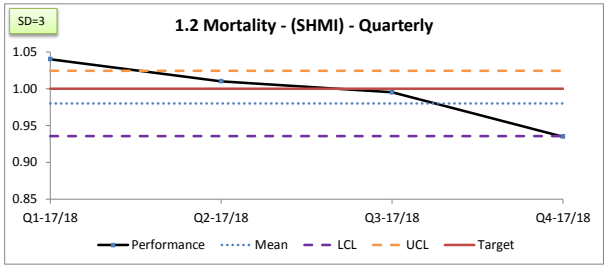
✓	Achieving YTD Target
	Within Agreed Tolerance*
✗	Not achieving YTD Target
✗	Annual Target breached

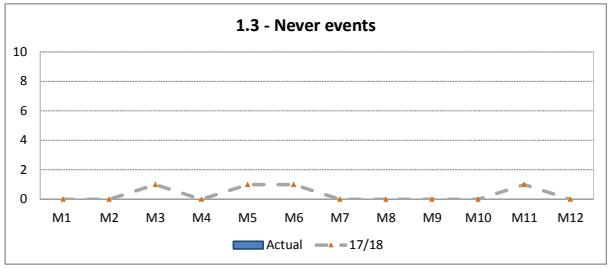
Data Quality Assurance Definitions

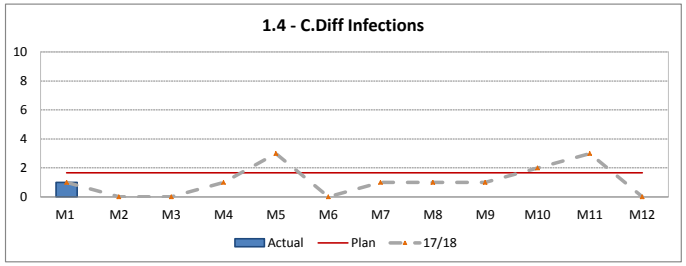
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory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

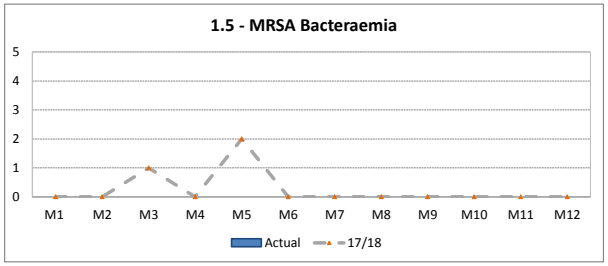
* Independently Audited – refers to an independent audit undertaken by either the Internal Auditor, External Auditors or the Data Quality Audit team.

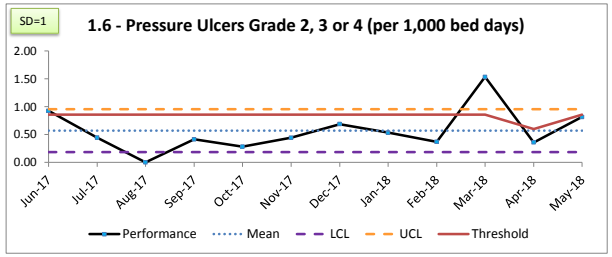


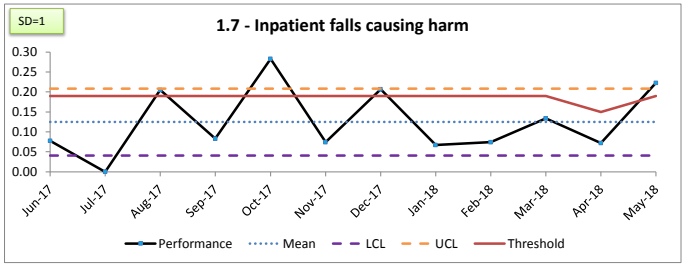


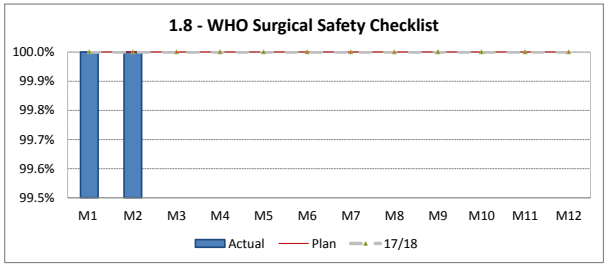


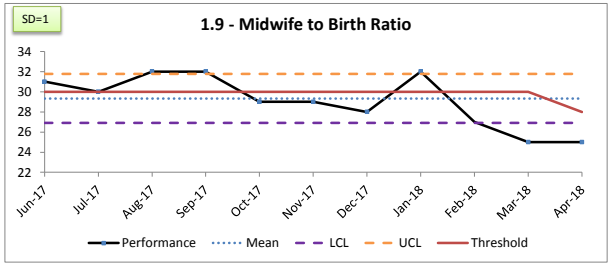


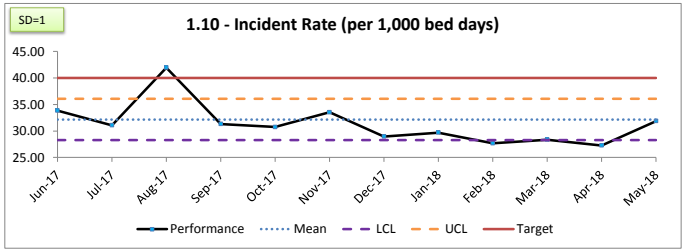


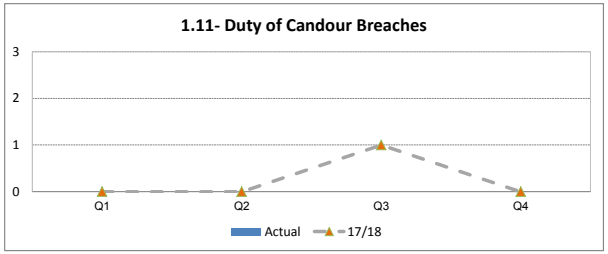


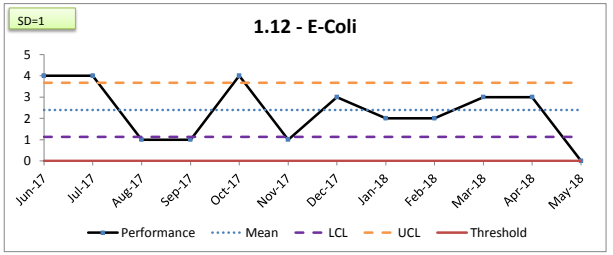






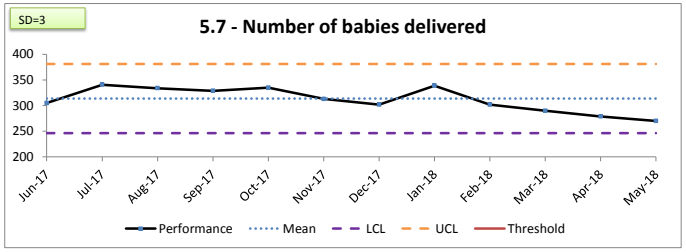


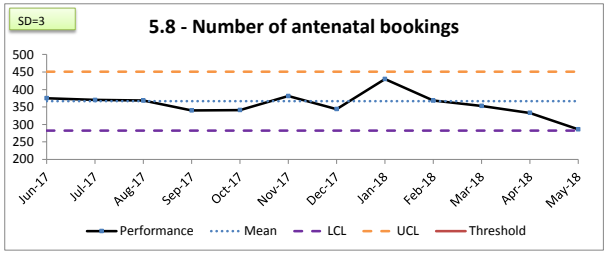


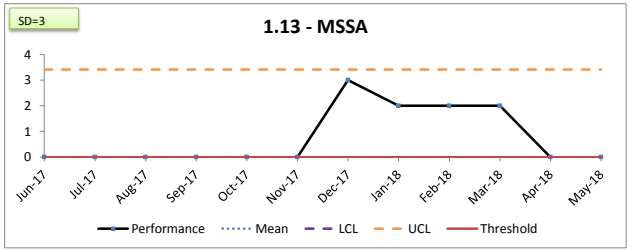


If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

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



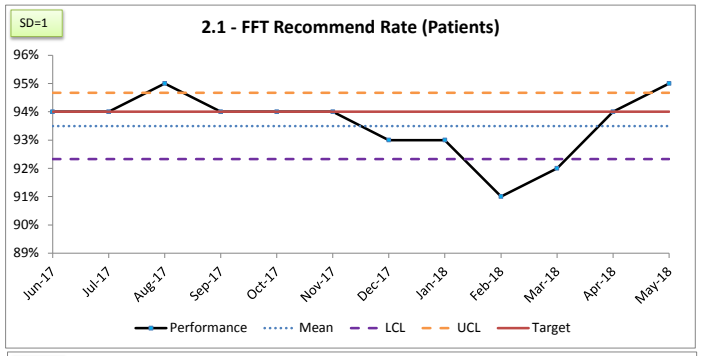


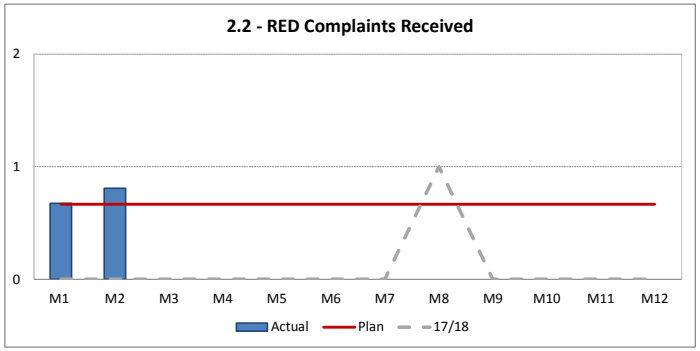


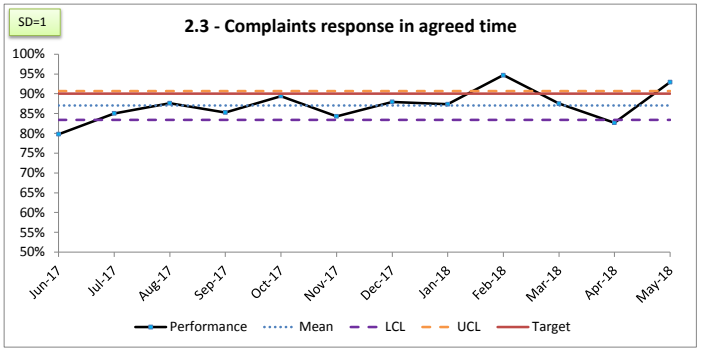
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

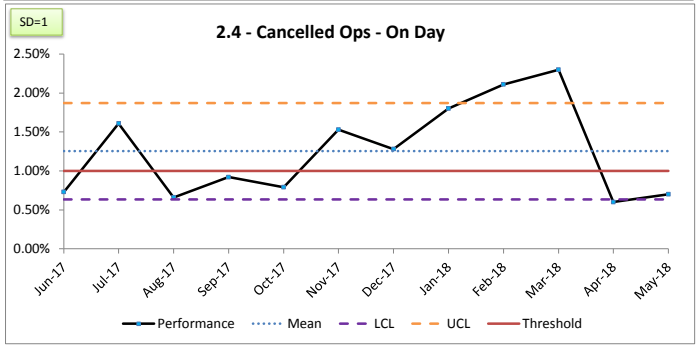
Performance activity on a rolling 12 months/quarterly
Average on a rolling 12 months/quarterly
Lower Control Limit (LCL)
Upper Control Limit
Targets/Thresholds/NHSI Trajectories

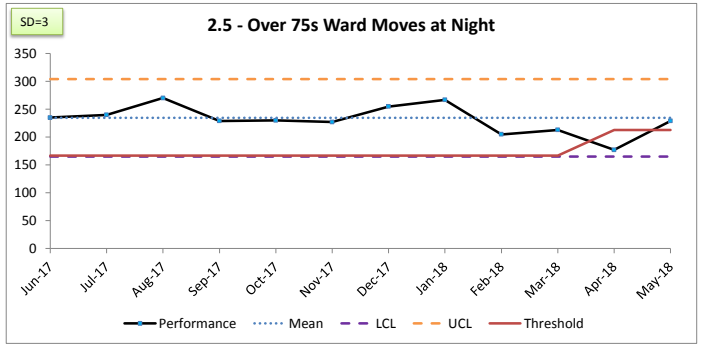
OBJECTIVE 2 - PATIENT EXPERIENCE

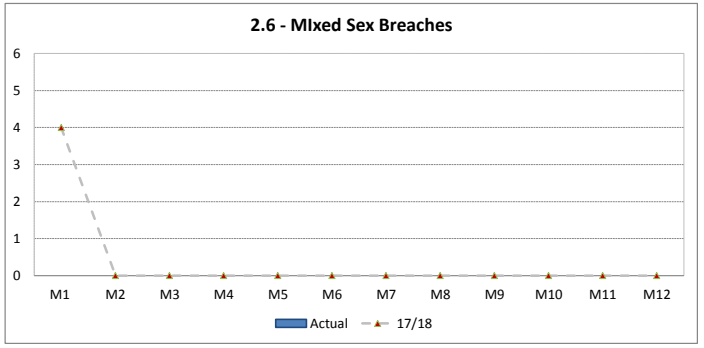








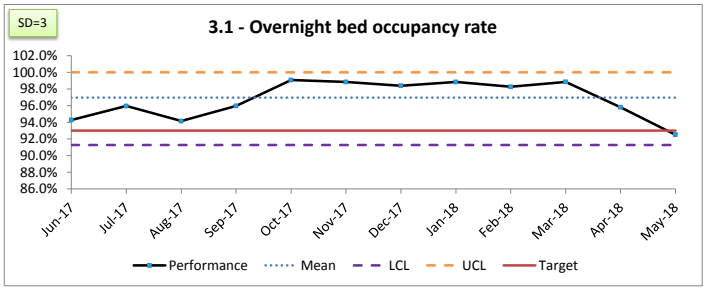


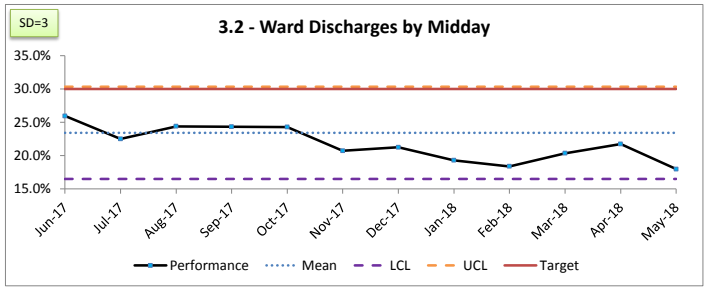


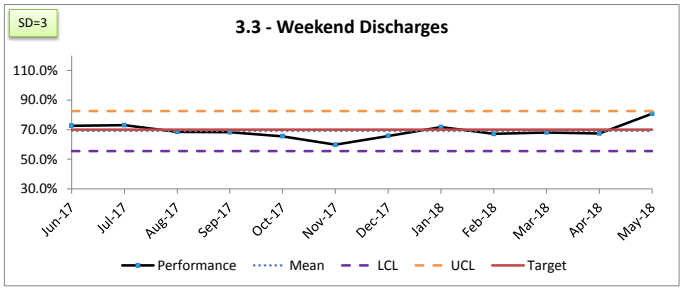
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

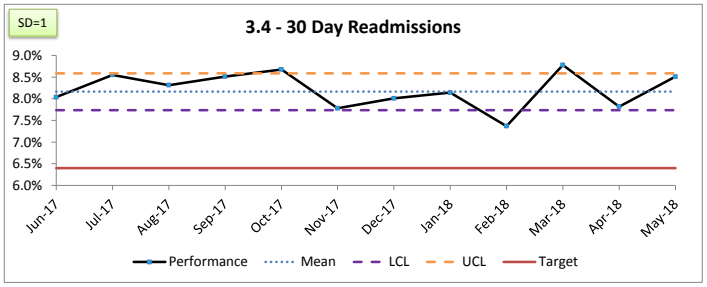
- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

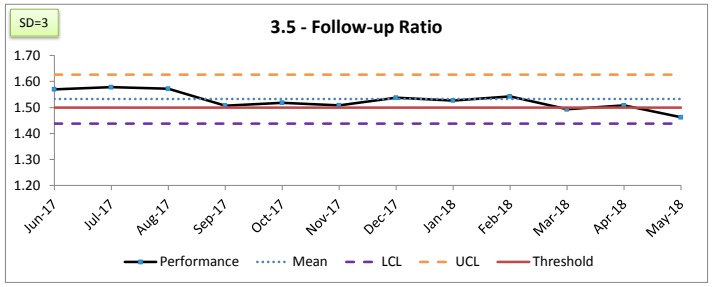
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

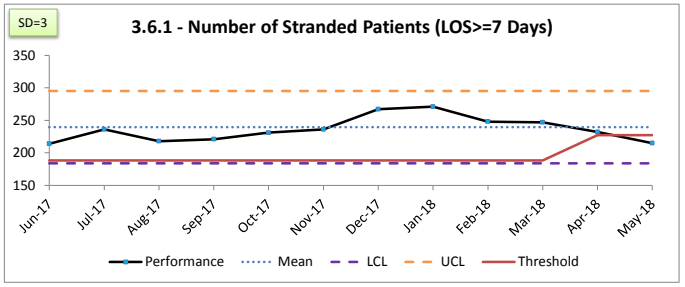


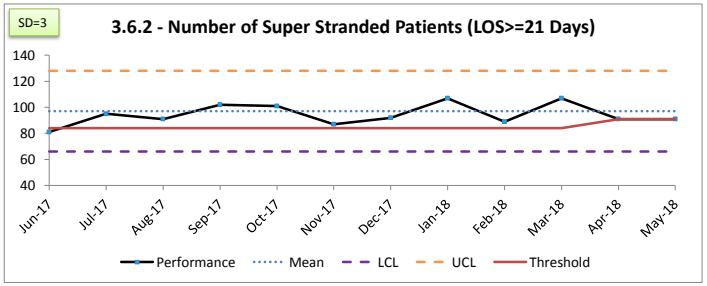


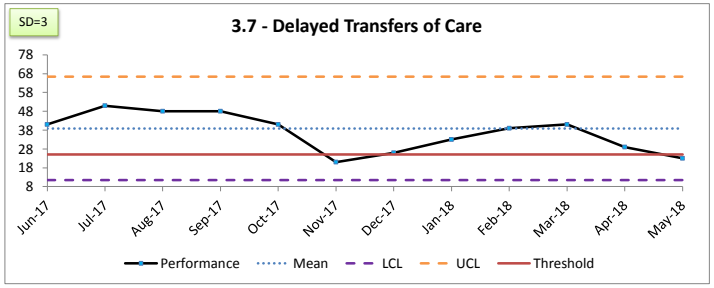


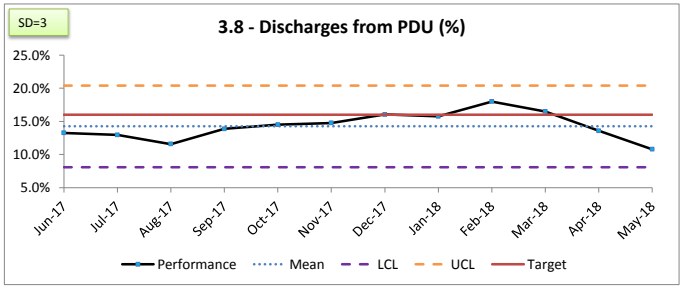


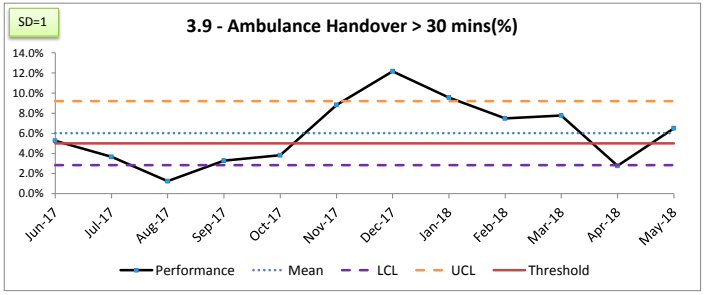








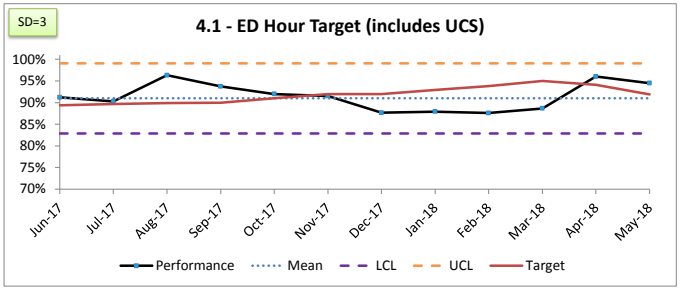


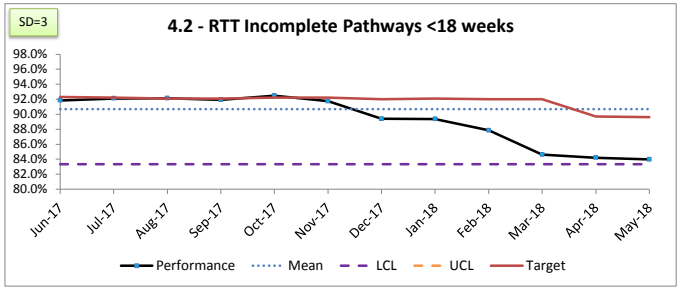


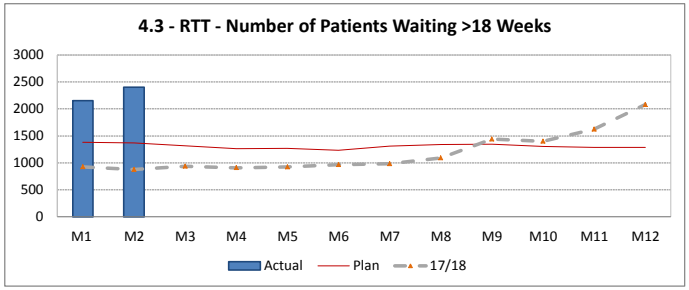
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

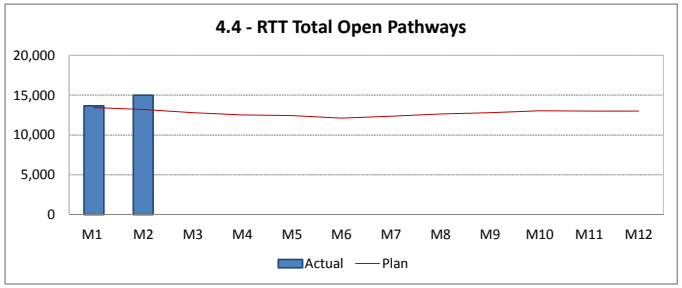
- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

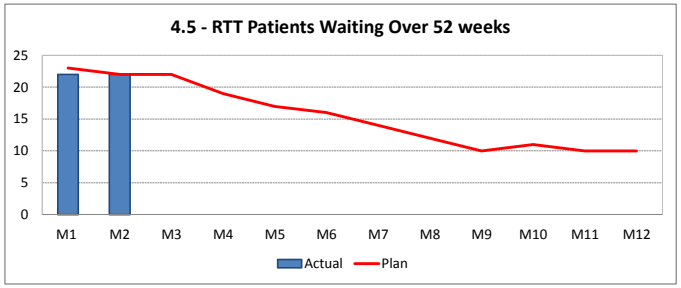
OBJECTIVE 4 - KEY TARGETS

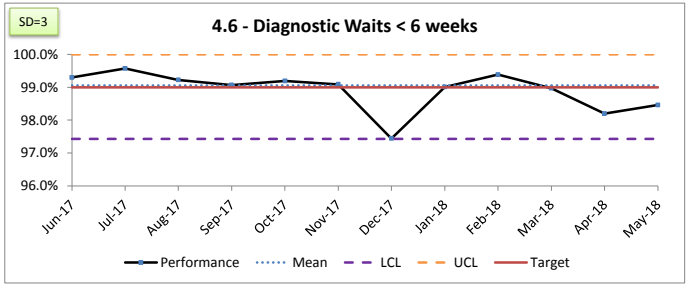


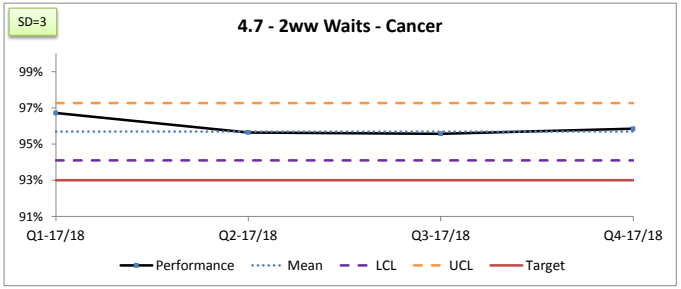


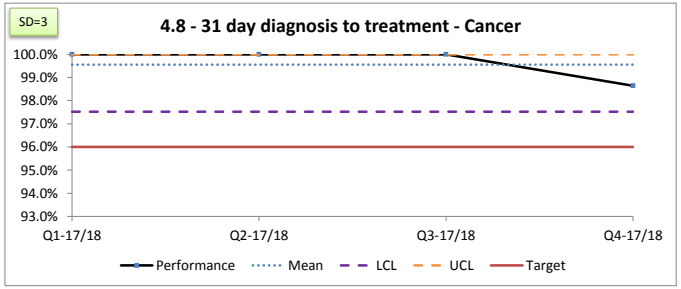


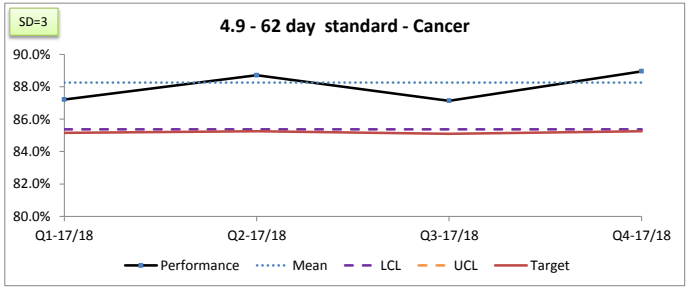






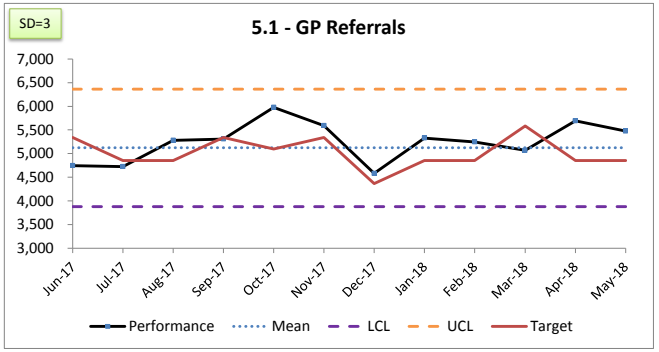


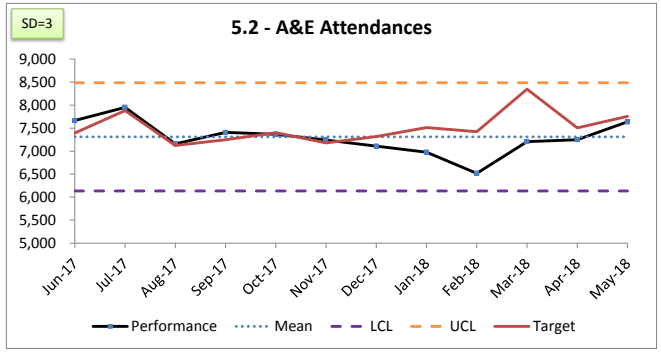


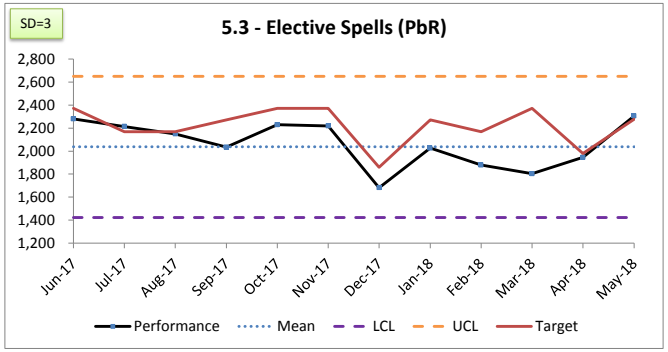


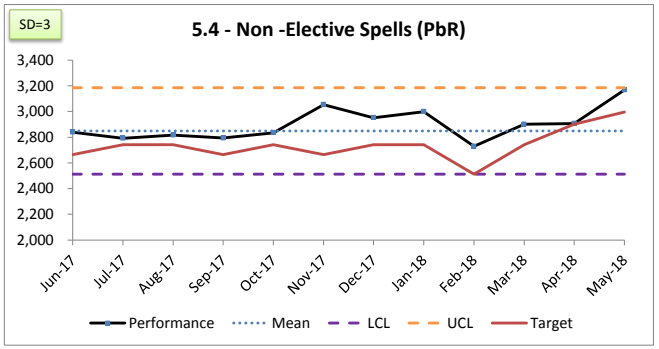
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

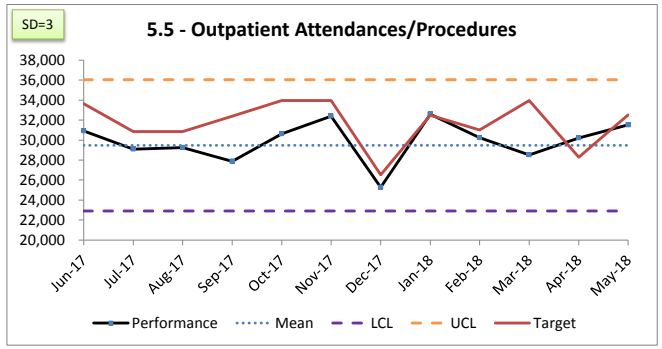
- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

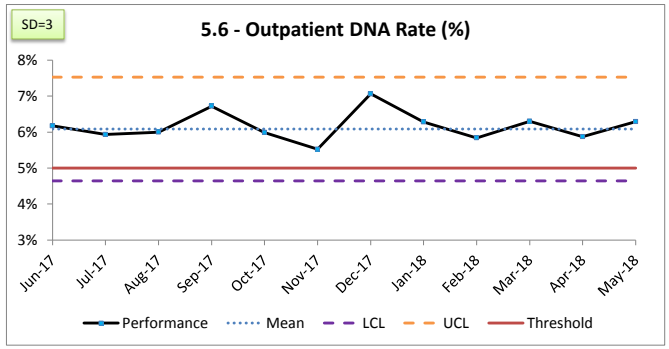






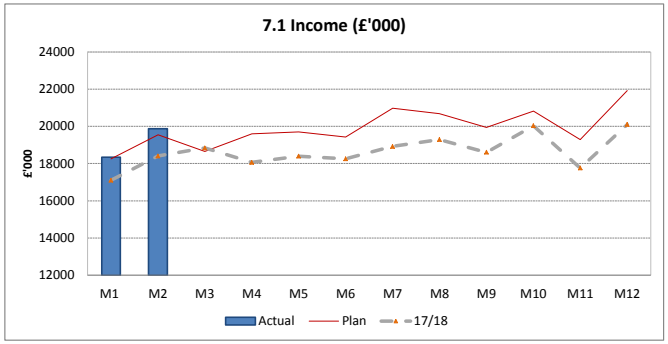


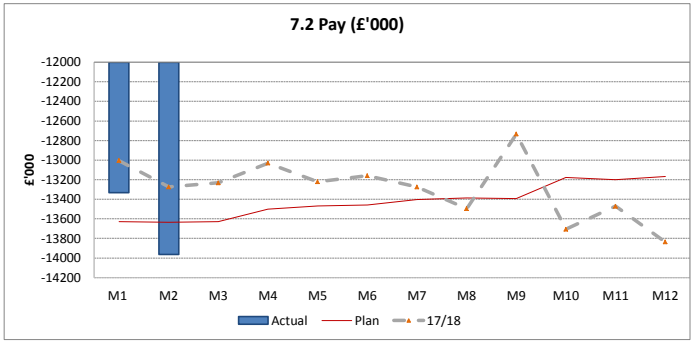


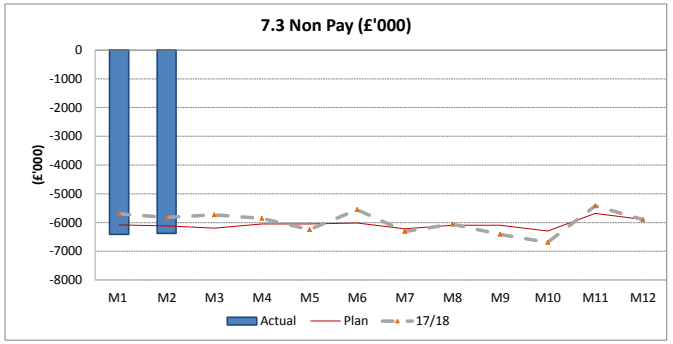


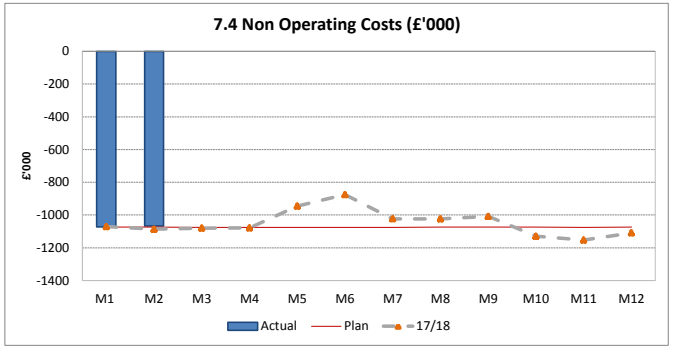
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

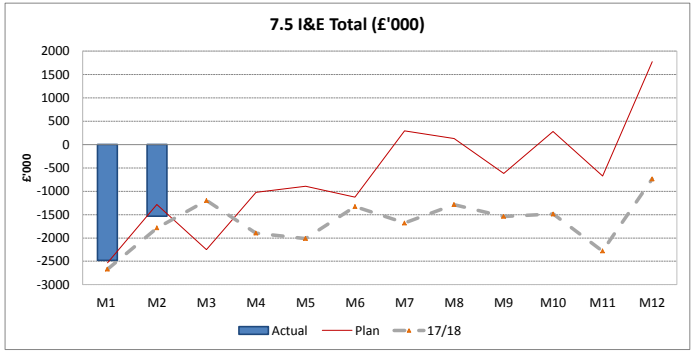
- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

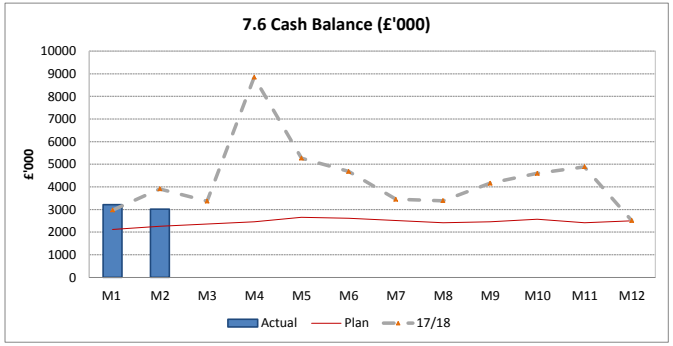

7.1 Income (£'000)
£'000
24000
22000
20000
18000
16000
14000
12000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

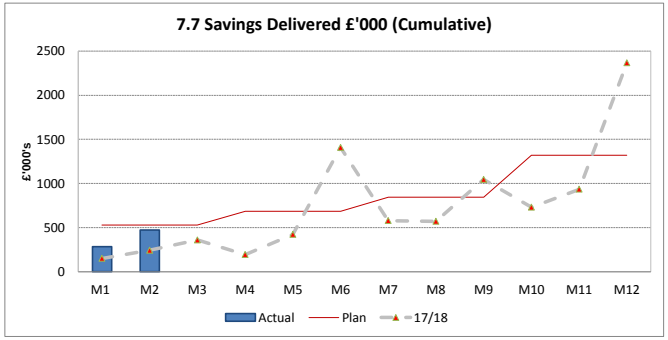

7.2 Pay (£'000)
£'000
-12000
-12200
-12400
-12600
-12800
-13000
-13200
-13400
-13600
-13800
-14000
-14200
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

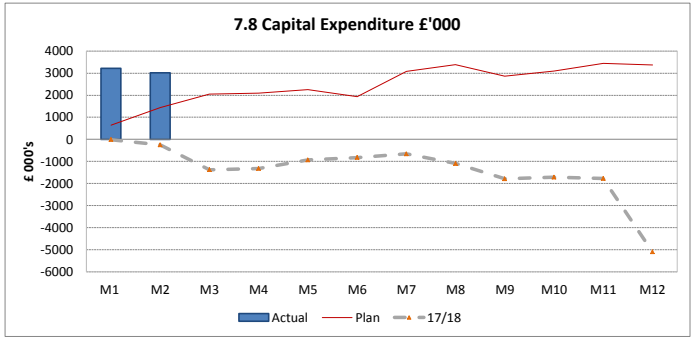

7.3 Non Pay (£'000)
(£'000)
0
-1000
-2000
-3000
-4000
-5000
-6000
-7000
-8000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18


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

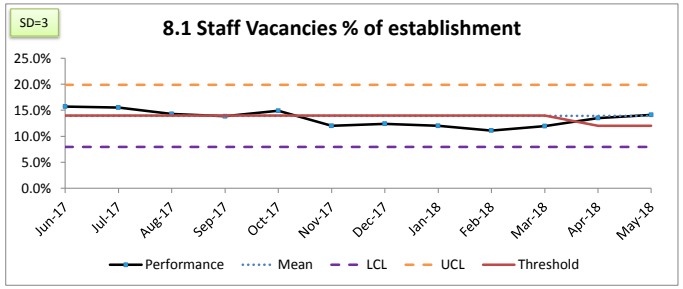

7.5 I&E Total (£'000)
£'000
2000
1500
1000
500
0
-500
-1000
-1500
-2000
-2500
-3000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

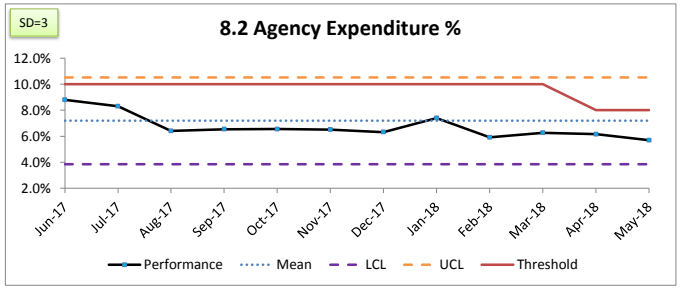

7.6 Cash Balance (£'000)
£'000
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

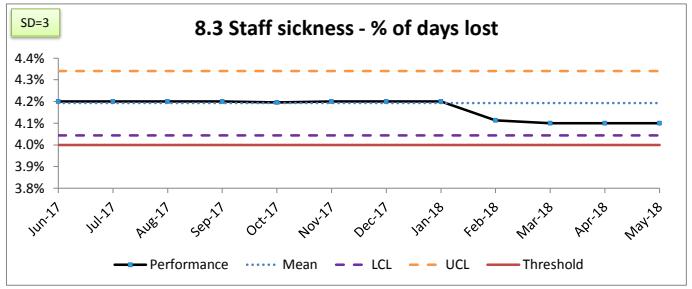

7.7 Savings Delivered £'000 (Cumulative)
£'000's
2500
2000
1500
1000
500
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

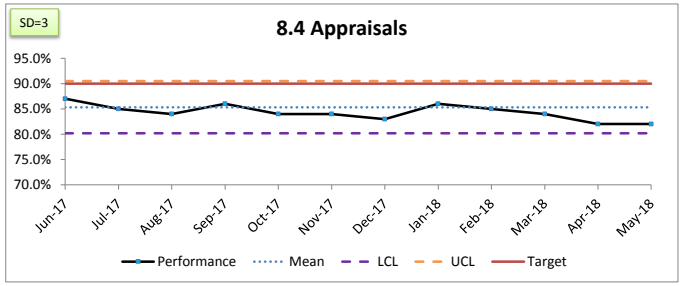

7.8 Capital Expenditure £'000
£ 000's
4000
3000
2000
1000
0
-1000
-2000
-3000
-4000
-5000
-6000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

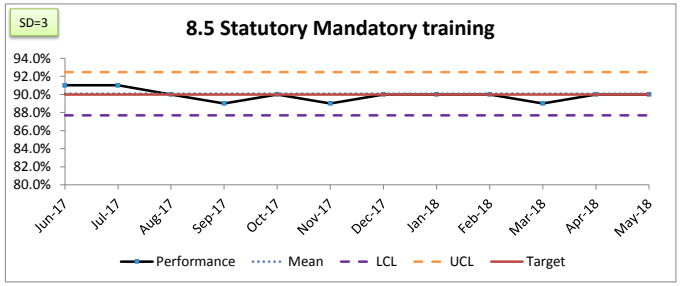
OBJECTIVE 8 - WORKFORCE PERFORMANCE

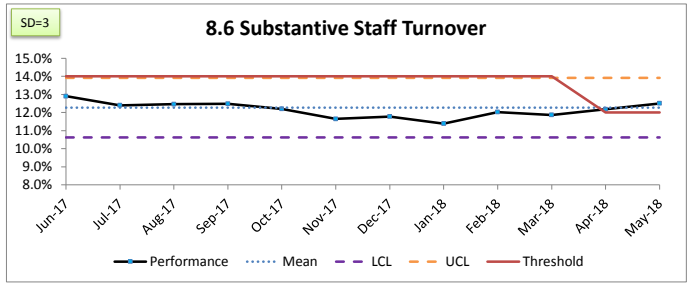


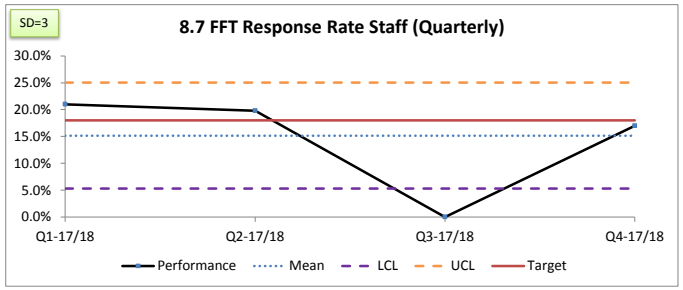






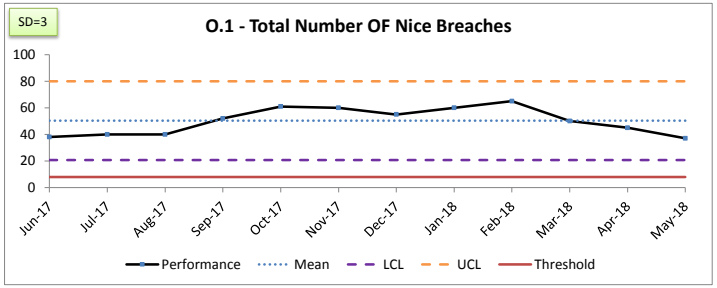


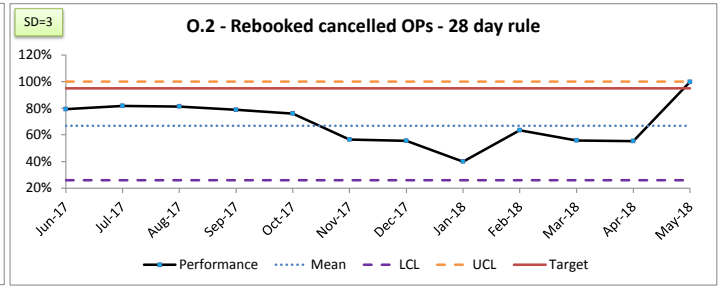


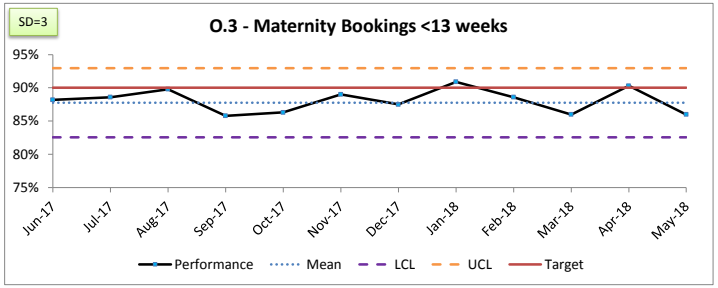


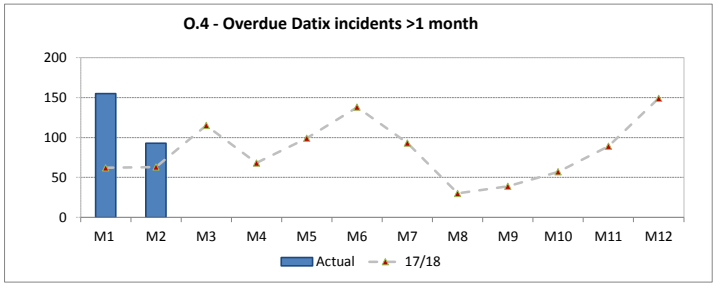
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

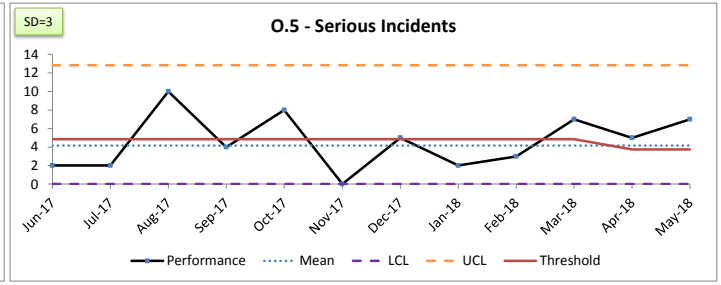
- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

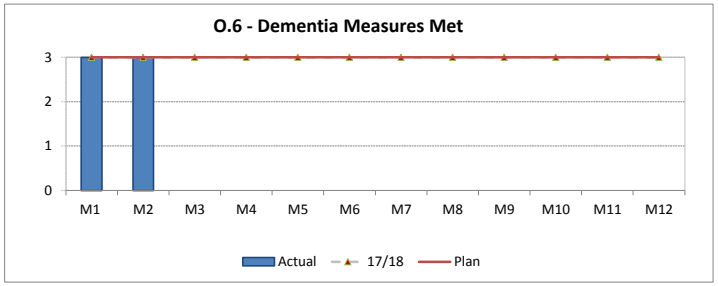


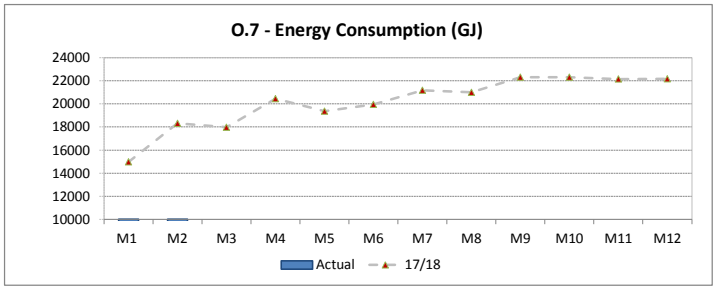


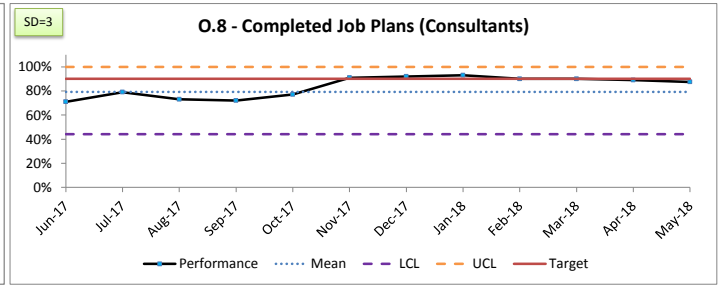












If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

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

Meeting title	**Board of Directors**	**Date: 6 July 2018**
Report title:	**Finance Paper Month 2 2018-19**	**Agenda item: 5.2**
Lead director **Report authors**	Mike Keech Daphne Thomas Christopher Panes	Director of Finance Deputy Director of Finance Head of Management Accounts
FoI status:	Private document	

Report summary	**An update on the financial position of the Trust at Month 2 (May 2018)**			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** X	**Decision** ☐
Recommendation	Management Board to note the contents of the paper.			

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

Report history	None
Next steps	None
Appendices	1 to 3

FINANCE REPORT FOR THE MONTH TO 31st MAY 2018

PUBLIC BOARD MEETING

PURPOSE

1. The purpose of the paper is to:

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

EXECUTIVE SUMMARY

2. *Income and expenditure* –The Trust's deficit for May 2018 was £1.5m which is £0.25m negative to budget in the month and £0.2m negative to budget year to date.

3. *Cash and capital position* – the cash balance as at the end of May 2018 was £3.0m, which was £0.7m above plan due to the timing of capital expenditure and early than expected settlement of prior year invoices. The Trust has spent £1.25m on capital year to date of which £0.8m relates to eCare, and a further £0.3m for the cancer centre enabling works and multi-storey car park.

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

5. *Cost savings* – overall savings of £0.5m were delivered in month against an identified plan of £0.5m and the target of £0.5m. Overall for the year £8.4m of plans have been identified, of which £5.1m have been validated and approved against a target of £10.1m.

INCOME AND EXPENDITURE

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

All Figures in £'000	Month Plan	Month Actual	Month Var	YTD Plan	YTD Actual	YTD Var	Full Year Plan	Full Year Forecast	Full Year Var
Clinical Revenue	17,435	17,670	235	33,590	33,912	322	200,842	200,842	0
Other Revenue	1,593	1,694	100	3,183	3,279	96	19,107	19,107	0
Total Income	19,028	19,363	335	36,774	37,192	418	219,949	219,949	0
Pay	(13,648)	(13,964)	(317)	(27,286)	(27,297)	(11)	(161,178)	(161,178)	0
Non Pay	(6,104)	(6,376)	(272)	(12,179)	(12,791)	(612)	(72,662)	(72,662)	0
Total Operational Expend	(19,752)	(20,340)	(589)	(39,464)	(40,088)	(623)	(233,841)	(233,841)	0
EBITDA	(723)	(977)	(254)	(2,691)	(2,896)	(205)	(13,892)	(13,892)	0
Financing & Non-Op. Costs	(1,015)	(1,009)	6	(2,029)	(2,025)	4	(12,191)	(12,191)	0
Control Total Deficit (excl. STF)	**(1,739)**	**(1,986)**	**(248)**	**(4,720)**	**(4,921)**	**(201)**	**(26,082)**	**(26,082)**	**0**
Adjustments excl. from control total:									
Performance STF	109	109	0	219	219	0	2,190	2,190	0
Financial STF	255	255	0	511	511	0	5,110	5,110	0
Provider Sustainability Fund	148	148	0	296	296	0	2,964	2,964	0
Control Total Deficit (incl. STF)	**(1,226)**	**(1,473)**	**(248)**	**(3,694)**	**(3,895)**	**(201)**	**(15,818)**	**(15,818)**	**0**
Donated income	0	0	0	0	0	0	8,592	8,592	0
Donated asset depreciation	(58)	(58)	0	(116)	(116)	0	(697)	(697)	0
Reported deficit	**(1,284)**	**(1,531)**	**(248)**	**(3,810)**	**(4,011)**	**(201)**	**(7,923)**	**(7,923)**	**0**

Monthly and year to date review

7. The **deficit** in month 2 is £1,534k which is £248k adverse against a planned deficit of £1,284k. The Trust implemented its eCare system (Electronic Patient Record system) in May, this has resulted in implementation costs and unforeseen disruption in activity recording. In addition to this there was a flood on the hospital site at the end of May over the Bank holiday weekend affecting a number of areas leading to unforeseen costs as well as cancelled elective operations.

8. **Income** is £335k favourable to plan in April and £418k YTD. Lower than planned births and inpatient elective activity was offset by high use of high cost pass through drugs and outpatient throughput.

9. **Operational costs** in May are adverse to plan by £589k and £612k YTD.

10. **Pay costs** are £317k adverse to budget in month 2. Positive variance on agency is offset by higher substantive and bank expenditure. Substantive costs are above plan, and have significantly increased in-month; however the in-month position includes non-recurrent pay costs relating to eCare go live.

11. **Non pay costs** were £272k adverse to plan in month. The majority of the variance can be attributed to high levels of high cost pass through drugs, unidentified CIP targets and one off costs relating to flood damage.

12. **Non-operational costs** are on plan in month.

COST SAVINGS

13. In Month 2, £472k was delivered against an identified plan of £519k and a target of £528k.

14. £8.4 of scheme have been identified, of which £5.1m have been validated and approved against a full year target of £10,131k.

15. The Trust has identified a further £3,300k of opportunities and is working to convert these into robust schemes and identify the remaining £1,700k planning gap.

CASH AND CAPITAL

16. The cash balance at the end of May 2018 was £3.0m, which was £0.7m above plan due to the timing of capital expenditure and early than expected settlement of prior year debts. There has been a delay in the month 2 SLA income from Bucks CCG, formerly Aylesbury CCG and Chiltern CCG due to technical issues arising from their merger. However these have been resolved and payment is expected by mid-June. The details of the Trust's current loans are shown below. The Trust required revenue funding in May of £2m with a further drawn down in June of £1.6m for which it has NHSI/DHSC approval for.

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

- Non-Current Assets are below plan by £0.8m; this is mainly driven by the timing of capital projects.
- Current assets are above plan by £0.7m. The variance relates to cash £0.7m and inventories £0.1m above plan offset by receivables £0.1m below plan.
- Current liabilities are above plan by £1.5m. This is being driven entirely driven by Trade and Other Creditors.
- Non-Current Liabilities are below plan by £1.2m. This is being driven by the Trust not requiring revenue funding from NHSI in April.

27. The Trust has spent £1.25m on capital up to month 2 of which £0.8m relates to eCare, cancer centre £0.04m, multi-storey car park £0.2m, and £0.2 on other essential schemes.

RISK REGISTER

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDATIONS TO THE BOARD

29. The Public Board is asked to note the financial position of the Trust as at 31st May 2018 and the proposed actions and risks therein.

Appendix 1

Milton Keynes Hospital NHS Foundation Trust
Statement of Comprehensive Income
For the period ending 31st May 2018

	May 2018			2 months to May 2018			Full year
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME							
Outpatients	3,636	3,651	15	6,813	7,015	202	40,880
Elective admissions	2,459	2,445	(14)	4,597	4,474	(123)	27,584
Emergency admissions	5,415	5,240	(175)	10,656	10,454	(202)	63,759
Emergency adm's marginal rate (MRET)	(279)	(290)	(11)	(549)	(555)	(6)	(3,287)
Readmissions Penalty	(258)	(265)	(7)	(507)	(393)	114	(3,032)
A&E	1,130	927	(203)	2,223	1,987	(236)	13,302
Maternity	1,977	1,883	(94)	3,816	3,484	(332)	22,856
Critical Care & Neonatal	525	481	(44)	1,033	1,025	(8)	6,181
Excess bed days	0	0	0	0	0	0	0
Imaging	422	442	20	789	860	71	4,732
Direct access Pathology	407	406	(1)	762	782	21	4,569
Non Tariff Drugs (high cost/individual drugs)	1,407	1,655	248	2,775	3,250	476	16,607
Other	594	1,094	500	1,184	1,528	344	6,692
Clinical Income	**17,435**	**17,670**	**235**	**33,590**	**33,912**	**322**	**200,842**
Non-Patient Income	**2,106**	**2,207**	**100**	**4,209**	**4,305**	**96**	**37,963**
TOTAL INCOME	**19,541**	**19,876**	**335**	**37,800**	**38,218**	**418**	**238,805**
EXPENDITURE							
Total Pay	**(13,648)**	**(13,964)**	**(317)**	**(27,286)**	**(27,297)**	**(11)**	**(161,178)**
Non Pay	(4,697)	(4,721)	(24)	(9,404)	(9,540)	(136)	(56,055)
Non Tariff Drugs (high cost/individual drugs)	(1,407)	(1,655)	(248)	(2,775)	(3,250)	(476)	(16,607)
Non Pay	**(6,104)**	**(6,376)**	**(272)**	**(12,179)**	**(12,791)**	**(612)**	**(72,662)**
TOTAL EXPENDITURE	**(19,752)**	**(20,340)**	**(589)**	**(39,464)**	**(40,088)**	**(623)**	**(233,841)**
EBITDA*	**(210)**	**(464)**	**(254)**	**(1,665)**	**(1,870)**	**(205)**	**4,965**
Depreciation and non-operating costs	(941)	(936)	5	(1,882)	(1,877)	4	(11,309)
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**(1,152)**	**(1,400)**	**(248)**	**(3,547)**	**(3,749)**	**(201)**	**(6,343)**
Public Dividends Payable	(132)	(131)	0	(263)	(263)	0	(1,579)
OPERATING DEFICIT AFTER DIVIDENDS	**(1,284)**	**(1,531)**	**(248)**	**(3,810)**	**(4,012)**	**(201)**	**(7,923)**
Adjustments to reach control total							
Deferred Income	0	0	0	0	0	0	(8,592)
Donated Assets Depreciation	58	58	0	58	58	0	697
Control Total Rounding	0	0	0	0	0	0	0
Prior Year STF	0	0	0	0	0	0	0
CONTROL TOTAL DEFECIT	**(1,226)**	**(1,473)**	**(248)**	**(3,752)**	**(3,954)**	**(201)**	**(15,818)**

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

Appendix 2

Milton Keynes Hospital NHS Foundation Trust
Statement of Cash Flow
As at 31st May 2018

	Mth 2 £000	Mth 1 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	(3,390)	(2,165)	1,225
Operating surplus/(deficit) of discontinued operations			
Operating (deficit)	**(3,390)**	**(2,165)**	**1,225**
Non-cash income and expense:			
Depreciation and amortisation	1517	758	(759)
(Gain)/Loss on disposal	0	0	0
(Increase)/Decrease in Trade and Other Receivables	1755	2,246	491
(Increase)/Decrease in Inventories	(3)	(3)	0
Increase/(Decrease) in Trade and Other Payables	784	831	47
Increase/(Decrease) in Other Liabilities	(2)	157	159
Increase/(Decrease) in Provisions	(3)	1	4
Other movements in operating cash flows	(1)	(1)	0
NET CASH GENERATED FROM OPERATIONS	**657**	**1,824**	**1,167**
Cash flows from investing activities			
Interest received	6	4	(2)
Purchase of Property, Plant and Equipment, Intangibles	(1,292)	(798)	494
Net cash generated (used in) investing activities	**(1,601)**	**(915)**	**686**
Cash flows from financing activities			
Public dividend capital received	0	0	0
Loans received from Department of Health	2,000	0	(2,000)
Loans repaid to Department of Health	(159)	0	159
Capital element of finance lease rental payments	(24)	(12)	12
Interest paid	(315)	(158)	157
Interest element of finance lease	(51)	(29)	22
PDC Dividend paid	0	0	0
Net cash generated from/(used in) financing activities	**1,451**	**(199)**	**(1,650)**
Increase/(decrease) in cash and cash equivalents	**507**	**710**	203
Opening Cash and Cash equivalents	**2,507**	**2,507**	0
Cash and Cash equivalents at start of period for new FTs			
Cash and Cash equivalents changes due to transfers by absorption			
Closing Cash and Cash equivalents	**3,014**	**3,217**	**203**

Appendix 3

Milton Keynes Hospital NHS Foundation Trust
Statement of Financial Position as at 31st May 2018

	Audited Mar-18	May-18 YTD Plan	May-18 YTD Actual	In Mth Mvmt	YTD Mvmt	% Variance
Assets Non-Current						
Tangible Assets	171.9	172.1	170.9	(1.2)	(1.0)	(0.6%)
Intangible Assets	10.0	10.4	10.8	0.4	0.8	8.0%
Other Assets	0.4	0.4	0.4	(0.0)	(0.0)	(1.7%)
Total Non Current Assets	**182.3**	**182.9**	**182.1**	**(0.8)**	**(0.2)**	**(0.1%)**
Assets Current						
Inventory	3.3	3.2	3.3	0.1	(0.0)	(1.2%)
NHS Receivables	19.1	17.2	16.3	(0.9)	(2.8)	(14.7%)
Other Receivables	4.1	4.4	5.2	0.8	1.1	26.8%
Cash	2.5	2.3	3.0	0.7	0.5	19.7%
Total Current Assets	**29.0**	**27.1**	**27.8**	**0.7**	**(1.2)**	**-4.3%**
Liabilities Current						
Interest -bearing borrowings	(32.3)	(32.1)	(32.1)	0.0	0.2	-0.6%
Deferred Income	(1.6)	(1.6)	(1.6)	0.0	0.0	0.0%
Provisions	(1.4)	(1.4)	(1.4)	0.0	0.0	-1.3%
Trade & other Creditors (incl NHS)	(28.4)	(27.6)	(29.1)	(1.5)	(0.7)	2.4%
Total Current Liabilities	**(63.7)**	**(62.7)**	**(64.2)**	**(1.5)**	**(0.5)**	0.7%
Net current assets	**(34.7)**	**(35.6)**	**(36.4)**	**(0.8)**	**(1.7)**	**4.9%**
Liabilities Non-Current						
Long-term Interest bearing borrowings	(83.6)	(86.8)	(85.6)	1.2	(2.0)	2.4%
Provisions for liabilities and charges	(1.1)	(1.1)	(1.1)	(0.0)	(0.0)	3.8%
Total non-current liabilities	**(84.7)**	**(87.9)**	**(86.7)**	**1.2**	**(2.0)**	2.4%
Total Assets Employed	**62.9**	**59.4**	**58.9**	**0.0**	**(4.0)**	**(6.3%)**
Taxpayers Equity						
Public Dividend Capital (PDC)	99.2	99.4	99.2	(0.2)	(0.0)	0.0%
Revaluation Reserve	78.7	78.7	78.7	0.0	0.0	0.0%
I&E Reserve	(115.0)	(118.7)	(118.9)	(0.2)	(3.9)	3.4%
Total Taxpayers Equity	**62.9**	**59.4**	**58.9**	**(0.4)**	**(3.9)**	**(6.3%)**

Meeting title	**Trust Board**	**Date: 6 July 2018**
Report title:	**Workforce report**	**Agenda item: 5.3**
Lead director **Report author**	**Name: Ogechi Emeadi** **Name: Paul Sukhu**	**Title: Director of workforce** **Title: Deputy director of workforce**
FoI status:	**Disclosable**	

Report summary	This report provides a summary of key workforce key performance indicators for the full year ending 31 May 2018 (Month 2).			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [x]	**Decision** [ ]
Recommendation				

Strategic objectives links	Objective 8 : Improve Workforce Effectiveness
Board Assurance Framework links	None
CQC outcome/ regulation links	Well Led Outcome 13 : Staffing
Identified risks and risk management actions	1606 - IF we are unable to recruit sufficient numbers of qualified nurses THEN we may be unable to provide staffing levels as we would wish LEADING TO reduction in patient experience and clinical risk. 1608 - IF there is inability for employees to undergo a well-structured appraisal THEN they will not have a development plan and a review of their performance LEADING TO the inability to meet CCG Target which is 90% 1609 - IF staff are unable to remain compliant in all aspects of mandatory training linked to their job requirements THEN staff may not have the knowledge and skills required for their role LEADING potential patient/staff safety risk and inability to meet CCG compliance target for 2015-2016 of 90% 1613 - IF there is inability to retain staff employed in critical posts THEN we may not be able to provide safe workforce cover LEADING TO clinical risk.
Resource implications	
Legal implications including equality and diversity assessment	

Report history	Full monthly corporate workforce information report - Executive Management Board, Divisional Accountability 20 June 2018
Next steps	
Appendices	

Workforce report – Month 2 2018/19

1. Purpose of the Report

1.1. This report provides a summary of key workforce key performance indicators for the full year ending 31 May 2018 (Month 2).

2. Staff in post

2.1. The Trust's staff in post by whole time equivalent (WTE) was 3027.2 as at 31 Mayl 2018, which is an increase of 103.0 WTE since May 2017.

2.2. The Trust's headcount is 3512, an increase of 118 since May 2017.

2.3. The largest increases in staff in post since May 2017 have been in the professional, scientific and technical and medical and dental staff groups.

3. Temporary staffing

3.1. The temporary staff usage (bank + agency) for the year was 5959.8 WTE, which was 14.5% of total WTE staff employed.

3.2. Agency staff usage was 4.2% of the total WTE staff employed for the year but was 6.7% of the total annual staff expenditure, predominantly driven by medical and dental agency locums.

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

4. Sickness absence

4.1. The sickness absence rate (N.B. 12 months to 30 April 2018) for the Trust remains slightly above the trust target of 4.0% at 4.1% (1.80% short term and 2.30% long term).

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

4.3. The top 3 stated reasons for absence by staff group are common to most acute NHS trusts. Steps are being taken to address under-reporting of sickness absence in the medical and dental profession.

4.4. Following KPMG's internal audit of the trust's sickness absence policy (and compliance), improvement measures include:

- Training of new procedure, trigger points and policy toolkit for managers
- Electronic return to work forms

4.5. The launch of the newly approved sickness absence policy has been delayed to allow for the development of the toolkit and electronic return to work forms (slower progress with IT support, due to implementation of eCARE)

4.6. The electronic turnaround document is under development. This will support more accurate information returns with our payroll providers UHB Payroll and is currently being piloted in Domestics and Imaging (including Breast Screening). Full trust-wide roll out is envisaged by the end of Q3 2018/19.

4.7. Sickness absence improvement will continue through the workforce transformation agenda, reporting to the quarterly workforce board.

4.8. More detail on sickness absence is reported and discussed at divisional executive performance reviews (monthly) and workforce and development assurance committee (quarterly).

5. Turnover

5.1. Overall, the trust's leaver turnover rate has been lower in 2017/18 than it was in 2016/17 but it has exceeded this level in February, March and May 2018 (12.6% against 2018/19 target of 12%). 2017/18 target was 14%

5.2. In line with the trust's work in Cohort 3 of the Retention Direct Support Programme with NHS Improvement:

- ✓ Introductory call with NHSI – 16 May 2018
- ✓ NHSI Retention Direct Support Programme visit – 13 June 2018 (including Ward 8 visit)
- Submit full improvement plan – by 04 July 2018

5.3. Through the previously reported workstreams, the overall aim is to reduce turnover in Surgery by 2% by the end of June 2019. Although initial focus is on Band 5 nurses, it is believed that this work will provide MKUH with greater benefit across professions and staff groups.

5.4. Working through task and finish subgroups, this work will report to the quarterly workforce board.

5.5. Initial feedback from NHSI from the 13 June visit was positive; the Clinical Lead, Siobhan Heafield, was reassured that the trust had a good handle on its data, its plans and organisational governance for the scope of work.

6. Statutory and mandatory training

6.1. Statutory and mandatory training compliance as at the end of May 2018 was 90% against the trust target of 90%.

6.2. Despite the organisation-wide focus and commitment to eCARE (electronic patient record) training, this sustains the level reported in M1.

Training Compliance by Division	
Core Clinical	93%
Corporate Services	92%
Medicines Unplanned Care	89%
Surgical Planned Care	88%
Women's and Children's	89%
Trust Total Compliance	**90%**

7. Appraisal compliance

7.1. Appraisal compliance as at the end of May 2018 was 82% against the trust target of 90%.

7.2. Compliance has deteriorated from 86% since January 2018 but remains at the M1 level of 82%; it was anticipated in the Month 12 report that the trust level would increase further, following the implementation of eCARE and its associated training.

Appraisal Completion by Division	
Core Clinical	94%
Corporate Services	75%
Medicines Unplanned Care	79%
Surgical Planned Care	74%
Women's and Children's	83%
Total Trust	**82%**

8. Recommendations

8.1. Trust Board is asked to note the Workforce report.

Meeting title	**Board of Directors**	**Date: 6 July 2018**
Report title:	**Board Assurance Framework**	**Agenda item: 6.1**
Lead director **Sponsor(s)**	**Kate Burke** **Joe Harrison**	**Director of Corporate Affairs** **Chief Executive**
FoI status:	**Public meeting**	

Report summary	To present the updated Board Assurance Framework.						
Purpose *(tick one box only)*	**Information**	x	**Approval**		**To note**	x	**Decision**
Recommendation	**That the Board note the outcomes of the Committees' scrutiny of the Board Assurance Framework, and comment on the scoring, controls, mitigation and development in relation to the respective risks.**						

Strategic objectives links	Objective 7: Well Governed
Board Assurance Framework links	
CQC regulations	Regulation 17: Good Governance
Identified risks and risk management actions	
Resource implications	Contained within individual risks
Legal implications including equality and diversity assessment	Contained within individual risks

Report history	Monthly Board reporting
Next steps	Executive ownership of individual risks, Board Committee scrutiny of risk areas and Audit Committee oversight
Appendices	Papers follow

Update report to the Board of the Board Assurance Framework and Risk Management Process

The Board Assurance Framework continues to be developed, with the Board Committees holding the executive holders of the individual risks to account for their effective management.

At the Audit Committee meeting on 21 June, members expressed the opinion that the BAF remains a rather reactive tool – it was suggested that steps be taken to make it more active. It was also agreed that the Committees should build upon and formalise their processes for reporting back to the Board.

Quality and Clinical Risk Committee
BAF ID 1.6 – implementation of eCARE: Despite the successful rollout of the system, the amount of the data that it had expected to generate is not yet forthcoming. It was therefore agreed that the score will remain as is for now.

Finance and Investment Committee
BAF ID 7.1 – affordable levels of agency and locum staffing: The residual score for this risk had been increased from 12 to 20 reflecting the more challenging target that NHS Improvement has imposed on the Trust for 2018/19. It was agreed that this risk will be closely monitored particularly over the winter period when the hospital will be under the most pressure. In the meantime, it was agreed that the score could be reduced to 16.

BAF ID 7.2 - capital and revenue funding: The residual rating for this risk is currently 16, on the basis that only a part of the full allocation for the capital plan has been funded. Clarification is also still to be received on repayment of the revenue support loan after March 2019.

BAF ID 7.3 – financial efficiency within the Transformation Programme: Currently rated at 20as only £4m worth of schemes has been identified from a target of £10.1m. It is expected that the rating will fall as more schemes are identified and validated.

BAF ID 7.4 – agreement with commissioners over the level of performance to be funded: there is now a better understanding between the Trust and its main commissioner, including better alignment of their respective plans. However, it is anticipated that there will continue to be contract challenges.

BAF ID 7.5 – sustainability and transformation funding: the rating of this risk remained unchanged.

Workforce and Development Assurance Committee
BAF ID 8.1 – inability to recruit to critical vacancies: it was noted that the Trust's vacancy rate is at its lowest for a year, and work is ongoing with NHS Improvement around nurse retention. However the Trust has had some exposure to the difficulties of obtaining visas for overseas doctors. It was agreed that the target score for this risk should be increased from 6 to 12.

BAF ID 8.2 – inability to retain staff employed in critical posts: following receipt of the results of the staff survey, the Trust's workforce strategy is to be worked up to address staff engagement. The outcome of the NHS Improvement work is to be reflected, as are the steps being taken locally to support line managers in retaining their staff, particularly in areas of high turnover.

Recommendation

The Board is asked to note the contents of the BAF and seek any further information and assurance on the risks presented as required.

Exec Lead	Risk Ref	Objective	Committee	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance				Residual risk rating	Progress since last report	Further mitigation/assurances	Completion date	Target risk score
						Consequence v Likelihood		Level 1 Operational (management)	Level 2 Oversight functions (Committees)	L3 Independent	Overall					
CH	1-1	SO1	Quality & Clinical Risk	Strategic failure to manage demand for emergency care	Lack of demand management by the local health economy Inadequate primary care provision/ capacity Inadequate community care provision/ capacity Inadequate social care provision/ capacity	4x4=16	Working with partners to manage peak demand periods (e.g expediting discharge; using full community/ social care capacity)	Strategic planning at trust-wide and service level Strategic planning within local health economy (CCG, CNWL, GP Federation)	Regular strategic planning withing the system - include Emergency Care Delivery Board Regular reporting to Management Board; Committees and Trust Board on strategic planning	System-wide Emergency Care Delivery Board Regular NHSI oversight (PRMs) External scruitny through Transformation Board, Health and Wellbeing Board and Health Overview and Scrutiny Committee Part of ICS (STP) priority programme on acute care	Good	3x4=12	Executive strategy session 23/03/17	System-wide strategic plan		2x5=10
CH	1-2	SO1	Quality & Clinical Risk	Tactical failure to manage demand for emergency care	Annual emergency and elective capacity planning inadequate or inaccurate Daily flow/ site managmement plans inadequate or ineffectual Poor clinical/ operational relationships impacting on patient flow through the organisation Poor operational/ managerial relationships impacting on escalation Ineffective engagement with stakeholders to support patient flow day-to-day	4x4=16	Introduction of ED streaming Working with UCC to manage demand Implementation of national flow improvement programmes - Red2Green; 100% Challenge; EndPJParalysis; SAFER Strong clinical and operational leadership and ownership; good team working Clear escalation and well-known and understood flow management and escalation plans Positive relationships with stakeholders through daily working and medium-term planning	Daily operational oversight Medium-term planning at service-level Daily and short/ medium-term planning with local health economy partners to support flow and right care/ right place	Regular strategic planning withing the system - include Emergency Care Delivery Board Regular reporting to Management Board; Committees and Trust Board on strategic planning	System-wide Emergency Care Delivery Board Regular NHSI oversight (PRMs) External scruitny through Transformation Board, Health and Wellbeing Board and Health Overview and Scrutiny Committee Part of ICS (STP) priority programme on acute care	Good	3x4=12	Daily management	Continue the implementation of ED streaming Continue the roll out of Red2Green and SAFER across the hospital in order to improve flow through the hospital. Continue to work with external partners to help to reduce ED attendances and reduce delayed discharges		2x5=10
CH	1-3	SO1	Quality & Clinical Risk	Ability to maintain patient safety during periods of overwhelming demand	Significantly higher than usual numbers of patients through the ED Significantly higher acuity of patients through the ED Major incident/ pandemic	5x4=20	Clinically and operationally agreed escalation plan Adherence to national OPEL escalation management system Clinically risk assessed escalation areas available	Daily operational management command structure in place to manage emergency and elective activity safely Clinical site team 24/7 SMOC and EOC 24/7 Daily patient safety huddle	Daily reporting to clinical, oeprational and executive management Daily sit-rep reporting to regulatory and commissioning bodies Twice-monthly oversight at Management Board (formal reporting)	Daily sit-rep reporting and review by external bodies (CCG, NHSI, NHSE)	Good	4x4=16	Daily management	Continue to clinically review escalation plans in line with demand to ensure patient safety is no compromised		4x3=12
IR	1-4	SO1	Quality & Clinical Risk	Failure to appropriately embed learning and preventative measures following Serious Incidents	Failure to appropriately report, invesitgate and learn from incidents and complaints	5x3=15	All SIs and action plans processed through the Serious Incident Review Group Actions including learning distribution tracked through SIRG Core component of all Clinical Improvement Group Meetings Lessons communicated via Trust-wide channels Debriefing embedded in specialties and corporately Training and skills programme annually Cultural work (inc Greatix and FTSU Guardians	Incident reports and action plans Performance information on incident numbers Emerging or existing trends analysed and reported Repeat incidents analysed and reported - particularly for failure to learn	Serious Incident Review Group Oversight at Clinical Quality Board Oversight at Quality and Clinical Risk Committee	CCG satisfaction with RCA reporting Stakeholder involvement with RCA/SI investigation Internal Audit review of SI process	Satisfactory	5x2=10				4x2=8

IR	1-5	SO1	Quality & Clinical Risk	Failure to recognise and respond to the deteriorating patient	Non compliance with the NEWS protocols; failure to appropriately escalate NEWS scores or failure to clinically assess patients outside protocols (i.e. 'hands on, eyes on' patients who are ill but not triggering on NEWS)	4x3=12	National NEWS protocol in place Level 1 pathway in place	Performance is reported to the Clinical Quality Board and is regularly audited Serious Incident Review Group process where issues around deteriorating patient identified eCare implementation supports early earning systems Standardised mortality review process to identify issues and learning	Serious Incident Review Group Oversight at Clinical Quality Board Oversight at Quality and Clinical Risk Committee	Coronial review of deaths	Satisfactory	3x3=9				4x2=8
CH	1-6	SO1	Quality & Clinical Risk	Failure to manage clinical risks throughout the implementation of eCARE (particularly refers to eCARE go-live)	Clinical risks are underestimated or not identified prior to and during the implementation of eCARE	4x4=16	Risk and hazard logging and tracking system in place (Cerner and Trust) Clinical safety lead in place with clinical safety sign-off process part of the go-live gateway Clinical Advisory Group in place to reivew all decisions	Clinical Advisory Group in place - key decision-making body for clinical/ operational risks and issues Clinical safety lead in place - decision making alongside Medical Director and Director of Nursing	Oversight at Health Informatics Programme Board Oversight at Management Board Oversight at Trust Board		Satisfactory	4x3=12	Roll-out of eCARE has been as successful as could have been expected. Howewver, the expected amount of data from the system has not yet materialised. This is being worked through by the eCARE team.			

LK	2-1	SO2	Quality & Clinical Risk	Failure to provide an appropriate patient experience	Despite largely positve feedback that is received via social media and through the Friends and Family Test, the Trust has scored relatively poorly in most of the annual patient surveys. There are also a number of recurring themes from complaints, including poor communication, unsatisfactory food, and patients being unable to have a proper say in their care	4x4=16	Risk and incident reporting awareness campaign ongoing Risk and incident training programme in place Integrated Datix system Embedded governance and assurance teams to provide more resource, internal challenge and audit. Lesson of the week shared through the weekly CEO message, supported by divisional publications, briefings and plenary. Appointment of Picker to manage FFT responses and capture more qualitative feedback from patients Appointment of patient experience manager; clinical leads Launch of hellomynameis across the Trust Implementation of new complaints system, and raising the profile of complaint handling across the divisions Receipt of patient stories at the Trust Board Production and monitoring of action plans followjng annual patient surveys Real time feedback provided as appropriate to issues and comment on social media	Oversight at Risk and Compliance Board and Serious Incident Review Group	Oversight at Quality and Clinical Risk Committee and at the Quality and Clinical Risk Committee – reports include details of themes from complaints and evidence that learning is taking place		Poor	4x4=16		Feedback from various patient surveys – inpatient, maternity, ED and children's.		3x3=9
KB/IR	3-1	SO3	Risk	Lack of assessment against and compliance with best evidence based clinical practice through clinical audit	Insufficient resource to introduce or embed process and lack of engagement by clinicians	3x4=12	Forward audit plan agreed and published annually Clinical audit leads in place with new (2018) job descriptions and agreed time within job plans Clinical governance leads and audit support in place to support audit leads in CSUs/ divisions Audit assessment process in place - supported and monitored by clinical governance leads and central audit support team New clinical governance structure (2018) in place to improve oversight and escalation of audit	Oversight and scrutiny at Clinical Effectiveness Board; Risk and Compliance Board and Clinical Quality Board Internal compliance monitoring and reporting monthly Reporting to CIGs and divisional management meetings	Oversight at the Quality and Clinical Risk Committee and the Audit Committee	External audi (KPMG) reivew in 2017/18 which identified areas for improvement. On forward audit plan for external audit review in 2018/19.	Satisfactory	3x4=12				2x3=6
KB/IR	3-2	SO3	Quality & Clinical Risk	Lack of assessment against and compliance with NICE guidance	The Trust has a significant backlog of NICE guidelines	3x4=12	Monthly assessments of compliance against published NICE baseline assessments Process in place to manage baseline assessments with relevant clinical lead - supported by clinical governance leads Independent review by compliance and audit lead Requires clinical engagement and ownership	Oversight and scrutiny at Clinical Effectiveness Board; Risk and Compliance Board and Clinical Quality Board Internal compliance monitoring and reporting monthly Reporting to CIGs and divisional management meetings	Oversight at the Quality and Clinical Risk Committee		Satisfactory	3x4=12				3x2=6

CH	4-1	SO4	Executive Management	Failure to meet the 4 hour emergency access standard	The Trust is unable to meet the target to see 95% of patients attending A&E within 4 hours	4x5=20	Operational plans in place to cope with prolonged surges in demand Cancelling of non urgent elective operations New elective surgical ward open to reduce liklihood of above control Opening of escalation beds Working with partners for social, community and primary care	Divisional and Trust performance reports Rates of discharge; DTOC	A&E Delivery Board	Ongoing NHSI review of key indicators Internal audit work on data quality Quality Report testing of key indicators by external auditors	Satisfactory	4x4=16				3x2=6
CH	4-2	SO4	Executive Management	Failure to meet the key elective access standards - RTT 18 weeks, non-RTT and cancer 62 days	The Trust is unable to meet the 18 week RTT and 62 day cancewr targets, and unable to reduce its non-RTT backlog as required	4x3=12	Regular PTL meetings Work on improving administrative pathways Work with tertiary providers on breach allocations RTT and non-RTT action plans	Divisional and Trust performance reports Management Board scrutiny and oversight of RTT and non-RTT action plans	Finance and Investment Committee scrutiny of financial and operational performance Quality and Clinical Risk Committee oversight	NHSI regional information on performance against key access targets	Satisfactory	4x3=12				3x3=9
JB	4-3	SO4	Audit	Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure	Data quality governance and processes are not robust	4x4=16	Robust governance around data quality processes including executive ownership Audit work by data quality team	Oversight of progress against action plans by Data Quality Compliance Board	Standing agenda item at the Audit Committee	Outcome of Internal audit assessment of data quality Outcome of External Audit Quality Report testing Outcome of NHSI review	Satisfactory	4x3=12				3x3=9
JB	5-1	SO5	Audit	Failure to adequately safeguard against major IT system failure (deliberate attack)	Weakneses in cyber security leave the trust vulnerable to cyber attack	3x3=9	Investment in better quality systems GDE investment NHS Digital audits and penetration tests	Results of penetration and phishing tests	Audit Committee review of cyber security	Performance against NHS Digital standards	Good	5x2=10				3x2=6
JB	5-2	SO5	Finance & Investment	Failure to adequately safeguard against major IT system failure (inability to invest in appropriate support systems/infrastructure)	Lack of suitable and timely investment leaves the Trust vulnerable to cyber attack	3x3=9	2 dedicated cyber security posts funded through GDE All Trust PCs less than 4 years old Robust public wifi network EPR investment	Robust capital prioritisation process overseen by Managment Board	Oversight of IT investment strategy and decision making by the Finance and Investment Committee	External oversight of uses of the GDE funding	Good	4x2=8				3x2=6
CH	5-3	SO5	Executive management	Failure to successfully deploy EPR in a way that diminishes disruption	That the roll out of EPR disrupts clinical and operational services	5x3=15	Robust programme management, including executive oversight Involvement and engagement of all operational and clinical staff Good undertsanding of risks at go live and either accepting or planning for them Understanding the phasing of the programme and the specific operational challenges at each phase	Oversight by the Health Informatics Programme Board chaired by the Chief Executive and attended by all Executives. This Board reports to Management Board, and in turn, Trust Board	Regular updates to the Finance and Investment Committee Updates to the Trust Board Council of Governors, and shortly to the Trust membership		Satisfactory	4x3=12				4x2=8
CH	5-4	SO5	Executive Management	Failure to maximise the benefits of EPR	That the Trust does not derive all of the benefits in terms of efficiency and productivity from the EPR system as had been anticipated in the business cases	4x3=12	Under review									3x2=6

MK	7-1	SO7	Finance & Investment	Inability to keep to affordable levels of agency and locum staffing	Inability to recruit to difficult to recruit to posts (across disciplines but particularly in medicine) Short notice sickness absence Poor planning around activity peaks Poor rostering of annual leave/ other leave requirements Increased requirement for enhanced observation levels of care National price caps mean that in a range of areas the Trust has little prospect of full compliance in short term future.	5x4=20	Weekly vacancy control panel review agency requests. Control of staffing costs identified as a key transformation work stream Bank rates and enhancements Capacity planning Robust rostering and leave planning Escalation policy in place to sign-off breach of agency rates Fort-nightly executive led agency reduction group meeting with aim of delivering reduction in both quantity and cost of agency used. Agency cap breaches are reported to Divisions and the FIC .	Transformation plans with tracked delivery. Oversight at the Vacancy Control Panel. Action plan reviews at fortnightly Executive Director Meetings Divisional deep dive sessions Monthly reports to Workfoirce Board and then to Management Board	Performance reported to the F&I Committee Oversight by the Workforce and Development Assurance Committee	Internal audit assessment on the use of medical locums NHSI performance review meetings NHSI agency weekly returns	Good	4x3=12	The Agency spend up to mth 11 is £10.6, in mth £0.8m . The Trust's Y/E ceiling is £15.15m. The trust is below the target future months run-rate of £2.7m and is performing better than its agency plan year to date. The rise in the residual score from 12 to 20 reflects the more challenging target for 2018/19. This risk will be closely monitored particularly over the winter period.	More robust and comprehensive capacity planning. Consistent approach to rostering and leave planning across the trust.	Current and ongoing	4x3=12
	7-2	SO7	Finance & Investment	Timing and release of capital and revenue funding for 2017/18		5x5=25	Ongoing dialogue with NHSI regarding status of cash commitment from the DH. Revenue funding for July has been approval by the DoH in the form of an uncommitted term loan. Revenue plan submitted in line with 2017/18 control total of £18.8m deficit. The Trust is reaching its limit of being re-profiling its Capital Expenditure for 2017-18 until it receives Strategic capital funding approval. Currently only funds of emergency nature are being released by the Trust.	Capital Expenditure is reviewed at the monthly capital control group and management board	Updates reported to the F&I Committee and Trust Board on a monthly basis	The Trust discusses the position at its monthly PRM calls with NHSI	Good	4x4=16	The Trust has received confirmation of the EPR capital funding for 17/18, 18/19 and 19/20. The Trust has also received confirmation that the revenue support loan due for repayment in March 2018 will be extended to March 2019. The Trust will continue to seek approval for funding of other capital schemes in 2018/19 in line with it's annual plan, and for clarity over what will happen with its revenue support loan due now for repayment in March 2019 (as the Trust has not reasonable prospect of repaying the loan).		Current and ongoing	3x2=6
MK	7-3	SO7	Finance & Investment	Inability to achieve the required levels of financial efficiency within the Transformation Programme	Increased unplanned activity Inability to identify sufficient savings schemes, or to achieve the expected levels of savings Inability to deliver identified schemes	5x4=20	Tracker in place to identify and track savings and ensure they are delivering against plan Savings measured against trust finance ledger to ensure they are robust and consistent with overall financial reporting All savings RAG rated to ensure objectivity	Fortnightly CIP review meetings between with the Director of Service Development, DoF, divisional managers and project managers Recovery plans requested for off-track schemes Savings plan for 17/18 financial year not yet fully identified.	Monthly CEO chaired Transformation Board oversight, providing leadership and scrutiny of programme delivery		Satisfactory	5x4=20	Savings of £6.6m up to mth 11 against a full year target of £10.5m	Further saving schemes to be identified to deliver maximum savings in 2017/18 and full year effect benefits in to 2018/19. Although the posiiton is better than it was this time last year, many schems are yet to be identified or validated. To date £4m of schemes have been identified, but the target is £10.1m	Current and ongoing	3x3=9

	7-4	SO7	Finance & Investment	Disagreement with main commissioner over the level of performance that they are prepared to fund	MKCCG has included £4m of QUIP schemes within its contract with the trust for 2017-18. Historically this has not delivered Over performance is not payable until up to four months after the activity undertaken, putting pressure on cash flows CCG financial position is such that ability to hold their financial plan will be challenging if over-performance continues at a similar level to 2016-17.	5x4=20	Clearly defined quarterly reconciliation process of contract payments made with close monitoring of the payment for over performance invoices. Escalation of issues to NHSI for intervention where required.	Twice monthly meetings with MKCCG, attended by the DoF and the Deputy CEO to discuss contractual and actual levels of activity	Updates reported to the F&I Committee and Trust Board on a monthly basis		Satisfactory	4x4=16	The Trust has held a number of meetings with MKCCG to understand the contract challenges in respect of the 2017/18 contract. The Trust is chasing all commisioners for payment of overperformance amounts. There is better understanding of the risk this year, and good alignment between the commissioner and provider plans.	The Trust to continue to work closely with the CCG on demand management solutions.	Current and ongoing	3x3=9
MK	7-5	SO7	Finance & Investment	The Trust is unable to access £7.3m of Sustainability & Transformation Funding	That Trust does not meet the performance targets in relation to the A&E 4 hour standards and cancer treatment and therefore does not qualify for STF	5x5=25	In order to receive the full amount of £7.3m of S&T funding in FY 2017-18, the Trust needs to achieve its financial control total (ie 70% of the funding) and its A&E performance trajectory (30% of the funding). The Trust has agreed a control total of £18.8m deficit and its performance trajectory with NHSI and is forecasting to achieve its control total	Financial performance and A&E performance is reviewed at the Executive Director meetings.	F&I committee reviews the monthly financial performance against the control total and receives updates in respect of the A&E performance a monthly basis. The Trust Board reviews A&E performance as well as financial performance on a monthly basis		Satisfactory	4x4=16	The Trust has met its mth 11 Finance control total and achieved Q3 A&E target. The Q4 A&E performance requirement is unlikely to be met, but this does not effect acehivement of the Trust's control total	The Trust will continue to closely monitor its performance against the financial and activity targets	Current and ongoing	3x4=12
MK	7-6	SO7	Finance and Investment	The Trust fails to utilise available capital funding according to strategic and clinical priorities	That the process of prioritising projects oin which the Trust's limited capital funds should be spent does not properly align with its broader strategic priorities	3x4=12	CBIG forum including clinical, corporate and executive representation Capital prioritisation programme	Management Board processes		Internal audit oversight of capital programme	Satisfactory	Scoring under review				
LK	7-7	SO7	Board of Directors	Failures in compliance leading to regulatory intervention (CQC)	That the Trust fails to meet the CQC's fundamental standards and receives a critical report foollowing an inspection	4x4=16	Compliance assessments embedded in divisions and CSUs (through CIGs and compliance reporting) Divisions undertaken Well Led Assessment in quarter three 2017/18 Trust commissioned GGI to prepare for corporate Well Led Assessment review process Corporate governance structure updated to further strengthen quality and compliance oversight and reporting - effective quarter one 2018/19	Oversight through CIGs Oversight at Risk and Compliance Board Oversight at Nursing and Midwifery Board Oversight at Clinical Quality Board Oversight at Management Board	Regular engagement with the local CQC relationship manager Oversight at Quality and Clinical Risk Committee Trust Board engagement in GGI review	Well Led peer review exercise to be held with kingston Hospital Commissioned GGI to undertake Well Led Assessment preparatory review	Satisfactory	4x3=12				4x3=12
OE	8-1	SO8	Workforce	Inability to recruit to critical vacancies	National shortages of appropriately qualified staff in some clinical roles, particularly at consultant level Competition from surrounding hospitals Buoyant locum market National drive to increase nursing numbers leaving market shortfall (demand outstrips supply)	4x4=16	Participation in local and regional job fairs Targeted overseas recruitment activity Apprenticeships and work experience opportunities Exploration and use of new roles to help bridge particular gaps Use of recruitment and retention premia as necessary Use of the Trac recruitment tool Use of a system to recruit pre-qualification students Use of enhanced adverts, wsocial media and recruitment days Rollout of a dedicated workforce website	Vacancy control panel Divisional deep dive sessions Monthly reports to Mangement Board Workfoce Board oversight Use of workfoce planning templates Outcomes from the recruitment and retention task and finish group Workforce transformation reports	Quarterly reports to the Workforce and Development Assurance Committee	NHSI Model Hospital benchmarking Staff survey results	Satisfactory	4x3=12	The Trust's vacancy rate is at its lowest for a year. The Trust is working with NHSI on nurse retention, but it has been affected by the difficulties in obtaining visas for overseas doctors.	More attempts are to be made to optimise the Trust's workforce website.		3x2=6

OE	8-2	SO8	Workforce	Inability to retain staff employed in critical posts	Poor working and management envinroment, lack of progression or development opportunities make it difficult to retain key staff	4x4=16	Variety of organisational change/staff engagement acitivities, e.g. Event in the Tent Schwartz Rounds and coaching collaboratives Recruitment and retention premia We Care programme Onboarding and exit strategies/reporting Staff survey Learning and development programmes Health and wellbeing initiatives, including P2P and Care First Staff friends and family results/action plans Links to the University of Buckingham Staff recognition - staff awards, long service awards, GEM Leadership development and talent	Monthly reports to Workforce Board and Managment Board Workforce transformation reports	Reports to Workforce and Development Assurance Committees and the Finance and Investment Committee	NHSI Model Hopsital benchmarking, Staff survey results	Satisfactory	4x3=12				3x2=6
KJ	9-1	SO9	Finance & Investment	Failure to achieve the required level of investment (including appeal funds) to fund the Cancer Centre	Lack of suitable and timely engagement with key players within the city and wider area during the private phase of the appeal, and an inability to enthuse and gain the support of potential donors more broadly, means that the Charity is unable to achieve the required level of charitable contribution to the project	4x3=12	Fundraising strategy and plan in place Financial forecasts under very regular scrutiny Experienced consultancy engaged to support existing senior and experienced fundraising staff Tactical plan for private and public appeal phase developed and implemented	Regular reporting to Committee Operational oversight	Oversight at Charitable Funds Committee	Appeal Leadership Committee	Satisfactory	4x3=12				3x2=6
JH	10-1	SO10	Board of Directors	Inability to progress the Milton Keynes Accountable Care System and wider ACS/STP programme	Lack of effective collaboration among all the key local partners means that the goal of a comprehensive and integrated place based health and social care solution within MK is not realised	4x3=12	Chief Executive and Executive team engagement both at ICS and MK Place levels. MK Place leaders chairing 3 of the 5 ICS priority workstreams	Direct MKUH senior invokvement in decision making. Regular CEO progress updates to Management Board	Standing agenda item at the Trust Board		Satisfactory	4x3=12				3x2=6

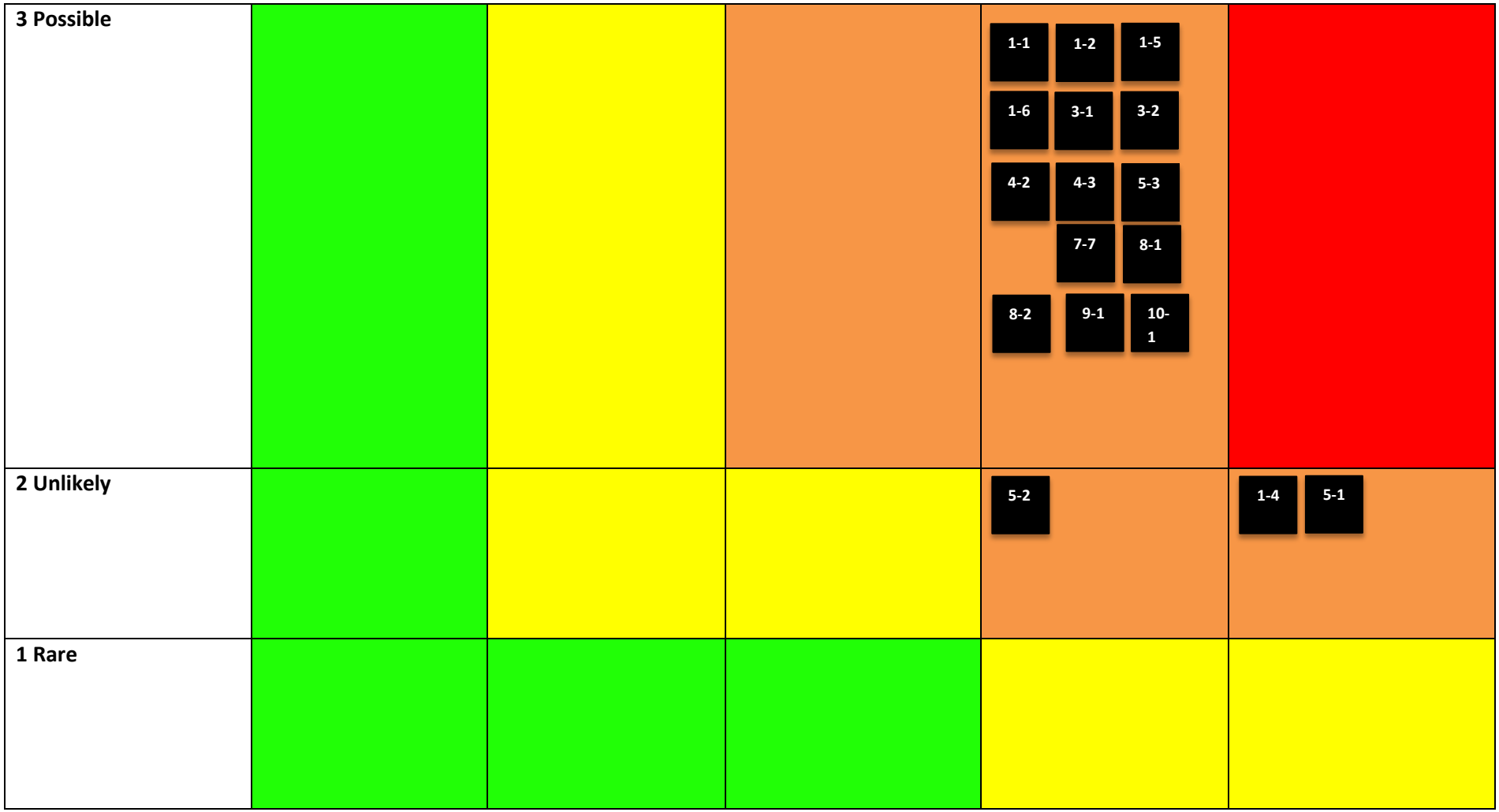
Strategic Objective	Risk Ref	Committee	Risk Description	Proximity	Risk Score (consequence v likelihood)						Trend	Target	Distance from target	Movement towards target (since Mar 2018)	Risk Appetite
					Jan-18	Apr-18	Jun-18	Sep-18	Dec-18	Mar-19					
SO1: Patient Safety	1-1	Quality and Clinical Risk	Strategic failure to manage demand for emergency care	Next 3 to 6 months	Not on BAF	(4x3) = 12	(4x3) = 12								Avoid
SO1: Patient Safety	1-2	Quality and Clinical Risk	Tactical failure to manage demand for emergency care		Not on BAF	(4x3) = 12	(4x3) = 12								Avoid
SO1: Patient Safety	1-3	Quality and Clinical Risk	Ability to maintain patient safety during periods of overwhelming demand		(4x5) = 20	(4x4) = 16	(4x4)= 16								Avoid
SO1: Patient Safety	1-4	Quality and Clinical Risk	Failure to appropriately embed learning and preventative measures following Serious Incidents	Next 3 to 6 months	(5x2) = 10	(5x2) = 10	(5x2) = 10								Avoid
SO1: Patient Safety	1-5	Quality and Clinical Risk	Failure to recognise and respond to the deteriorating patient	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(3x3) = 9								Avoid
SO1: Patient Safety	1-6	Quality and Clinical Risk	Failure to manage clinical risks through the implementation of eCARE (go-live)		Not on BAF	(4x3) = 12	(4x3) = 12								Cautious
SO2: Patient Experience	2-1	Quality and Clinical Risk	Failure to provide an appropriate patient experience	Next 3 to 6 months	(4x4) = 16	(4x4) = 16	(4x4)= 16								Cautious
SO3: Clinical Effectiveness	3-1	Quality and Clinical Risk	Lack of assessment against and compliance with best evidence based clinical practice through clinical audit	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12								Cautious
SO3: Clinical Effectiveness	3-2	Quality and Clinical Risk	Lack of assessment against and compliance with NICE guidance	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12								Cautious
SO4: Key Targets	4-1	Management Board	Failure to meet the 4 hour emergency access standard	Next 3 to 6 months	(4x5) =20	(4x4) =16	(4x4)= 16								Cautious
SO4: Key Targets	4-2	Management Board	Failure to meet the key elective access standards - RTT 18 weeks, non-RTT and cancer 62 days	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12								Cautious
SO5: Sustainability	4-3	Audit	Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure	Next 3 to 6 months	(4x5) = 20	(4x3) = 12	(4x3) = 12								Cautious
SO5: Sustainability	5-1	Audit	Failure to adequately safeguard against major IT system failure (deliberate attack)	Next 3 to 6 months	(3x3) = 9	(5x2) = 10	(5x2) = 10								Cautious
SO5: Sustainability	5-2	Finance	Failure to adequately safeguard against major IT system failure (inability to invest in appropriate support systems/infrastructure)	Next 3 to 6 months	(3x3) = 9	(4x2) = 8	(4x2) = 8								Cautious
SO5: Sustainability	5-3	Management Board	Failure to successfully deploy EPR in a way that diminishes disruption	Next 3 to 6 months	(5x3)=15	(4x3) = 12	(4x3) = 12								Cautious
SO5: Sustainability	5-4	Management Board	Failure to maximise the benefits of EPR	Next 3 to 6 months	(4x3) = 12	Reassessment required	Reassment required								Open
SO7: Finance and Governance	7-1	Finance	Inability to keep to affordable levels of agency and locum staffing	Next 3 to 6 months	(5x4)=20	(4x3) = 12	(5x4)=20								Open
SO7: Finance and Governance	7-2	Finance	Timing and release of capital and revenue funding	Next 12 months	(5x5) = 25	(4x4) = 16	(4x4)= 16								Open
SO7: Finance and Governance	7-3	Finance	Inability to achieve the required levels of financial efficiency within the Transformation Programme	Next 12 months	(5x4) = 20	(4x4) = 16	(5x4) = 20								Seek
SO7: Finance and Governance	7-4	Finance	Disagreement with main commissioner over the level of performance that they are prepared to fund	Next 12 months	(5x4) =20	(4x4) = 16	(4x4)= 16								Seek
SO7: Finance and Governance	7-5	Finance	The Trust is unable to access £7.3m of Sustainability & Transformation Funding	Next 3 to 6 months	(5x5) = 25	(4x4) = 16	(5x4) = 20								Seek
SO7: Finance and Governance	7-6	Finance	The Trust fails to utilise available capital funding according to strategic and clinical priorities	Next 12 months	(3x4) = 12	Reassessment required	Reassment required								Seek
SO7: Finance and Governance	7-7	Finance	Failures in compliance leading to regulatory intervention (CQC)	Next 12 months	(4x3) = 12	(4x3) = 12	(4x3) = 12								Cautious

SO8: Workforce	8-1	Workforce	Inability to recruit to critical vacancies	Next 3 to 6 months	(4x4) = 16	(4x3) = 12	(4x3) = 12								Seek
SO8: Workforce	8-2	Workforce	Inability to retain staff employed in critical positions	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12								Seek
SO10: Corporate Citizen	9-1	Charitable Funds	Failure to achieve the required level of investment (including appeal funds) to fund the Cancer Centre	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12								Open
SO10: Corporate Citizen	10-1	Board	Inability to progress the Milton Keynes Accountable Care System and wider ACS/STP programme	Next 3 to 6 months	(4x3) = 12	(4x3) = 12	(4x3) = 12								Seek

Board Assurance Framework Heat Map June 2018

The heat map reflects residual scores. The map for June still depicts clustering of risk in the major/ likely or possible category, but the impact scores of a number of the finance related risks have also risen. These scores will be given particular scrutiny in the June/August review round to assess whether they can be mitigated further.

	1 None	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Certain					
4 Likely			7-6 8-2	1-3 2-1 4-1 7-2 7-4	7-3 7-1 7-5


3 Possible
1-1
1-2
1-5
1-6
3-1
3-2
4-2
4-3
5-3
7-7
8-1
8-2
9-1
10-1
2 Unlikely
5-2
1-4
5-1
1 Rare

Meeting title	**Trust Board**	**Date: 6 July 2018**
Report title:	**Medical Revalidation Annual Report**	**Agenda item: 6.2**
Lead director **Report author** **Sponsor(s)**	**Name: Dr Ian Reckless** **Name: Elisa Scaletta**	**Title: Medical Director** **Title: Deputy Business Manager**
FoI status:	**PUBLIC**	

Report summary	**Overview of Appraisal and Revalidation systems and outcomes for 2017-18**			
Purpose *(tick one box only)*	**Information** ☐	**Approval** X	**To note** ☐	**Decision** ☐
Recommendation	That the approval of the 'statement of compliance' confirming that the organisation, as a designated body, is in compliance with the regulations is endorsed.			

Strategic objectives links	1. Improve Patient Safety 2. Improve Patient Experience 7. Become Well-Governed and Financially Viable 8. Improve Workforce Effectiveness
Board Assurance Framework links	None
CQC regulations	This report relates to: CQC outcome – 12 (Suitability of staffing) CQC outcome – 14 (Supporting workers) NHLSA standard – 1.9 (Governance) NHSLA standard – 5.1 (Supervision of medical staff in training)
Identified risks and risk management actions	None as a result of this report
Resource implications	None as a result of this report
Legal implications including equality and diversity assessment	None as a result of this report

Report history	Annual Report
Next steps	Completion and submission to NHS England of the 'Statement of Compliance' by the Chief Executive on behalf of MKUH as a designated body
Appendices	Appendix A – GMC Revalidation Case Study

Executive summary

Milton Keynes University Hospital has a prescribed connection with 284 Doctors as a Designated Body for the purpose of Medical Revalidation. This number includes: Consultants; Specialty and Associate Specialist (SAS) doctors; Trust Grade doctors; and NHS locums. It excludes General Dentist Council (GDC) registered dentists, trainee doctors and agency locums.[1]

In the appraisal year from 1st April 2017 – 31st March 2018 (17/18 appraisal year) the following medical appraisals were completed:

- 269 doctors completed an enhanced appraisal
- 2 doctors had approved reasons for not completing an appraisal (sabbatical leave or sick leave)
- doctors completed their appraisal but the meeting took place after 1st April 2018
- 4 doctors had not yet completed their 17/18 appraisal at the time of completion of the Annual Organisational Audit (AOA) on 01 June 2018[2]

This represents a 95% completion of appraisals in 17/18, this compares to 16/17 appraisal completion of 93%.

Purpose of the Paper

The purpose of this paper is to assure the Trust Board that we are discharging our statutory responsibilities in respect of Medical Appraisal and Revalidation for doctors who have a prescribed relationship with Milton Keynes University Hospital as designated body.

Background

Medical Revalidation was launched in 2012 to strengthen the way in which doctors are regulated, with the aims of: improving the quality of care provided to patients; improving patient safety; and, increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations **[References 1&2]** and it is expected that Trust Boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and,
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

[1] GDC registrants (dentists) do not revalidate but are appraised under the same Trust policy and process as their medically registered and licensed colleagues at MKUH. Trainee doctors are appraised by, and connected to, HETV (the Deanery). Agency locums are appraised by, and connected to, their agencies.

[2] Since AOA submission, 1 of these 4 appraisals has been completed and 2 doctors have had their appraisal meeting and have been asked for further documents before sign off.

To ensure that their appraisal is completed on time for 18/19, their appraisal date has been moved back to their original appraisal due date or as close to this as possible. We will continue to do this until everyone's appraisal is in line with their original anniversary month. The Medical Director's Office is also ensuring that all appraisals are scheduled between April – January to also ensure all appraisals are completed within the appraisal year.

The purpose of revalidation is to provide assurance to patients and the public, employers and other healthcare professionals that licensed doctors are up-to-date and fit to practise.

In respect to appraisals, doctors are required to maintain a portfolio of supporting information to demonstrate that they continue to meet the attributes set out in the GMC Domains of Good Medical Practice **[Reference 3]** and this portfolio should include clear evidence of:

- Continuing professional development;
- Quality improvement activity;
- Reflection and learning from significant events;
- Feedback from colleagues;
- Feedback from patients; and,
- Review of complaints and compliments.

Governance Arrangements

a. Organisational structure and responsibilities:

Responsible Officer (RO) – Dr Ian Reckless, Medical Director and Consultant Physician (as of 18 April 2016).

The Responsible Officer has executive responsibility for overseeing the appraisal process for all Doctors with a prescribed connection and making revalidation recommendations to the General Medical Council (GMC). Recommendations are based on assessment of annual enhanced appraisal portfolios and any other governance information available to the RO.

Revalidation Support Committee – Chaired by Mr Graham Anderson (Lay Person)

The Revalidation Support Committee is responsible for reviewing all appraisal portfolios due for revalidation, carrying out triangulation checks on GMC and local concerns, complaints and serious incidents. This occurs prior to the RO making a revalidation recommendation.

The committee also supplies feedback to both appraisers and individual doctors on issues relating to quality of appraisal portfolios at revalidation and can request that additional evidence is supplied in the portfolio.

The revalidation support group is formed of 2 lay representatives, appraisers (Consultants) and a representative from the Medical Director's Office. The committee reports to the Responsible Officer and provides an update to Workforce Board.

Trust Appraisal Lead – Dr Andrew Cooney, Consultant Anaesthetist

The Trust Appraisal lead is responsible for the quality improvement of appraisals in respect to inputs and outputs. The lead delivers this through training, recruitment, and review and performance management of Trust appointed appraisers.

Medical Appraisers – Various Consultants and Specialty Doctors

Medical appraisers are responsible for reviewing and advising individual doctors on their appraisal portfolios and assessing whether they have met the GMC Domains of Good Medical Practice **[Reference 3]**, giving their final recommendation to the Responsible Officer and agreeing a personal development plan with the individual.

Appraisers are trained by an externally recognised training provider. Appraisers are expected to do a minimum of 6 appraisals per year to maintain proficiency.

Our current appraisers are all qualified doctors or dentists of varying grades in the employment of Milton Keynes University Hospital, and have attended certified enhanced appraiser training. They also have access to yearly top-up training and quarterly peer support groups.

Risk Management & Patient Experience Departments

Both the Risk and Patient Experience departments supply information to individual doctors on their named involvement in complaints and Serious Incidents Requiring Investigation (SIRIs). This then provides them with a specific source of evidence to reflect upon in their appraisal portfolio.

The Risk and Patient Experience department then provide the Revalidation Support Committee / Medical Director's Office with reports on named involvement in complaints and serious incidents, for triangulation checks at the point of revalidation portfolio review.

Clinical Line Managers

Clinical line managers (CSU Leads, Divisional Directors) are required to provide a reference at appraisal for each of their direct reports. Clinical Managers are also expected to resolve issues that might arise out of appraisal or non-engagement with the appraisal process.

Medical Directors Office (MDO)

The Medical Director's office is responsible for administering:

- The appraisal system;
- The revalidation reschedule and process;
- Tri-angulation checks on concerns, complaints and serious incidents for doctors for revalidation;
- Communications around revalidation deferrals;
- Administering the non-engagement process;
- All reporting functions and progress monitoring; and,
- Communications with staff around appraisal on behalf of the Responsible Officer.

b. Maintaining accurate lists of prescribed relationships

The list of doctors with a prescribed relationship is maintained from:

- A monthly comparison to the ESR payroll list of currently employed doctors and leavers reports.
- All newly employed doctors receive a letter from the RO in their welcome pack and are encouraged to contact the Medical Director's Office to receive 1-2-1 training to get up and running with their appraisals.

c. Progress Monitoring

Monitoring of appraisal and revalidations is carried out through the following:

1. Quarterly Appraisal Rates

Appraisal rates are reported to the Responsible Officer and then through him to the Regional Responsible Officer and is in the format of a Quarterly Appraisal Return as required by the Framework of Quality Assurance for Responsible Officers and Revalidation.

2. Annual Organisational Audit (AOA)

The AOA is a tool to help ROs and Boards assure themselves that the system underpinning the recommendations they make to the GMC on doctors fitness to practice, the arrangements for medical appraisal and responding to concerns are in place.

3. Annual Board Report

An annual report (this document) is reviewed by the Trust Board to assure members of the progress made and asks them to confirm to the Regional RO that we are fulfilling our statutory requirements.

4. Monthly Engagement Checks & Escalation process

The MDO checks the progress of every due appraisal and escalates overdue appraisals to the Responsible Officer.

d. Policy and Guidance

The current policy was reviewed and amended in December 2016. The new policy and associated documentation was specifically updated to ensure that there is joined up process for appraisal with the University of Buckingham in relation to medical school activities and the lessons learnt since inception of the first policy in 2014.

5. Medical Appraisal

For the 1st April 2017 – 31st March 2018 appraisal year, 95% of appraisals were completed. This is compared to 93% in last year's appraisals. The below tables illustrate the appraisal performance for the 17/18 appraisal year by category of doctor. Please note that NHS England has altered the classifications for completed appraisal to include:

> ***Complete Appraisal (1A)*** – The appraisal is completed within the 3 months preceding the appraisal due date, is signed off with 28 days of meeting, and the entire process occur between 1st April and 31st March.
>
> ***Complete Appraisal (1B)*** – The appraisal was completed, but one or more of the categories for 1A (above) is not true.

Approved incomplete or missed appraisal (2): – the appraisal was not completed due to unavoidable reasons such as maternity leave, extended sick leave, career break or suspension.

Unapproved incomplete or missed appraisals (3) –Appraisal not completed

Table 1 *– Completed appraisals by grade or contract type for 17/18*

Grade	Total	1A: Complete	1B: Complete	2: Approved Incomplete	3: Unapproved In complete
Consultants	173	98	68	2	5
SAS Doctors	82	34	42	0	6
Temp Post Holders	18	13	5	0	0
Other	11	4	5	0	2
Total	**284**	**149**	**120**	**2**	**13**

From the above table, you can see that there were 13 doctors that had unapproved incomplete appraisals, however this includes those that were not signed off by 31st March 2018. There were only 4 doctors that had not had their appraisal signed off by 1st June 2018. The remaining 9 doctors who completed their appraisal (but not by the 31st March) have been included in the figures for completed appraisals on page 2, paragraph 1.

Table 2 *– Completed appraisals by grade or contract type for 16/17*

Grade	Total	1A: Complete	1B: Complete	2: Approved Incomplete	3: Unapproved In complete
Consultants	161	31	118	4	8
SAS Doctors	85	18	61	2	4
Temp Post Holders	6	4	2	0	0
Other	4	1	3	0	0
Total	**256**	**54**	**184**	**6**	**12**

a. Appraisers

Currently there are 46 Trust appraisers with an average of 6 doctors per appraiser currently assigned. The agreement is that each appraiser must do up to 6 appraisals per annum.

Each appraisal year, we re-recruit appraisers allowing people to continue, drop-out or take up the role. Every January, the Lead Appraiser and MDO write out to all Consultants and SAS doctors for expressions of interest to being an appraiser. The MDO collate the list and go through this with the Lead Appraiser. Training is then organised for those that have expressed an interest and then the list is reassessed to remove those that will no longer be carrying out appraisals and add those joining. The appraisers are managed by the Lead Appraiser who also offers internal training for current appraisers.

Training entails a full day with a certified trainer and each appraiser will receive a certificate demonstrating that they have completed this training.

Further update training is given on a yearly basis for all appraisers and appraisers also have quarterly peer support groups to help them further develop best practice.

b. Quality Assurance

For Appraisers - *Appraiser Quality Assurance Programme*

To ensure ongoing improvement in appraisal:

- Appraisers are recruited and managed by the Trust Appraisal Lead;
- Trust Appraisal Lead is required to review performance of appraisers including doctor's feedback, timeliness of completion of appraisal, quality of inputs (evidence), quality of outputs (appraisal summaries and personal development plans) and compliance to policy. Additional requirements have been detailed in the new draft policy;
- The appraisal lead is required to review appraisals, monitor quality and take appropriate remediation steps if necessary;
- The Medical Appraiser role is recognised within the job plan and attracts a tariff;
- Appraisal feedback from the appraisee is collected after appraisal;
- Appraisers must carry out a minimum of 6 appraisals annually;
- Appraisers must attend quarterly appraiser support groups (private group meetings where appraisal issues can be discussed amongst appraisers and knowledge shared);
- Yearly externally facilitated refresher appraiser training (0.5 day); and,
- New appraisers must attend facilitated training prior to carrying out an appraisal (1 day).

For the appraisal portfolio

To ensure ongoing improvement in appraisal:

- Appraisal portfolios are reviewed by the Revalidation Support Committee with written feedback given to both appraiser and individual where necessary. Specific areas of focus include Complaints, SIRIs, CPD and an agreed PDP.

For the organisation

- Feedback on the doctor's experience of both the appraisal and the systems around it is sought from all individuals after successful completion of appraisal.
- Yearly review of policy and guidance documentation is carried out by the Medical Director's Office.

6. Access, Security and Confidentiality

Appraisal portfolios, revalidation notes and feedback surveys are managed through the electronic database system (Allocate e-Appraisal and e-360). This system is available on any computer with internet access but only registered users with logins and passwords have access. Individuals only have access to their own information and there are a limited number of administration roles (controlled by the RO) that have access to other people's information.

When a doctor leaves the trust their account is closed and they no longer have access to system. However Individual users are able to download all their appraisal portfolios to transfer to a new system if they should desire, but this needs to be done before leaving the Trust.

Any request for appraisal and revalidation information for a doctor must come from the new Responsible Officer or his/her office. This request must be received on a MPIT or similar form and will be handled by the Medical Director's Office and approved for sending by the Responsible Officer. No requests for appraisal data will be supplied to individual doctors who have left the Trust or other agents, other than a new Responsible Officer.

7. Clinical governance

Individual Doctors are required to provide, discuss and reflect on involvement in complaints, compliments or serious incidents. Individuals are required to provide:

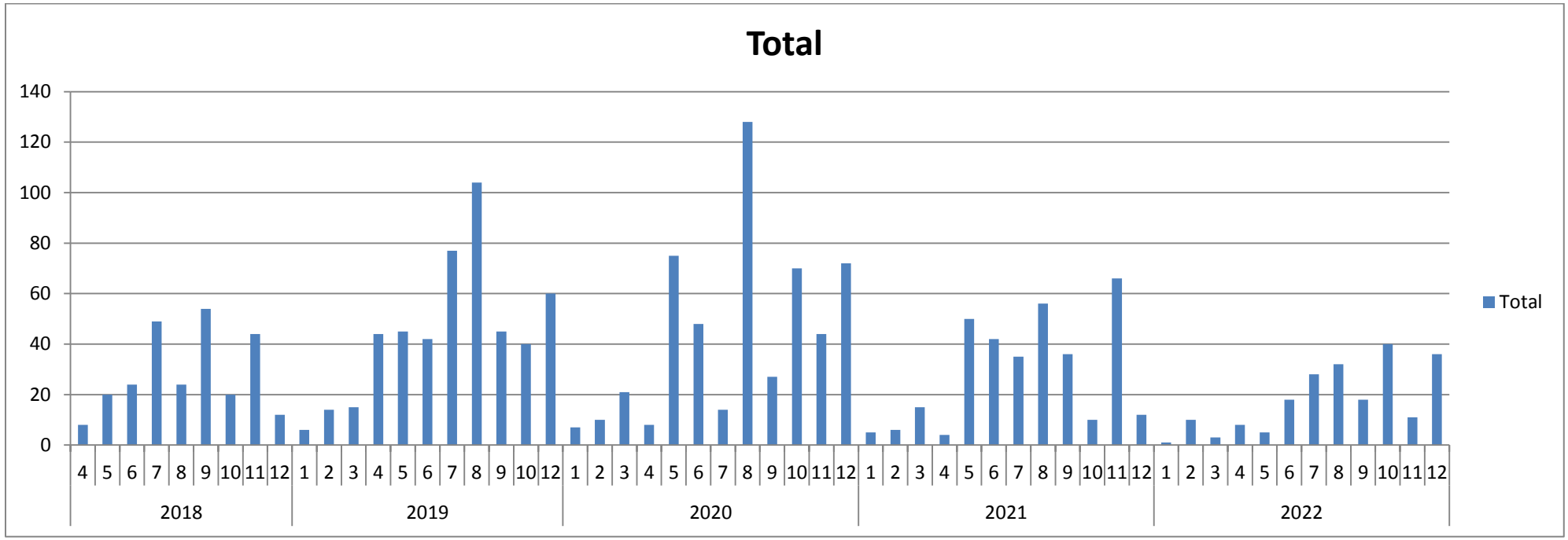
- Written evidence from the Patient Experience department and Risk Management detailing all events listed on the Datix system where the individual is named in the past 12 months
- A reference from their clinical line manager indicating involvement in complaints, compliments and Serious Incidents
- A letter from any other external body where the individual practices detailing involvement in any complaints, compliments or SIs.

As part of the role of the Revalidation Support Committee, these reports are also sought independently of appraisal and compared to those discussed in the appraisal.

8. Revalidation Recommendations

Between 1st April 2017 and 31st March 2018, we have made a total of 24 recommendations to the GMC about our doctor's revalidations compared to 38 in the previous year.

Please see the below forecast for the next 5 years. The demand of revalidation recommendations varies each month which can be seen below. Further changes will occur with retirements / resignations and new appointments.



There are 3 possible recommendations that can be made by the Responsible Officer through the GMC Connect website:

Revalidate

The requirements of a positive revalidation recommendation from the Responsible officer are:

"Based on the outcomes of such appraisal or assessment, and any other information available to me from relevant clinical and corporate governance systems, I am satisfied that:

- *Where relevant, each of the named medical practitioners is practising in compliance with any conditions imposed by, or undertakings agreed with, the General Medical Council.*

- *Where relevant, each of the named medical practitioners is practising in compliance with any conditions agreed locally".*

There are no unaddressed concerns identified by the above systems and processes about the fitness to practise of any of the named medical practitioners"

- The GMC protocol for making revalidation recommendations **[Reference 4]**

Defer

Deferral is a request to delay the revalidation decision pending either a local management process or for further information. This is a neutral act and does not reflect that there is an issue with an individual doctor. The minimum period of deferral is 4 months and the maximum (for one request) is 12 months. Repeat deferrals are challenged by the GMC revalidation team.

Non-engagement

This is the final confirmation to the GMC that a doctor is not engaging with the process. At this point the GMC enact their own non-engagement process which can ultimately end of with a removal of the licence to practice for the individual involved.

Table 3 *– Summary of recommendations made to the GMC*

Count of Recommendation		Recommendation		
Year	**Month**	**Defer**	**Revalidate**	**Grand Total**
2017	April	1	1	2
	June	1		1
	August		2	2
	September		2	2
	October		3	3
	November	2		2
	December	1	2	3
2017 Total		**5**	**10**	**15**
2018	January	2		2
	February	2		2
	March		5	5
2018 Total		**4**	**5**	**9**
Grand Total		**9**	**15**	**24**

***Deferral requests are typically made because mandatory information is not included in the appraisal, but also (on rare occasions) because an individual is going through a management process that has not been resolved.*

Late recommendations made by the RO to the GMC

We have not made any late recommendations to the GMC.

Higher level Responsible Officer

Each RO has a prescribed connection to NHS England or Department of Health. The Responsible Officer's higher level RO is based at NHS England Midlands and East. The higher level RO will submit revalidation recommendations to the GMC for all ROs connected to them. The recommendation will be based, as it is for all doctors, on information from appraisal and from routine monitoring of performance and fitness to practise.

Revalidation Case Study

The Responsible Officer & Lay Chair have been interviewed by the GMC as they would like to use MKUH's Revalidation Committee as a case study for good practice. The case study is finalised and has been publicised on the GMC website.. The GMC website is being redesigned and relaunched (hopefully at the end of March) so they plan to include it in the new revalidation pages then. This was also shared with ROs via the RO bulletin in January 2018. **[Appendix A]**

9. Recruitment and engagement background checks

The recommended employment checks are already carried out by the Human Resources recruitment team and where specific information is required in respect to appraisal information this is collected by the Medical Director's Office.

Where the checks are carried out by a third party, i.e. Locum Agency reliance is placed on the framework agreements/contracts that these checks are done by the agency.

10. Monitoring Performance

Performance of all doctors is monitored through the clinical line management structure of clinical leads for specialties and CSU leads for service units and divisional directors.

11. Responding to Concerns and Remediation

A responding to concerns policy has been created and is now on the Trust intranet.

12. Risks and Issues

There are no specific risks or issues that need to be brought to the Board's attention.

13. Board / Executive Team Reflections

Not applicable

14. Recommendations

The Board to receive the report (noting that it will be shared, along with the annual audit, with the Higher Level Responsible Officer) and to consider any needs/resources highlighted.

The Board is asked to approve the 'statement of compliance' confirming that the organisation, as a designated body, is in compliance with the regulations.

15. References

[1] *The Medical Profession (Responsible Officers) Regulations 2010*, Found at URL:
http://www.legislation.gov.uk/uksi/2010/2841/pdfs/uksi_20102841_en.pdf

[2] *The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012*, Found at URL:
http://www.gmc-uk.org/LtP_and_Reval_Regs_2012.pdf_50435434.pdf

[3] *Good medical Practice*, General Medical Council (2013), Found at URL:
http://www.gmc-uk.org/static/documents/content/Good_medical_practice_-_English_0914.pdf

[4] *The GMC protocol for making revalidation recommendations,* Third Edition, General Medical Council (2014), Found at URL:
http://www.gmc-uk.org/Responsible_Officer_Protocol.pdf_56096180.pdf

16. Appendices

[A] GMC Revalidation Case Study

Appendix A

Patient and public involvement in local revalidation processes

Quality assurance from a lay perspective: Milton Keynes University Hospital Revalidation Committee

How are lay people involved in local revalidation processes?

Since 2014, Milton Keynes University Hospital Trust (MKUHT)'s has had two lay members on their Revalidation Committee. The Committee plays a key role in supporting the responsible officer in making recommendations and driving up the quality of appraisal. Chaired by a lay member, the committee consists of lead appraisers, staff from the responsible officer's office and a further lay member.

The Committee review the appraisal documentation for every one of the Trust's doctors. They identify issues for consideration by the responsible officer including gaps in the sufficiency or quality of evidence submitted, and feedback areas of improvement to both doctors and appraisers.

The lay members play a full role in the business of the Committee: reviewing individual appraisal portfolios, preparing recommendations for the responsible officer, and providing ratings and feedback to appraisers.

What are the benefits?

Dr Ian Reckless, Medical Director and RO:

"Many ROs have staff supporting them in reviewing doctors' portfolios, flagging grey areas and advising them on quality. Having a Committee with lay representation performing this role provides a robust and objective approach. Revalidation is all about providing assurance to the public so it's right that I obtain that perspective."

Andrew Kerr, Business Manager, Medical Director's Office

"The committee enables a level of review that might not have been possible if revalidation was the sole responsibility of one person. Our process adds robust quality control and hopefully assurance to our patients.

Both the revalidation process and the committee have brought significant benefits to the Trust, helping to identify individuals that need more support and raising awareness of continuing professional development (CPD) and quality improvement.

The committee assists the responsible officer in fulfilling his statutory responsibilities, but also importantly involves lay input and it provides constructive feedback for appraisers. There is not always agreement on portfolio evidence, due to the differing interpretation of the requirements, but a panel helps balance this."

Graham Anderson, Chair of the Revalidation Committee:

Graham is a former Non-Executive Director of the Trust and retired businessman. He is supported by a second lay person who was recruited using a bespoke person specification.

"Revalidation is all about patient care and the patient experience. The Lay involvement brings independent challenge, business acumen and impartiality to the process which includes a robust line of questioning on the quality and sufficiency of appraisal evidence. I play a role in achieving consensus when there are conflicting views across the medical members of the Committee on either a particular case or approach.

The quality of appraisal documentation has risen significantly over the life of the Committee. In the early days, we rejected many portfolios because they failed to meet the prescribed standards: examples included the multi-source feedbacks being limited to one source only or because doctors did not present evidence to cover their work outside the Trust. Both were unacceptable.

Supported by the Committee, I strongly encouraged better and continual appraisal training and instituted a record of appraisers' scoring against narrative criteria for triangulation purposes. Through several other initiatives, there has been a sustained improvement in the quality of both appraisals and appraisers. Again supported by the Committee, I challenged the Committee to review its own performance and this was completed rigorously and satisfactorily earlier this year."

Making it work at your organisation

- Bring greater independence and robustness to your quality assurance processes by looking for opportunities to involve lay representatives.

- Design a job description for lay representatives that reflect the right knowledge, skills and experience needed to work constructively alongside medical professionals.

- Where lay representatives are involved in reviewing documentation for individual doctors, be clear on the arrangements and safeguards in place to protect the doctor's confidentiality.

Meeting title	Board of Directors	Date: 6 July 2018
Report title:	Report of the Management Board meeting held on 6 June 2018	Agenda item: 6.3
Report author	Name: Joe Harrison	Title: Chief Executive
FoI status:	Public document	

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

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

Report history	
Next steps	
Appendices	None

Chief Executive's Report - key points arising from the Management Board meeting on 6 June 2018

1. **Action log/Matters arising from previous meetings**
   A new Catering Manager has taken up post. A trial run of the proposed new process for preparing patients' meals is to take place during the month.

2. **Chief Executive's update**

- The implementation of eCARE has gone remarkably well. The Chief Executive thanked everyone for their efforts over the go-live period and since.
- The Chief Executive also thanked all staff, particularly those in the catering, portering and estates teams for their hard work in getting the organisation back up and running following the recent flash floods. He confirmed that the flooding had been caused by the sheer volume of water over a short space of time, rather than any issues with the Trust's estate.
- The CQC were on site on 11 June to hold a drop in session for staff. Staff were encouraged to go to speak to them about working at the Trust. The CQC team would also be attending a number of key meetings, including the Quality and Clinical Risk Committee.
- A formal process is underway to put in place combined governance arrangements for the 3 CCGs within the BLMK footprint – Milton Keynes, Luton and Bedfordshire. The Trust is also working with the STP on a number of bids for capital funding.
- Following a useful Board discussion about the Trust's strategy, two distinct threads of work have emerged – the need to work closely with local partners on meeting the needs of a growing and changing local population, and meeting the challenge of delivering resilient 24/7 acute care across all services provided.

3. **Quarter 4 trust-wide complaints PALS and patient experience report and 2017/18 annual complaints report**

- The opening of the PALS office in the main entrance has resulted in a notable increase in the level of informal and verbal complaints, but a corresponding drop in the number of formal complaints received. Complaints now represent 0.25% of the Trust's footfall, and the majority are in the yellow (low harm) and amber (moderate harm) categories. It has been difficult to benchmark these numbers against other local trusts as they do not always count PALS figures.
- Improved processes have been in put in place to ensure that complaints reach the divisions in a timely manner. Weekly meetings are held with wards and matrons on how investigations are progressing.
- The number of cases referred to the Health Service Ombudsman has fallen.
- It would appear that not all consultants have time set aside within their job plans to deal with complaints. The Medical Director is to look into this.
- It was acknowledged that the Trust needs to focus on improving the quality of its customer care in order that poor interactions between patients and staff do not detract from the overwhelmingly good quality clinical care that is provided.

4. **Health and safety update**

- The case of the person who fell from the multi-storey car park and sadly died was highlighted. It was also noted that a previous incident had occurred in April when an

individual threatened to jump. Additional measures to make it more difficult to scale the perimeter fence at the top of the car park are being considered. In the meantime, some interim measures have been put in place, including locating security staff at the top of the car park. Public Health England and Central and North West London Trust are also instigating further preventative measures. This was the first incident in which harm occurred since the car park was built in 2007.

- A plenary session is being planned to demonstrate the learning from various incidents including the recent flooding.
- Audible fire alarm testing is to be reinstated. Fire warden training has also been revised.

5. Other business

- The public launch of the cancer centre appeal has taken place, with events in the MacMillan Unit and at the Intu centre in CMK.
- The NHS' 70th birthday will be celebrated on 5 July with tea and cake for staff and patients. BBC Look East will be presenting live from the hospital on that day and Reuters are using a montage of the hospital as part of the celebrations.

Meeting title	Board of Directors	Date: 6 July 2018
Report title:	Annual Complaints Report	Agenda item: 6.4
Lead director Report author	Name: Lisa Knight Name: Julie Goodman	Title: Director of Patient Care and Chief Nurse Title: Complaints and PALS Manager
FoI status:		

Report summary	All Foundation trusts are required under the Local Authority, Social Services and NHS Complaints (England) Regulations of 2009 to report on how they have handled patient complaints during 2017/18, and how any lessons learnt from complaints has been disseminated across the organisation.			
Purpose *(tick one box only)*	Information ☐	Approval ☐	To note ☒	Decision ☐
Recommendation				

Strategic objectives links	1. Improve patient experience 2. Improve patient safety
Board Assurance Framework links	
CQC regulations	
Identified risks and risk management actions	
Resource implications	None
Legal implications including equality and diversity assessment	None

Report history	Patient Experience Board
Next steps	
Appendices	

SUBJECT : Complaints Annual Report 2017 to 2018

DATE : April 2018

REPORT BY: Julie Goodman, Trust Lead for Complaints and PALS

Executive Summary

This is the complaints annual report for Milton Keynes University Hospital NHS Foundation Trust (MKUH) for the period 1 April 2017 to 31 March 2018. MKUH serves a population of 269,020 (estimated) and this year received 87,740 attendees to the Emergency Department, 24,444 elective admissions, 353,662 outpatient attendances and delivered 3763 babies.

The National Health Service Complaints (England) Regulations 2009 requires that all Trusts must prepare an annual report on the handling and consideration of complaints. This report provides detail of the required inclusions and will be made public on the Trust's website and sent to commissioners of the Trust.

These regulations are further supported by the publication of national reports including the Francis Report 2013, Clwyd and Hart Report 2013, Designing Good Together Parliamentary and Health Service Ombudsman (PHSO) 2013, Patients Association Good Practice Standards, and My expectations for raising concerns and complaints (PHSO) 2015 highlighting best practice in respect of dealing with concerns and complaints. Extensive analysis of the NHS England's toolkit - 'Assurance of Good Complaints Handling for Acute and Community Care- A toolkit for commissioners, has revealed that the Trust's complaints service and process is robust and accessible to our public.

Systems and processes are in place within the Complaints and PALS teams to provide the Trust's commissioners with assurance that:

- All complaints are well managed
- The learning from complaints is identified and used for improvement
- The complaints service is accessible, open and transparent

MKUH is committed to improving patient experience and outlines key strategic priorities to enhance the patient experience which include:

- Improve the patient experience by ensuring a welcoming environment
- Improve communication with our patients
- Improve our patient literature

Patient care is at the heart of what we do which is reflected in our We Care programme, valued and cared for as an individual, understood informed and involved and safe.

Each and every complaint is an opportunity as an organisation to learn and make improvements in the areas that patients, carers and relatives tell us are important to them when using our services. We understand that handling concerns and complaints effectively matters for people who use our services who deserve an explanation when things go wrong and want to know that a tangible change has been made to prevent something similar happening to anyone else.

In January 2015 the Health Select Committee MPS found that "in moving to a culture which welcomes complaints as a way of improving NHS services, the number of complaints about a provider, rather than being an indicator of failure, may highlight a service which has developed a positive culture of complaints handling"

Achievements

Complainants' Survey

Following national reports, as detailed previously, there was a recommendation for Trusts to undertake complainant satisfaction surveys to establish if their complaints service was meeting the expectations of complainants and that the complaints service was easily accessible. The recommendation was that there should be national survey that all Trusts could use which would allow for benchmarking across the NHS.

NHS England worked with the Picker Institute to create a survey centred on the report and guidance as detailed in: - A user-led vision for raising concerns and complaints in health and social care
'My expectations for raising concerns and complaints' PHSO, Healthwatch England, LGO (2014)

Once developed, NHS England asked for Trusts to consider trialling the survey for a period of 6 months or 100 surveys. MKUH agreed to take part in the trial. The trial was in place for 6 months until the end of May 2017.

A report, including the Trust's feedback on the administration of the survey, was submitted to NHS England who analysed all feedback from the trial sites. The agreed version of the survey is now available from NHS England for all Trusts to use should they so wish.

The feedback from MKUH on their experience with the trial survey was shared on the website of NHS England.

NHS England » Survey of Complaints: Milton Keynes University Hospital NHS Foundation Trust

Other achievements

A very clear process is in place for the complaints office which identifies key dates to be worked to and clear lines of escalation for any delays identified in the complaint's journey.

The feedback gained from complaints and PALS is triangulated with other patient experience feedback such as the Friends and Family Test (FFT), Inpatient survey data, patient opinion websites such as NHS Choices and the 15 steps challenge to ensure any highlighted issues are dealt with promptly to ensure our patients go on to have a good experience.

The Trust Lead for Complaints and PALS and the Patient Experience and Engagement Manager meet with the senior staff on wards/departments on a rolling programme to highlight the feedback received for the area. This allows the area to consider what is going well and to make improvements to the experience of the patients where needed. Improvements in the last year as a result of these meetings are changes to information on wards in respect of photographs of team members and their role, distinct staff name badges to highlight the 'Nurse In Charge', obtaining of charitable funds to purchase radios for a patient's use.

A weekly RAG report detailing the current status of all complaints is shared with the divisional triumvirates and is used as a tool to improve performance. The Board receive a RAG report detailing all complaint responses that are overdue.

The PALS team moved to the new Main Entrance in June 2017. This has ensured the PALS team is more accessible to all. There has been an increase in contacts with the PALS team of 30% when comparing the same period of July to March in 2016/17 and 2017/18. Within the same period the number of face to face meetings with callers to the service has risen by 790%.

In October 2017 the PALS team took part in the National Customer Service week by undertaking a number of engagement activities throughout the week. Some of the highlights involved the Chairman working in the PALS office for a morning and taking calls from the public giving the Chairman an insight to the work PALS undertake. The staff in PALS volunteered to work in the League of Friends shop serving customers and making them aware of the PALS service and getting to know staff better. Following on from this dedicated week, on a quarterly basis the team thank those staff who have gone above and beyond their role to help PALS or a patient by presenting them with a certificate and some chocolate to say 'thank you'.

To widen accessibility to the PALS service a mobile telephone number is now available to enable callers to text the service with their details to obtain a call back from PALS. Since October 2017, 72 contacts have used the text service.

Training on the complaints process and the PALS service is delivered across the Trust as requested by individuals and departments at present. In 2018/19 the aim is to have a rolling plan in place delivering appropriate training tailored to he needs of the staff group involved.

Summary of NHS Complaints Procedures

In April 2009 the NHS Complaints Procedure was amended and the latest NHS (Complaints) Regulations came into force. The Local Authority Social Services and NHS Complaints (England) Regulations 2009 are a Statutory Instrument that all Trusts, including Foundation Trusts, have a duty to implement. Whilst the procedures are not prescriptive, the regulations set out various obligations on NHS bodies in relation to the handling of complaints. Since 1 April 2009, there has been a single approach across Health and Adult Social Care to dealing with complaints. The regulations set out a two stage complaint system:

Stage 1 Local resolution – working with the complainant to understand and resolve their concerns in a timely and proportionate fashion.

Stage 2 Referral to the Parliamentary and Health Service Ombudsman (PHSO) – if local resolution is not successful and people are dissatisfied with the way their complaint has been handled, the complainant can refer their case to the Ombudsman for review.

The national complaints legislation requires that concerns raised by the public are responded to personally and positively and that lessons are learnt by the local organisation. The local resolution stage focuses on the complainant and enabling organisations to tailor a flexible response that seeks to ensure all complainants receive a positive response to their complaint or concern. It places an emphasis on resolving them as fairly and as quickly as possible and ensuring that lessons are learned and shared to improve the experience of care.

The Parliamentary and Health Service Ombudsman is a free and independent service, set up by Parliament. Their role is to investigate complaints where individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England. If local resolution is not successful, the complainant can refer their case to the Ombudsman for review. The Ombudsman makes the final decisions on complaints about the NHS for individuals. They use what they learn from complaints to help public services get better.

MKUH Complaints Process

The Complaints and PALS team aim to provide a person centred approach to all comments, compliments, concerns and complaints received. The Trust actively encourages staff closest to the care and services being received to deal with concerns and problems as they arise so that they can be remedied quickly and be responsive to individual need and circumstances. Such timely intervention can prevent an escalation of the complaint and achieve a more satisfactory outcome for all involved. The Trust looks to encourage concerns and complaints and ensure that any lessons learnt are shared throughout the Trust and information is used to inform service improvement for our patients and public.

When dealing with complaints the principles, as laid down by the Parliamentary Health Service Ombudsman (PHSO), should be taken into consideration and adhered to. The principles are as follows:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

Most importantly, the Trust should put the complainant at the centre of all that we do and ensure that we deal with their complaint in the way they wish. The Trust should not be deciding for the complainant how the complaint will be processed; the decision should be made in conjunction with the complainant.

Annual Complaints Figures

MKUH is organised into four divisions. These are Surgical Services, Medical Services, Women's and Children's Services and Core Clinical Services each of which are led by a triumvirate team which includes a Divisional Director, Head of Nursing and General Manager and collectively supported by Corporate Services.

The complaint numbers during 2017/18 have been collected for each division and the number and type of complaints received for MKUH has been closely monitored and analysed in order to identify themes and trends and inform future improvements moving forward.

The overall picture shows a large increase in the number of complaints being received compared to 2016/17, an increase of 50% with the largest increase being in Q2-4 when compared with 2016/17. This coincides with the PALS now being located within the new Main Entrance.

A total of 1256 complaints have been received by the Trust during 2017/18 as detailed on the chart below.

	Q1 Apr - Jun 17	Q2 Jul – Sep 17	Q3 Oct – Dec 17	Q4 Jan – Mar 18	**TOTAL**
Complaint Numbers	268	310	316	362	1256 (n = 838 2016/17, **increase 50%**)

Source: DATIX Risk Management System as at 18/04/2018

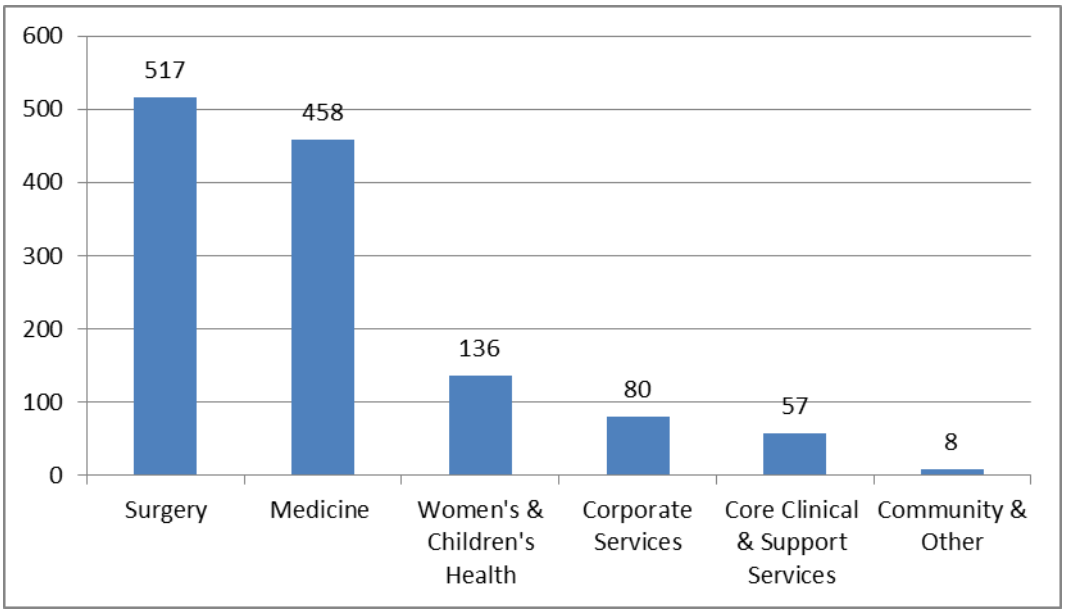
The chart below details the number of complaints received compared to the total attendances to MKUH.

Year	Total Complaints	Total Footfall (Inpatient and Outpatient including A&E attendances)	% of complaints to footfall
2013/14	442	335953	0.13%
2014/15	613	375264	0.16%
2015/16	902	461713	0.20%
2016/17	838	502562	0.17%
2017/18	1256	503793	0.25%

As can been seen from the above information the number of complaints received as a ratio to footfall has increased.

The 1256 complaints were represented across the divisions and are outlined in the table below:

Chart 1 – Number of complaints per division



Responding

The following definitions are used to provide clarity about whether an issue of concern is handled within the NHS complaints procedure and to ensure that the Trust provides the most appropriate response:

Formal Complaint – A complaint can be defined as an expression of dissatisfaction with the service provided (or not provided) or the circumstances associated with its provision which

requires an investigation and a formal response in order to promote resolution between the parties concerned.

Informal Complaint – An informal complaint can be defined as a matter of interest, importance or anxiety which can be resolved to the individual's satisfaction within a short period of time without the need for formal investigation and formal correspondence. Informal complaints are received by staff throughout the organisation. Where it has not been possible to resolve the complaint quickly (i.e. by the end of the next working day) and to the satisfaction of the person/s raising it, they will be asked if they would like their concern investigated as a formal complaint under the NHS Complaints Regulations (2009). All complaints whether resolved by the next working day or not, are recorded and reported and reviewed, collated and analysed along with the data recorded from complaints.

It is important that complaints are handled in accordance with the needs of the individual case and investigated fairly and proportionately.

The Trust follows the Department of Health guidance and legislation (the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009) which outlines the requirement to acknowledge all complaints within three working days. Under the current legislation Trusts have six months in which to resolve a complaint to the satisfaction of the complainant, providing a more flexible agreement with each complainant. MKUH aims to provide a response in as timely a manner as possible, working to an internal benchmark of 30 working days or 60 working days for complaints graded as Red (severe harm/death).

In order to ensure that people feel safe and supported to make a complaint, everyone is directed to additional information, advice and advocacy support. All complainants are signposted to the Parliamentary and Health Service Ombudsman (PHSO) (stage 2 of the NHS complaints process) in the case they are dissatisfied with the results of our investigation and complaint handling.

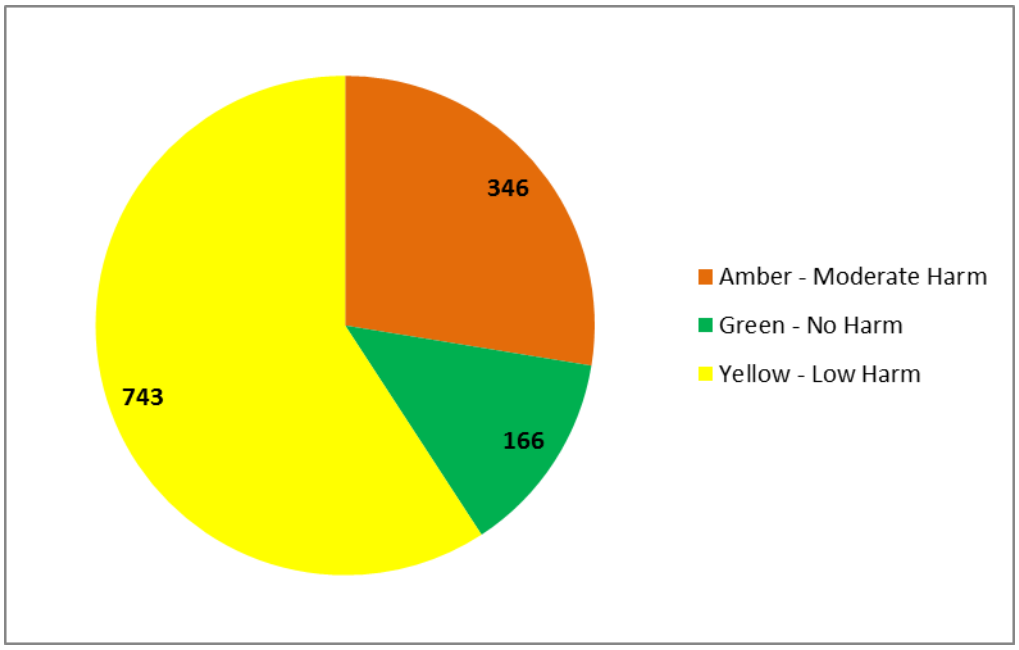
All complaints are dealt with in line with the Trust's complaints policy which includes an initial triage process to ensure complaints are investigated at the appropriate level and timeframe in relation to the severity of harm. The complainant is then contacted by the allocated complaint case officer to discuss the complaint in further detail and to gain clarity on their expectations from the complaints process. This includes gaining clarity on the issues they would like addressed and what they want to achieve as an outcome from the process along with how they would like to receive the response, in writing or a meeting with responsible medical staff or both.

All complaints triaged as Red or Amber (Severe or Moderate Harm) are allocated to the division and it is their responsibility to identify a complaint investigation lead.

Complaints by Severity in 2017/18

The chart below shows the number of complaints received by severity.

Chart 2 – Complaints by severity



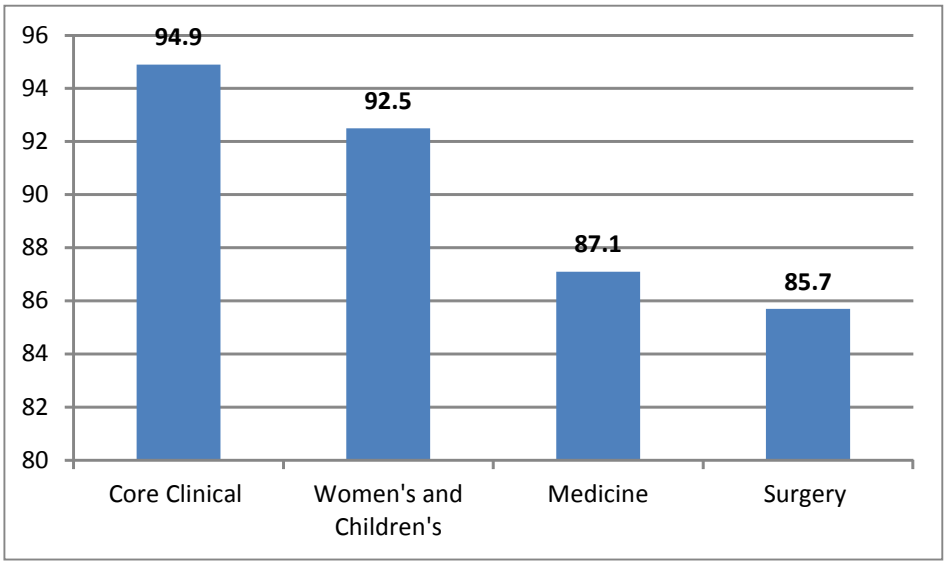
As can be seen above, the majority of complaints (72%) are low or no harm complaints. This is the same percentage as 2016/17.

Each category has associated timescales in which to respond to the complainant as follows:

Green (No Harm)	10 Days
Yellow (Low Harm)	15 Days
Amber (Moderate Harm)	30 Days
Red (Severe Harm)	60 Days

Complaints responded to on time per division in percentage terms

Chart 3 – Complaints responded to on time per division in percentage terms



In 2017/18, Trust wide 87.1% of complaints were responded to on time which is an increase in performance from 2016/17 of 7.1%. The delays in responses can be attributed to some of the more complex complaints. It remains a challenge across all divisions to achieve the required response timeframe particularly at times of increased clinical pressure. Many of the complaints closed outside of the agreed timescales were either complex which involved more than one service area or organisation, or those which raised additional issues during the course of the investigation and complaint handling.

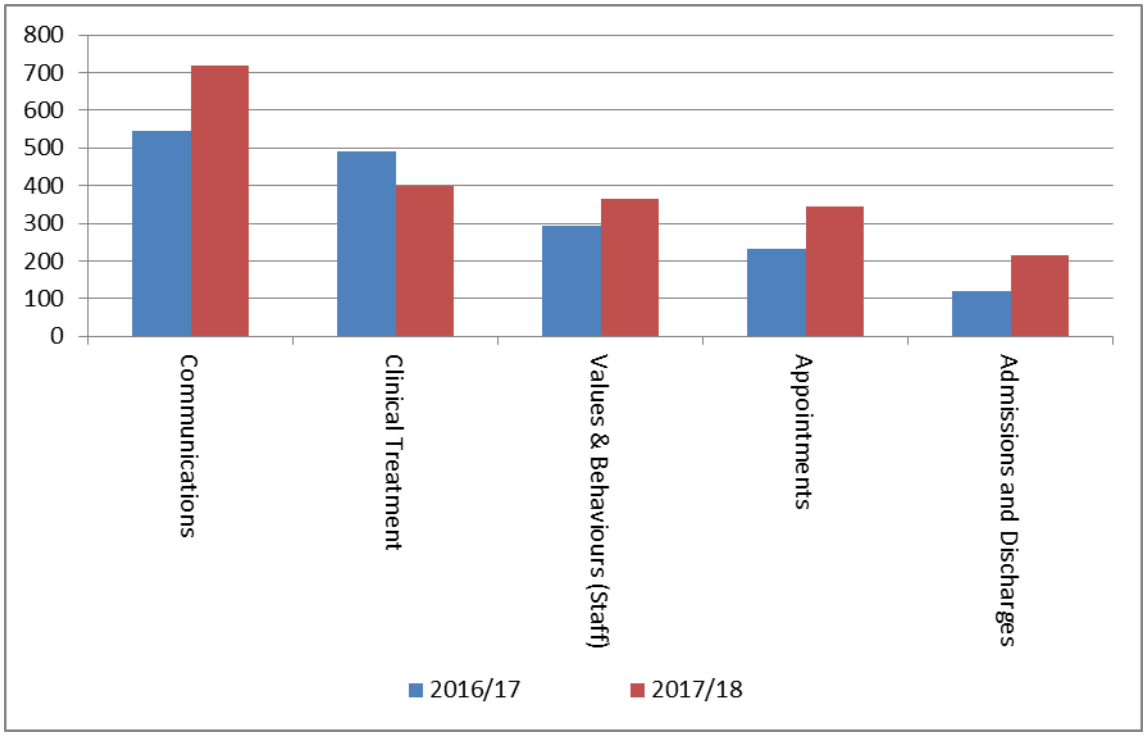
Category of Complaints

Complaints are recorded and categorised to help the organisation identify themes and trends and identify improvement actions in response to the findings.

Each issue reported in a complaint gets logged onto the complaints database (DATIX) using the category it pertains to. Some complaints have more than 1 issue and to ensure a true reflection of issues encountered all issues are recorded.

Comparison of top 5 categories of all complaints 2016/17 and 2017/18

Chart 4 – Comparison of top 5 categories

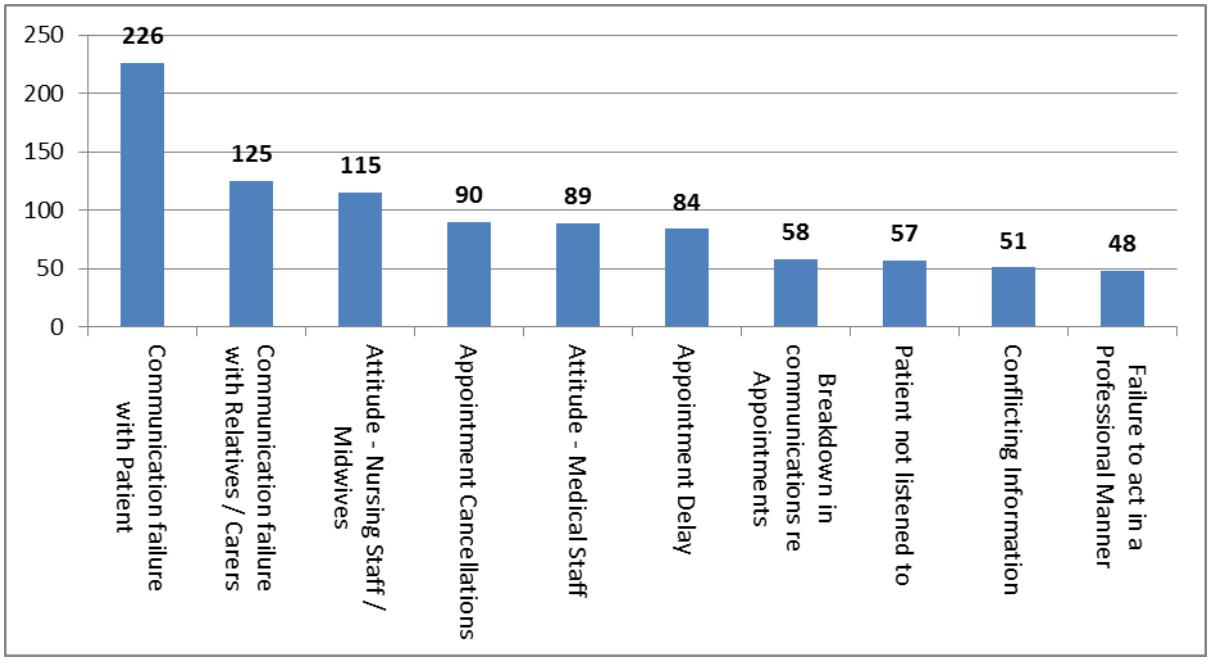


Clinical treatment, communications, appointment issues and staff behaviour and attitude account for the majority of the Trust's complaints for 2017/18 with this position not having changed when compared to 2016/17.

Complaint issues – Top 10 2017/18

Below is a breakdown of the top 5 issues for each of the top 5 categories of complaint for the year.

Chart 5 – Top 10 issues



These themes have become the focus locally for quality improvement initiatives and the Trust's transformation programme. The Trust sets out their commitment to uphold the values of the organisation underpinned by expected standards of behaviour that focus on caring for our patients with compassion respect and dignity.

In respect of complaints raised regarding staff behaviour and attitude, over the last year staff involved have been asked to ensure that they undertake a reflective piece of work following receipt of the complaint. This reflection should be shared with their manager/mentor to confirm that there has been learning as a result and they understand the effect that their behaviour has had on the person's experience as a whole.

If, during the course of a complaint investigation, issues of a serious nature come to light the Chief Nurse or Medical Director are made aware and their advice sought.

Internal monitoring

The numbers and subjects of complaints are shared with the Trust in the Patient Experience Report which is shared with the Board every quarter.

Governance Groups are provided with a summary of complaints for each CSU by their Governance Facilitator. The summary encompasses details of all complaints received for the service and more information on an individual service can be obtained from the Complaints

and PALS team who will be able, using DATIX, to drill down to the finite detail of complaints received by area and subject. The Medical Director/Chief Nurse and the appropriate Clinical Directors and CSU Leads receive copies of all relevant complaints.

Reopens

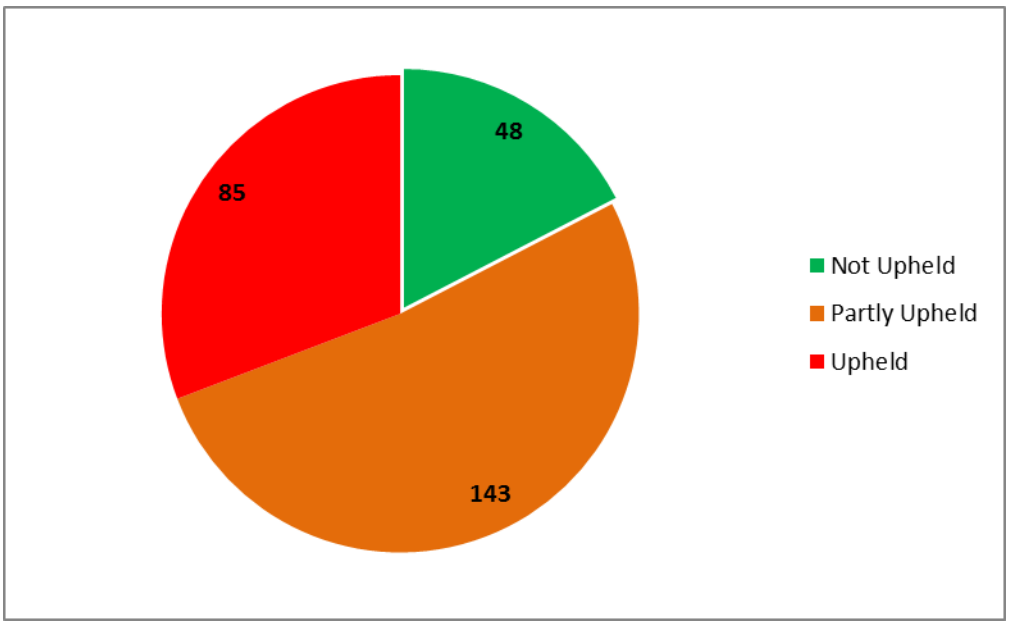
If a complainant remains unhappy with the response to their complaint they are encouraged to return to the Trust with their outstanding issues. These files are reopened and further investigation, if required, takes place with the final resolution taking the form of a meeting with the complainant or a further written response.

The number of complaints that have been reopened for further investigation in this year amounted to 106 (8%). This is in line with the same percentage of reopens from last year.

Complaints by outcome

The chart below shows the number of severe harm and moderate harm complaints upheld, partially upheld or not upheld (taken from those that were resolved as at 01/04/2018). There were 347 severe and moderate harm complaints received in 2017/18

Chart 5 - Severe and Moderate Complaints Outcome 2016/17



Complaints and the Parliamentary and Health Services Ombudsman (PHSO)

If a complainant is dissatisfied with the way their complaint has been dealt with by the Trust and local resolution of their complaint has not been satisfactory, they can take their complaint to the independent Parliamentary and Health Service Ombudsman (PHSO) for independent review. The PHSO will request copies of complaint files and medical records

and any other relevant documentation to enable them to fully consider how the complaint has been dealt with and if there is anything further the Trust should do to address the complaint.

During this year 8 (0.64%) complaints have been reviewed by the Parliamentary Health Service Ombudsman (PHSO). This is a slight improvement on performance compared with 2016/17 (0.72%).

.

Of the 8 complaints referred the following decisions were made:

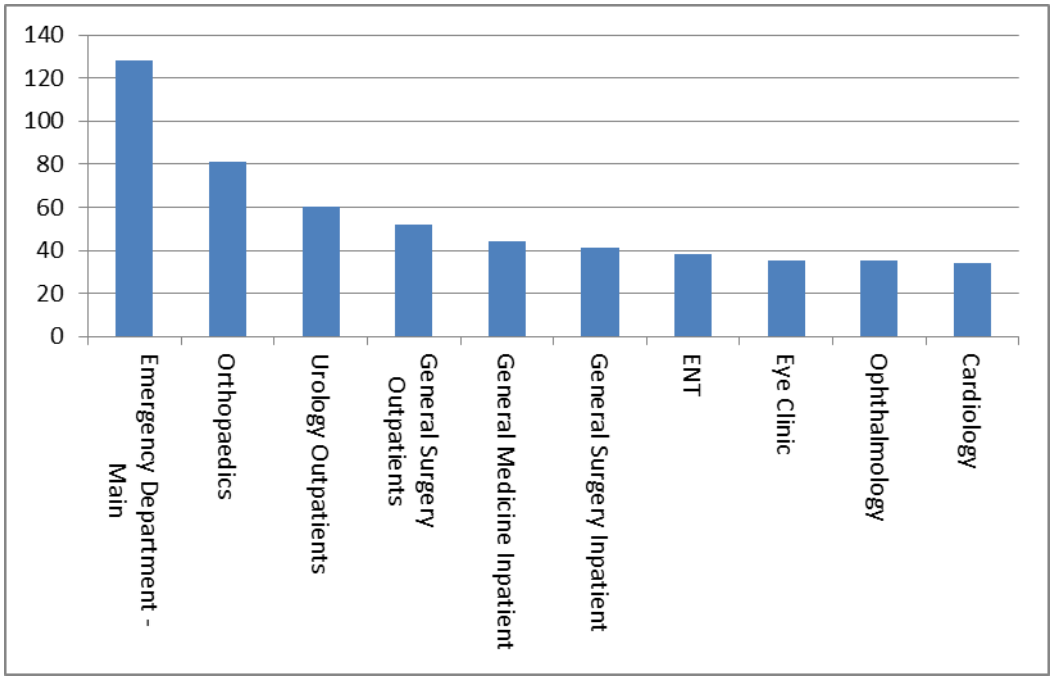
- 1 was partially upheld
- 3 were not upheld
- 4 is still under investigation

The information below relates to the partially upheld complaint.

Neurology

Issue upheld	**PHSO Recommendations and action taken**
The PHSO felt that the Trust may have had 2 opportunities in March 2016 to explore the neurological symptoms of a patient further. This would not however have changed the eventual outcome for the patient.	The recommendation was for the Trust to formally apologise to the patient for the distress suffered. Additionally the Trust was asked to reflect on the issues raised in the complaint for the purposes of learning across the organisation. The reflection and shared learning took place in February 2018 in the Medicine audit and governance afternoon.

Chart 6 -Top 10 Complaint Areas for all Complaints 2017/18



The top 3 areas for complaints remained constant in 2015/16, 2016/17 and 2017/18. The new areas to appear for 2017/18 in the top 10 are General Surgery inpatient and outpatient.

PALS activity

The PALS team also deal with calls from the patients and the public requesting information, advice or need signposting to a particular organisation or department or need re-directing to other organisations.

The number of calls in this respect for the year 2017/18 with a comparison for 2015/16 and 2016/17 is shown in below.

	2015/16	2016/17	2017/18
Feedback	194	142	77
Information	550	1072	960
Signposting	110	284	460
Total	854	1498	1457

Lessons learned and actions taken from complaints

The Trust values the opportunity that each complaint brings to learn and improve and recognises the importance of sharing the learning from complaints across the organisation for the benefit of our patients and staff. We continue to strive to demonstrate the changes that have made as a result of the learning from complaints and to sustain the changes for long term improvement.

We act on feedback to make improvements to our services wherever possible. Details of lessons learned and actions taken are inputted on DATIX. For every action mentioned in the response to the complainant, evidence of the action has to be given by the member of staff involved.

There have been many actions for complaints this year across the CSU's including:

- Dissemination of lessons learned/shared learning - by discussion at staff meetings, one to one supervisions for reflection and reiteration of correct practice to individuals or groups of staff
- Processes/Procedures/Guidelines/Policy - amended/revised or new
- Patient information leaflet – new
- Improvement of facilities
- Staff training, individual/group

A small selection of lessons learnt in respect of the top issues seen in complaints are summarised below to illustrate how complaints may drive service improvements.

Complaints regarding clinical treatment

Training session established in the medicine division teaching symptom control and end of life care for nursing staff.

Trauma Management course to be available for nurses and junior doctors in the Emergency Department.

The issues raised in a complaint with regard to a lack of diagnosis were shared at a morbidity meeting as a point of learning for a wide audience of consultants and junior doctors.

A revision of departmental guidelines in maternity to ensure any plan made by a consultant can only be altered following a discussion with the same consultant or the on call consultant.

Providing ENT patients who are being transferred to Northampton General Hospital at the weekend with a snack box to include snacks and a drink in case there is a delay in a bed being found for them upon arrival at Northampton General Hospital.

Complaints regarding communications

The creation of a protocol regarding renal tract anomalies which will include a parent/patient information leaflet to enable families to understand the condition.

Complaint shared at an Audit meeting to discuss how improvements can be made to communication when explaining the details of a procedure and what the next steps are for the patient.

Complainant met with Dementia nurses to give feedback on her first-hand experience of having a relative with dementia in hospital including the use of appropriate language for the patient. Also to ensure there is better communications from the therapy teams to ensure the family understands the patient's capabilities before they are discharged.

A revision of departmental guidelines in maternity to ensure any plan made by a consultant can only be altered following a discussion with the same consultant or the on call consultant

Values and Behaviours

Medical ward to create a handout for nursing staff, especially for use by temporary staff, to ensure they are aware of their responsibility with regard to mobile telephone usage.

Annual programme of training provided to midwives has been changed to include a patient experience session to provide an opportunity to listen to the feedback and to learn about the impact of the care they have provided.

Conclusion

It is the responsibility of all staff to deal with any complaint or concern that is brought to their attention. If the member of staff is not able to deal with the issue then they must escalate this to their manager. Patients and their families should never be discouraged from making a complaint and information on how to make a complaint is available on the Trust's intranet.

For 2017/18 our priority was to raise awareness of the PALS service and the help they can provide to our patients and their families. This has been successful as can be demonstrated in the increase in numbers of contacts to the service.

The Complaints and PALS team are more closely aligned with the Patient Experience team to ensure themes are shared and feedback gained to provide assurances of sustained service improvement for patients across the Trust.

Following the publication 'Hard Truths' the government's response to the Francis inquiry into the failings at Mid Staffordshire NHS Foundation Trust, the PHSO, the Local Government Ombudsman (LGO) and Healthwatch England committed to developing a user-led 'vision' of the complaints system. The vision aims to align the health and social care sector on what good looks like from the perspective of people raising concerns and complaints about health and social care. It builds on work that has previously been carried out by patient led organisations such as the Patients Association and National voices. The Care Quality Commission (CQC) will use the framework in its new inspection regime and the PHSO will integrate it into the principles of good complaint handling.

We understand that complaints are an important part of feedback and that they are a strong indicator of patient experience. We will consider how to use the framework as a definition of

‘what good looks like’ for our patients to measure our progress and identify actions needed to improve our complaint handling.

We share the vision that we want all people using our services to be able to say ‘I feel confident to speak up and making my complaint was simple’. ‘I felt listened to and understood.’ ‘I felt that my complaint made a difference.’

A user-led vision for raising concerns and complaints in health and social care
‘My expectations for raising concerns and complaints’ PHSO, Healthwatch England, LGO (2014)

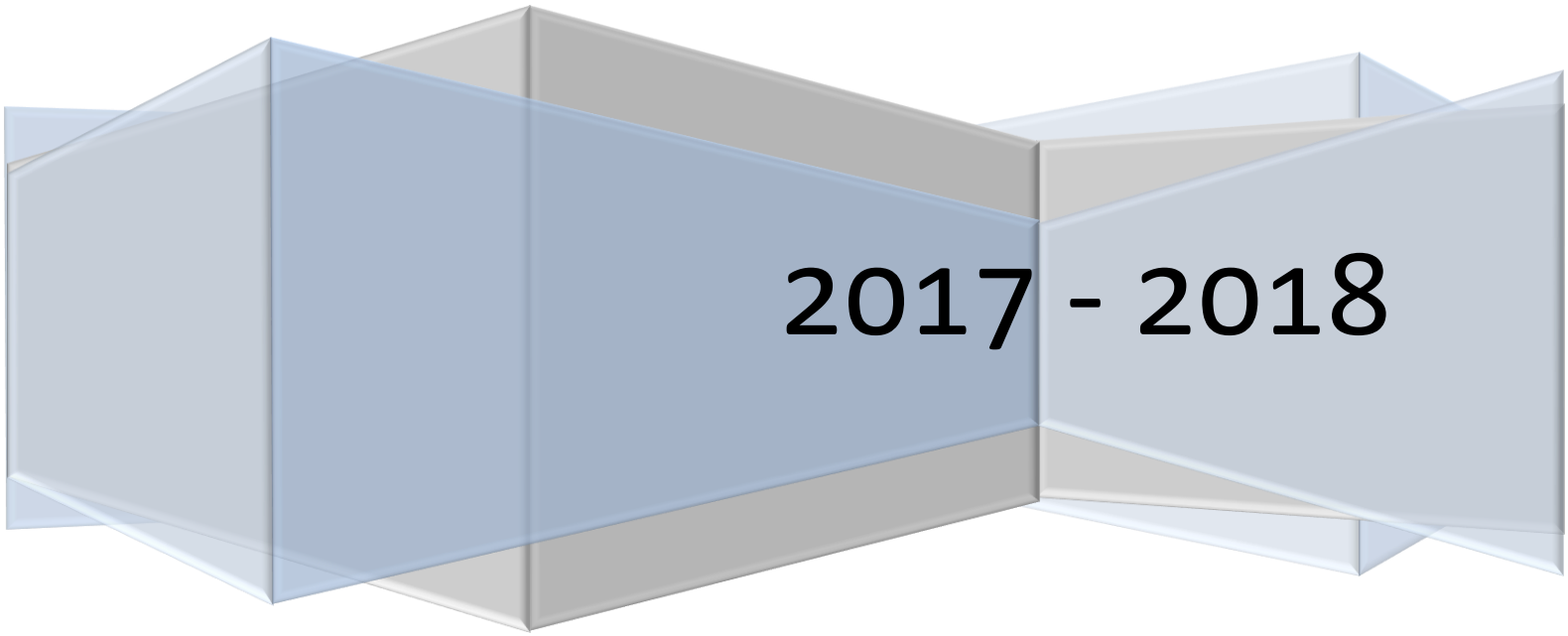
Meeting title	Board of Directors	Date: 6 July 2018
Report title:	Safeguarding Annual Report	Agenda item: 6.5
Lead director	Name: Lisa Knight	Title: Director of Patient Care and Chief Nurse
Report author	Name: Nadean Marsh	Title: Head of Nursing Quality and Improvement
FoI status:	Public Meeting	

Report summary	To receive and consider the Safeguarding Annual Report for 2017/18			
Purpose *(tick one box only)*	Information [x]	Approval [ ]	To note [x]	Decision [ ]
Recommendation	That the Report be received and noted			

Strategic objectives links	1. Improve patient experience 2. Improve patient safety 3. Improve clinical experience
Board Assurance Framework links	None
CQC regulations	
Identified risks and risk management actions	None
Resource implications	None
Legal implications including equality and diversity assessment	None

Report history	Safeguarding Committee, Management Board, Quality and Clinical Risk Committee
Next steps	
Appendices	

Safeguarding Annual Report



CONTENTS

Safeguarding Annual Report 2017 - 2018

Paper For	Safeguarding Annual Report 2017 - 2018
Director	Lisa Knight: Director of Patient Care and Chief Nurse
Authors	Nadean Marsh Head of Nursing Quality & Improvement Tracey Davies : Safeguarding Adults Lead Nurse Judy Preston : Safeguarding Children's Lead Nurse Carrie Tyas: Named Midwife Safeguarding
Contributions	Ruth Edwards: Lead Nurse for Dementia Louise Romeo: Lead Midwife Teenage Pregnancy Jill Peet: Lead Midwife Perinatal Mental Health
Executive Summary	**The Safeguarding Annual Report Provides:** Assurance that the Trust has effective processes in place to safeguard the adults and children who access services at Milton Keynes University Hospital Foundation Trust (MKUHFT) and demonstrates achievement in its statutory responsibility in relation to safeguarding. The report reviews the safeguarding activity and outcomes across the year at the trust including local developments, activity, challenges and demonstrates our successes. **Key Improvements:** • External assurance received regarding safeguarding processes within MKUHFT. • The breadth of safeguarding concerns that were raised and discussed with the lead nurses and midwives demonstrates staff awareness. • Monthly trust Safeguard Leads meeting, encouraging seamless working and sharing of best practice across Adults, Children's and Maternity. • Safeguarding assurance gained from internal and external processes. • Safeguarding Lead attendance at MKUHFT daily safety huddle • Integration and contribution with the MK Together new structure for MK Safeguarding Board, representation on MK Safeguarding Adult Programme Board and MKUHFT chairs the Children Programme Board. • Participation in shared learning events across both Adult and Children safeguarding arenas. • Redesign and development of a Safeguarding and Quality Trust Intranet resource page **Key Areas for Improvement:** • Continue integration work with all of the safeguarding leads. • Develop a collaborative approach to children's and adults training ensuring the learning outcomes for each speciality are met. • Review and evaluate the delivery programme for all safeguarding training levels and ensure they meet Trust trajectory performance consistently throughout the year with a focus on Level 3 training for safeguarding children. • Continue to develop and maintain robust safeguarding databases with EPR systems and new electronic patient record eCARE. • Analyse data and disseminate learning across the organisation by

	overseeing the process for raising of adult safeguarding alerts in relation to pressure ulcers (grade 3 and above) involving the safeguarding lead working closely with the Essential Skills training team and the Tissue Viability nurses. • To review DH Pressure Ulcers 2018 Safeguarding Adult Protocols in collaboration with CCG to agree an implementation strategy • Continue to embed education to identify and take appropriate actions in regard to Female Genital Mutilation, Children Sexual Exploitation and Neglect, fabricated induced illness Toolkits across MKUHFT. • Enhance engagement with multi agency partners to further improve communication and the quality of care and experience for our patients. • Build on the work with MKACT and the provision of their service within the maternity department and progress into the Emergency Department. • Review the pathways for children requiring Child Protection Medicals ensuring they occur in the most appropriate environment in a timely manner. • To review and action the safeguarding audit plan. • Review Dementia and Learning Disability practice

Introduction

Milton Keynes University Hospital NHS Foundation Trust (MKUHFT) recognises that Safeguarding is everybody's business and is a member of the Milton Keynes Local Safeguarding Board and Programme Boards (Children and Adults) and as such has specific responsibilities and duties in respect to safeguarding children and adults.

Safeguarding Children has been defined as

- *Protecting children from ill-treatment*
- *Preventing Impairment of children's health and development*
- *Ensuring children grow up in circumstances consistent with the implementation of safe and protected care*
- *Taking action to enable all children to have the best outcomes in life*

Working Together Document (2015)

'*Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop the risks and experience of abuse or neglect, while at the same time making sure that the adults wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action."*

Care Act (2014)

The Trust Safeguarding Children, Adults and Maternity teams work in collaboration to safeguard across all ages and pathways. This paper outlines the Trusts current position in regards to compliance of Safeguarding requirements in relation to:

- Care Quality Commission (CQC) Regulation
- Working Together 2015
- Care Act 2014

1. Safeguarding Self-assessment and Assurance Frameworks

The Organisation has a clear leadership structure and safeguarding is at the centre of the organisational operational and strategic work. Within MKUHFT management structure the roles and responsibilities of the various members of the management team have been clearly identified and set out in their job description and this includes their specific roles and responsibilities around safeguarding.

The organisation policies for safeguarding are current and reflect both national and local guidelines and legislation. This includes Safeguarding Children Policy, Safeguarding Adult Policy, Mental Capacity & Deprivation of Liberty Safeguarding policy, Chaperone Policy and Whistleblowing Policy. MKUHFT also has clear HR policies on Safe Recruitment, Performance Management and Disciplinary Policy. All staff working within MKUHFT including volunteers have been checked with DBS and should receive Annual Appraisal's to monitor their development and performance.

MKUHFT has a clear governance structure and this includes the investigation of incidents and complaints. Incidents and complaints if involving potential safeguarding concerns are dealt with in a timely manner and where appropriate action plans formulated to improve practice and share lessons learnt. The action plans are monitored in the Trust Safeguarding Committee. MKUHFT strives to promote a no blame culture to allow staff to learn from incidences and past experiences.

The Safeguarding Committee has been formed as a sub group to the Quality and Clinical Risk Committee to oversee the strategic delivery of the Safeguarding Strategy including the monitoring of assurance for training and learning key performance indicators. The Safeguarding Committee meets quarterly and is chaired by the Trust Director of Patient Care and Chief Nurse. It is well attended by a diverse membership which includes the Trust Nursing, Midwifery and Medical Safeguarding Leads, Senior Directorate representatives and invited external agencies, Safeguarding Leads from the local Care Commissioning Group (CCG), Milton Keynes Council, and MKACT.

The Trust assesses itself against the safeguarding self-assessment and assurance frameworks provided to the Trust (commissioned by the Clinical Commissioning Group (CCG) to assess, monitor and improve safeguarding on a quarterly basis, the results of which are presented and discussed at the quarterly Trust Safeguarding Committee.

1.1 Safeguarding Children's Assurance Framework including Section 11 Audit

This tool is an assurance framework to support organisations with their regard to the need to safeguard and promote the welfare of children and includes a specific audit for national requirements (Working Together 2015).

The Assurance framework is benched marked against a scoring process that is also reflected by a Red Amber Green (RAG) rating colour.

Table 1 Safeguarding Children Assurance Framework

Rag Rating	2016	2017	2018
Blue – excelling	1%	1%	3%
Green- effective and consistent	82%	83%	87%
Amber/ Green – meets most of the requirements	14%	16%	6%
Amber – met in part, improvement needed	3%	0	3%
Red / Amber – met in part, significant improvement needed	0	0	0
Red – not met	0	0	0

Following a review of the Section 11 Assurance Framework with the Clinical Commissioning Group assurance was given that good practice was being met and noted positive examples of continuous improvement. There was acknowledgement that despite capacity being limited due to long term sick leave the daily operational functioning of the safeguarding team had not been significantly impacted. Level 3 Training has been affected by the capacity issues and is reflected in the compliance data later in the report.

The main recommendations following this review were:

- MKUHFT to improve training compliance, particularly level 3 Children Safeguarding
- MKUHFT to implement partnership working with Oakhill Secure Training centre
- MKUHFT to roll out safeguarding supervision following the completion of supervision training
- MKUHFT to provide assurance of safeguarding practice following the implementation of e-Care
- MKUHFT to implement CP-IS checks for children attending Emergency Department

1.2 Safeguarding Adults Assurance Framework (SAAF)

This audit tool supports organisations with their regard to the need to safeguard and promote the welfare of adults. It links with the following Milton Keynes Safeguarding Adults Board Strategy Objectives (2014 – 2018)

- People in Milton Keynes know what to do if abuse or neglect happens
- Abuse of people with care or support needs is prevented whenever possible
- Adults are protected from harm when they need to be
- Staff and volunteers spot abuse and take timely, consistent and proportionate action
- Partners work together and link well with others
- Safeguarding Adults policies and procedures work

Following a review with the CCG at the end of the financial year the panel were pleased to be assured of the continued improvements in the service. The self-assessment frameworks examines six different sections, within these are 34 subcategories safeguarding adults and is rag rated.

A. Leadership, Strategy, Governance
B. Workforce, organisation culture & Learning
C. Organisations approach to workforce issues reflect a commitment to safeguarding & promoting the wellbeing of adults at risk
D. Effective multi-agency working to safeguard and promote the wellbeing of adults at risk
E. Mental Capacity Act & Deprivation of Liberty Safeguards
F. The service can demonstrate that people who use services are informed about safeguarding adults & empowered within the organisation's response's to it.

Table 2 below demonstrates the improvements in the rag rating from April 2015 to March 2017

Table 2 : Safeguarding Adults Assurance Framework

Rag Rating	March 2015	March 2016	March 2017	April 2018
Blue	0	0	0	6 (18%)
Green	13	20	25	22 (65%)
Brown	13	12	9	6 (18%)
Amber	8	2	0	0
Pink	0	0	0	0
Red	0	0	0	0

The following recommendations and actions have been developed following this review for MKUHFT and the safeguarding CCG:

- MKUHFT to recruit to Safeguarding Adult Lead Post –commences September 2018
- MKUHFT to continue to contribute to the MKSB multi-agency work
- MKUHFT to roll out safeguarding supervision following the completion of supervision training
- MKUHFT to provide assurance of safeguarding following the implementation of eCare.

1.3 Audit Safeguarding Adults and Children

The Safeguarding Committee has a planned audit schedule. During the 2017/18 financial year the safeguarding team capacity has been challenging which has resulted in some delays in the completion of audits.

For assurance an external review was requested by the trust of the Safeguarding Adults and Children Service and this was completed by KPMG in the last quarter of the financial year 2016/2017.

The conclusion of the review detailed the following:

- The safeguarding team are a committed and passionate workforce who are flexible in their approach to service delivery, and recognised to be accessible and visible throughout the hospital.
- The safeguarding team are providing a good service and delivering the key safeguarding roles required.

There were four recommendations and associated actions from the review as follows:

1. Updating of child safeguarding status / welfare tabs after discharge

- *A process of updating of children safeguarding alerts/Welfare tabs after discharge is in place and monitored via the safeguarding administrators and safeguarding children's lead*

2. Formality of update training for Child Safeguarding Link Nurses

- *Child safeguarding Link nurses meet monthly with Children's Safeguarding Lead who is developing a competency and guidance document for the role and will include the requirement to monitoring of training compliance.*

3. Provision of Safeguarding Supervision

- *Safeguarding supervision training has recently been provided by NHS England. In August y 2018 15 staff members will have attended the training. An action plan for the implementation of a safeguarding supervision programme will be developed by the Safeguarding leads and approved at the safeguarding committee in October 2018.*

4. Developing adolescent awareness in adult areas

- *A guideline for the care of young person (over 16 Years) on an adult ward is being developed by the safeguarding children's lead.*

1.4 Learning from Serious Case Reviews (SCR), Safeguarding Adult Reviews (SAR) and Serious Incident (SI)

As a member of the local Safeguarding Board the Trust may be asked to participate in in-depth reviews of individual cases. These can be single agency reviews or multi agency reviews. Occasionally the decision is made to undertake a Serious Case Review, when it involves a child, or Safeguarding Adult Review, when it involves and adult. All agencies involved in the care of the individual may be asked to share and learn from a case where it has been agreed that learning and action is required to prevent or limit similar circumstances arising again.

1.5 Serious Case Review (SCR)

MKUHFT has been involved in two SCRs. The first concerning antenatal pathways and awareness of drug and alcohol dependency increasing incidences of miscarriage. This case was for quality assurance in March 2018.The second case was a learning review which led to collaboration between agencies producing a toolkit to aid identification of fabricated induced illness.

1.6 Safeguarding Adult Review (SAR)

MKUHFT has been involved in two SARs. One was a learning event from incidences related to a local care home between 2014 and 2016.The second was a request from MKSB/Adult case review panel. We are awaiting the outcome of this following submission of information in March 2018.

1.7 Serious Incident (SI)

There has been one reported SI for Safeguarding children in February 2018 and an associated action plan has been developed which has been agreed by the CCG.

To note that there were 5 pressure ulcers which were reported as serious incidents, which this report does not detail due to other reporting mechanisms.

2. Training & Education

Successful provision of effective safeguarding clinical practices is dependent on all staff understanding their roles and responsibilities and the procedures they should follow in order to protect their patients. As such, compliance with attendance at training and assessment of learning objectives is paramount. Training compliance is monitored at the Trust Safeguarding Committee and the learning and development department. Clinical Service Units within MKUHFT that do not achieve the 90% compliance key performance indicators (KPI) are identified and challenges at monthly Executive Management performance meetings. Senior managers are then asked to identify and address why they are not meeting the KPI and a trajectory plan for improvement in compliance is completed and monitored.

2.1 Safeguarding Children Training

Safeguarding children training is mandatory for all staff and follows the guidance set out in the intercollegiate document published by the Royal College of Paediatrics and Child Health 2014.The level of training required depends on the level of contact with children staff have within their roles (Table 3). Issues covered within the training include Child Sexual Exploitation, Female Genital Mutilation, Neglect and Fabricated Induced Illness.

We have received support for training from external trainers such as COMPASS and effective questioning delivered by the MASH manager. As well as provision of bespoke ad-hoc training by the Lead Consultant for Safeguarding regarding fabricated induced illness following a learning event.

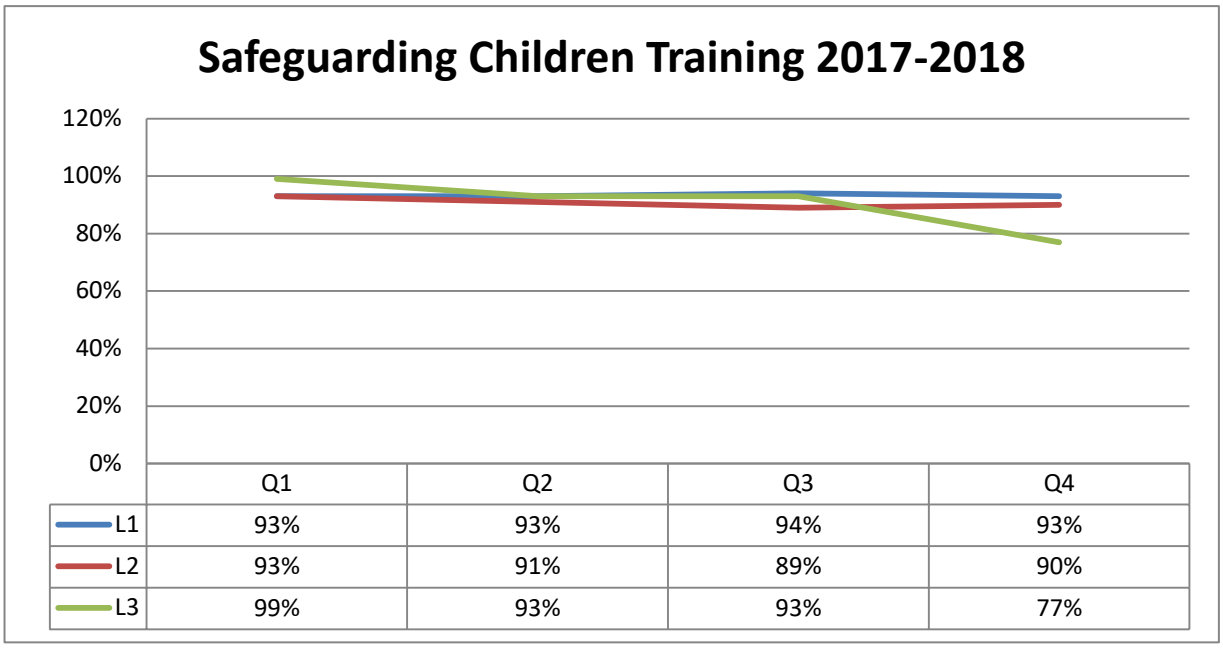
The safeguarding children level 3 training is currently under review .Currently, the Trust offers the mandatory 6 hours level 3 training over three 2 hour sessions and compliance is challenging. The new model proposed will be either attendance at 2 half day sessions or attendance to one full day mandatory session every 3 years and will contain elements of multi-agency training.

Table 3: Safeguarding Children Training Level

Level 1	All non-clinical staff and volunteers
Level 2	All clinical staff
Level 3	All high risk areas, i.e. Emergency Department, Paediatrics and Maternity
Level 4	All Lead personnel e.g. Lead Nurse Safeguarding Children/ Executive Lead.

Attendance and completion of training is recorded by the learning and Development Department on the Electronic Staff Record (ESR) system. Graph 1 displays the percentage of staff that is compliant with safeguarding children's training in 2017/18.

Graph 1 Training compliance by Level



	Q1	Q2	Q3	Q4
L1	93%	93%	94%	93%
L2	93%	91%	89%	90%
L3	99%	93%	93%	77%

- To note Level 3 training has declined in Q4 due to previously mentioned capacity issues

2.2 Safeguarding Adult Training

The training strategy for safeguarding adults' links with the objectives set by the Trusts Safeguarding Strategy and the Milton Keynes Safeguarding Adults Board Strategy Objectives (2014 – 2018)

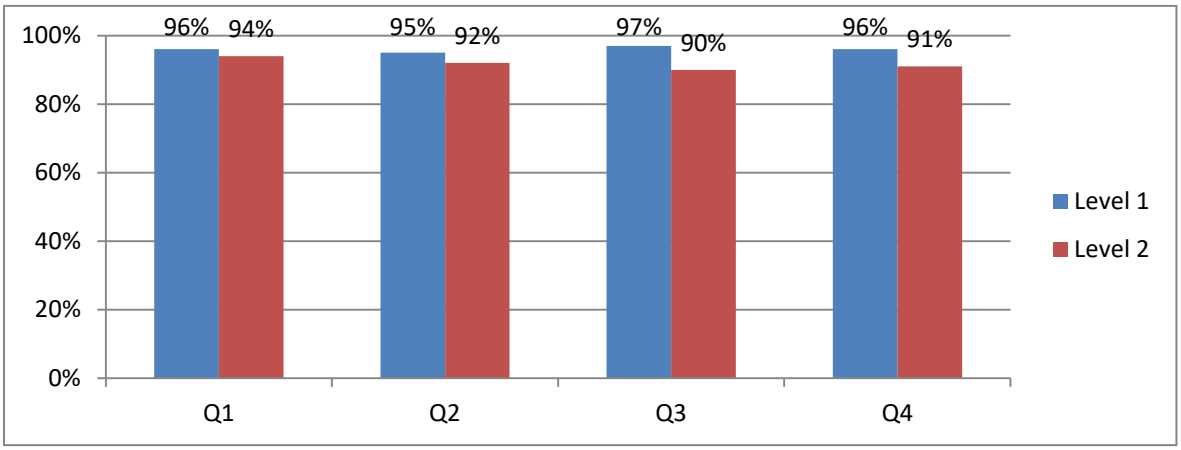
- People in Milton Keynes Know what to do if abuse or neglect happens
- Abuse of people with care or support needs is prevented whenever possible

Safeguarding Adults training is mandatory for all staff completed on a 3 yearly basis in a classroom setting face to face. All new staff receive this on Trust Induction and thereafter it is available on a monthly basis, again via face to face training (to update) and bespoke training is delivered to specific departments as appropriate.

There are two levels of training, level 1 for all staff and volunteers and level 2 for clinical staff and staff with regular patient contact.

Table 4 below demonstrates overall Safeguarding Adults training compliance for 2017/2018

Table 4: Training compliance by Level



The training compliance has risen well for both Level 1 and Level 2 Safeguarding Adults. The Learning and Development Department are receiving consistent positive feedback from staff attending the Safeguarding training; a few examples are as follows:

- *Very interesting and informative*
- *Thought provoking, good presentation*
- *Gained knowledge and awareness*

The assurance that learning is applied into practice is demonstrated with the wide variety and number of adult safeguarding alerts that are raised across the trust, with the details of these later in this report.

2.3 Mental Capacity Act and Deprivation of Liberty Safeguarding Training

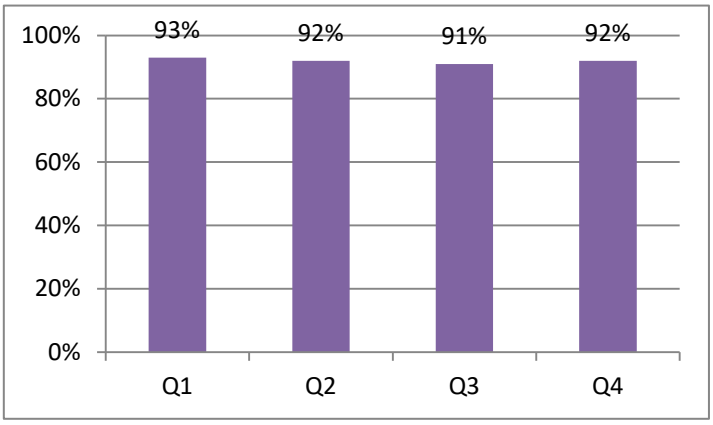
"The Mental Capacity Act 2005 provides a statutory framework for acting and making decisions on behalf of individuals who lack the mental capacity to do so for themselves. It introduced a number of laws to protect these individuals and ensure that they are given every chance to make decisions for themselves", (Mental Capacity Act, 2005).

Under the Mental Capacity Act we may be required to deprive a patient of their liberty to maintain their safety, reduce risk of harm to others or administer necessary treatment when we assess them as lacking mental capacity, (decision specific. This is a serious decision and only done in the persons best interest, (in discussion and in agreement with close family, friends, professionals, advocate), and only when it is unquestionably necessary. Therefore the trust and Milton Keynes Council policies and processes must be adhered to ensure we are safeguarding patients.

Mental Capacity Act and Deprivation of Liberty Safeguarding training is mandatory for all clinical staff. Training is provided on a 3 yearly basis in a classroom setting face to face and at Trust induction and it is available on a monthly basis, with bespoke training available for specific departments as appropriate.

Table 5 below demonstrates the training compliance for the Mental Capacity Act and Deprivation of Liberty Safeguarding training 2017 / 2018

Table 5 Training compliance by Quarter



The training compliance has continued to rise for Mental Capacity Act and Deprivation of Liberty Safeguards training. And feedback for the taught sessions is consistently positive, examples are as follows:

- *I like the capacity assessment paperwork*
- *Very good talk kept it interesting*
- *Very clear and relatable to practice*
- *Very insightful and thought provoking*

The assurance that learning is applied into practice is from the increased appropriate number of Deprivation of Liberty Safeguards that have been applied for over the year. These are reported later in the report.

2.4 Safeguarding Maternity Training

Within the Maternity Unit all midwives attended a protected week of mandatory and statutory training. The week includes sessions for:

- Child Protection and Safeguarding Level 3
- Female Genital Mutilation
- Perinatal Mental Health
- Domestic Abuse

The number of staff that attended sessions provided during 2017/18 was175. This includes both trained midwives and maternity care assistants. This is consistent with last year where 170 staff was trained.

In addition maternity staff receive safeguarding adults/Mental Capacity Assessment/Deprivation of Liberty training. For this maternity staff the compliance is 99%.

2.5 Prevent

Prevent is the United Kingdom's counter-terrorism strategy. Its aim is to safeguard individuals who are at risk of exposure to extreme ideologies and radicalisation. Its main focus is on prevention of people becoming or supporting terrorism.

Support, direction and guidance continue to be provided from Regional Prevent contact and the Safeguarding Adults Board sub-groups. Milton Keynes is not classed as a priority area.

Prevent awareness is included in all level 1 and level 2 safeguarding adults training. Prevent Wrap training has previously been delivered to all midwives

The Trust has not made any referral to Prevent in 2016/2017.

3. Activity and Outcomes

The Safeguarding Leads for children, adults and maternity monitor the number and details of the safeguarding issues raised by MKUHFT staff. The Safeguarding Leads meet monthly for peer supervision, sense check of active safeguarding concerns and to share good practice and successes. Supervision and sense check is also continued outside of these meetings regularly for support and communication. Good communication and linked working is vital in providing seamless safeguarding across the age ranges, specialities, Milton Keynes and outside boroughs.

Reviewing the data gives a greater understanding of the local issues of the population we serve and supports an evaluation of our staffs understanding of these.

3.1 Safeguarding Adults Activity

MKUHFT adult safeguarding team work closely with Milton Keynes Council Safeguarding Team and all council Safeguarding Teams (including across boundaries). The relationship is one of placing our vulnerable person(s) at the centre of information gathering and investigation, ensuring they are included along the journey as per the Care Act 2014. The hospital and the Council liaise regularly as to how investigations progress, other services that maybe required (multi-agency working) through to either the agreed point when risk is mitigated as much as possible or to the safe conclusion. The Trust has a Named Consultant for adult safeguarding who also works closely with the safeguarding team.

The Lead Nurse for Safeguarding Adults with support from the Head of Nursing for Quality and Improvement lead a team of specialist nurses to address the multi- faceted needs of the vulnerable adult patients, including the Vulnerable Adults Nurse (supporting both the Falls prevention agenda and those patients with additional needs such as Learning Disabilities), Dementia Care Nurses and Tissue Viability Nurses.

3.2 Safeguarding Adult Alerts

All Safeguarding Alerts raised either by external services or by MKUHFT go via the appropriate councils safeguarding team, screened and followed up by external safeguarding. The Council Safeguarding Teams will appoint an external safeguarding officer if this is required for investigation.

The Council will liaise with the hospital until they are satisfied that the investigation is closed and sufficient action done to mitigate risk to the person at the centre of the concern and completed with

their or their advocates collaboration and involving all necessary services to aid a safe closure to the concern(s).

Safeguarding alert numbers are reported and discussed at the trust Safeguarding Committee and any serious safeguarding alerts are immediately discussed with the Care Commissioning Group (CCG) Safeguarding Adults Lead. The Trust has an open policy on adult safeguarding alerts and will report on the electronic incident reporting system (Datix) when appropriate so the investigation is also overseen by the risk and governance team. On occasion the Council will be advised by the adult safeguarding lead how to redirect the concern through to the MKUHFT PALS/Complaints Team, when it is deemed to be the better process for a more suitable outcome for the patient, family, carer or friend. If agreed, a serious incident will be declared and a separate investigation required will also be shared with the CCG.

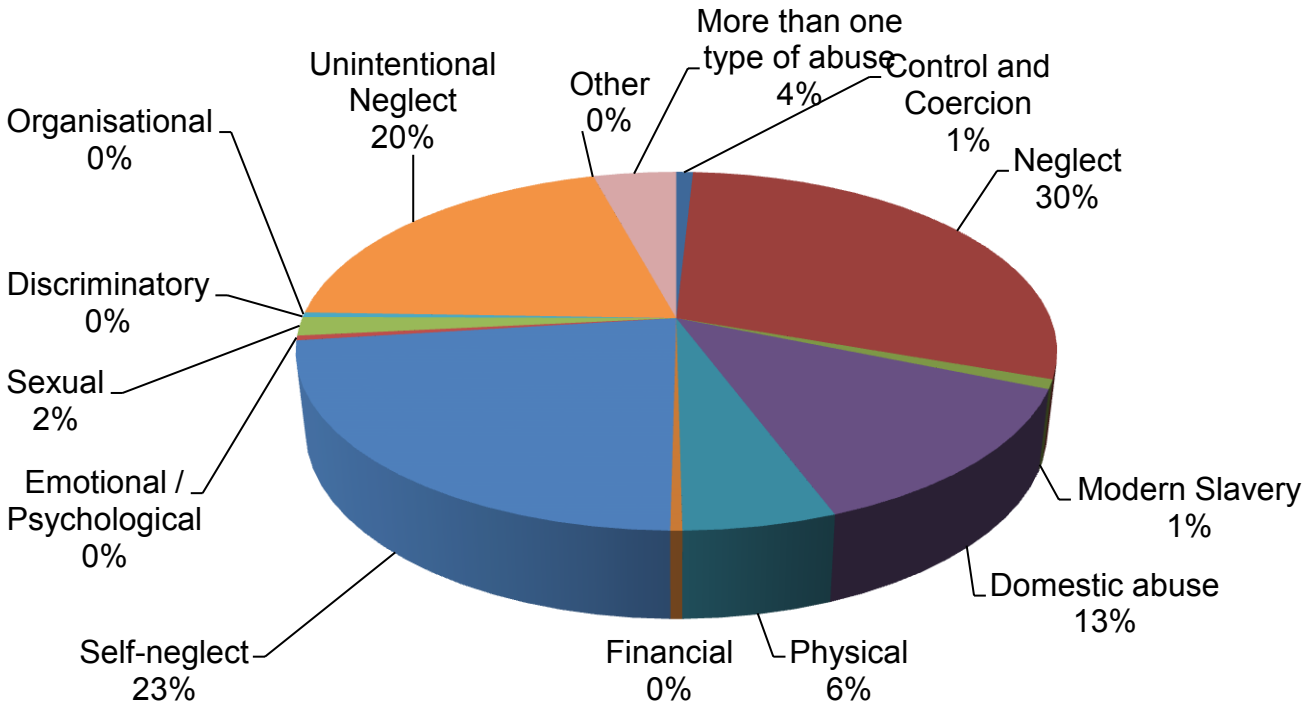
In 2017-18 MKUH raised 237 Adult safeguarding alerts, compared to 288 Adult Safeguarding alerts in 2016-2017.

Table 6 demonstrates the adult safeguarding alerts raised in total.

Table 6 Referrals by theme and location of alleged perpetrator and source

Category	MKUH vs MKUH	MKUH vs External	External vs MKUH	External vs External	Total 2017 / 2018
Control and Coercion		2			**2**
Neglect	1	34	35		**70**
Modern Slavery		2			**2**
Domestic abuse		31			**31**
Physical	1	10	2		**13**
Financial		1			**1**
Self-neglect		53		1	**54**
Emotional / Psychological		1			**1**
Sexual	1	3			**4**
Discriminatory					**0**
Organisational		1			**1**
Unintentional Neglect		34	13	**1**	**48**
Other					**0**
More than one type of abuse		8	2		**10**
Total	3	180	52	**2**	**237**

Chart 7 Safeguarding Alerts by theme



There has been a small decrease of 8% in adult safeguarding alerts raised last year. Staff continue to be confident in knowing how to access the safeguarding team, to discuss concerns and complete a safeguarding alert. There has been a wider variety of professions and departments contacting safeguarding adults to discuss concerns in the last year including inpatient and outpatient. This continuation of appropriate alerts provides assurance alongside the positive training compliance for the Trust.

The safeguarding alerts are no longer forwarded by Milton Keynes Council if they are required to go to the appropriate Council in relation to the address of the patient or location of the abuse. The safeguarding intranet site has been successfully redesigned and updated to provide the staff with tools to raise a safeguarding alert directly to the appropriate council. The safeguarding adults lead also continues to support this process.

Neglect and self-neglect is the largest reported category because it can encompass many concerns such as, pressure ulcers, concerns in relation to care given by healthcare (hospital and community), i.e., being unkempt, hair not brushed, poor mouth care, alleged new skin condition, the list is exhaustive, and unintentional neglect given by family or carer. For 2018/19 self-neglect has been agreed as one of the main focuses for the Milton Keynes Adult Programme Board to investigate.

Over the last year Domestic Abuse has continued with high reporting at 13% and 14% last year , with 31 cases coming through MKUHFT safeguarding in 2017/2018 . Staff have demonstrated their understanding and communication when discussing this type of abuse with patients and raising their concerns to the safeguarding lead, who has continued to follow up as appropriate.

It is difficult to directly correlate as a specific outcome from training or whether the victims or families and friends have been more courageous at coming forward and asking for help. It can be stated though that this is encouraging if victims and families are more confident in reporting.

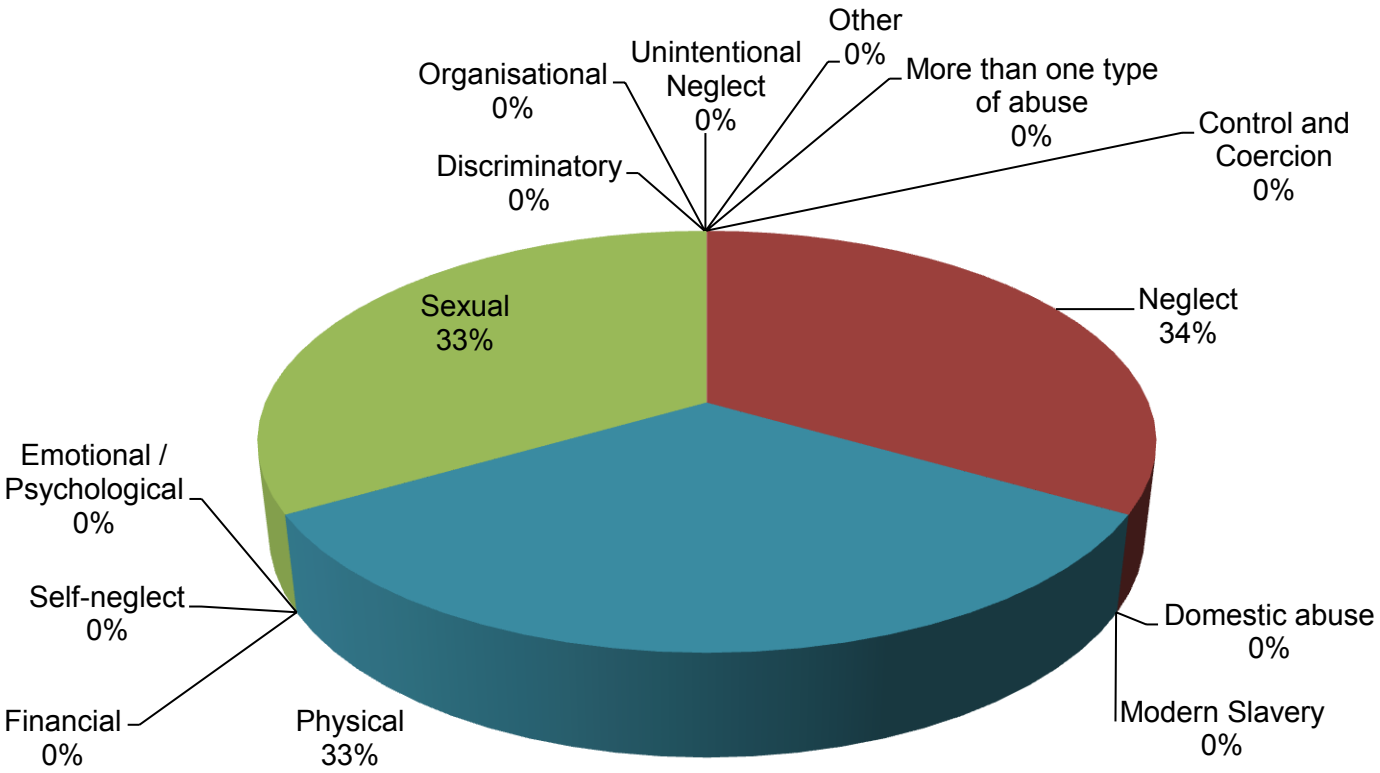
The categories of Control/Coercion and Modern Slavery continued this year to be reported on. This is a very positive step in the fact that Control and Coercion has been a recognised crime since December 2015. This type of behaviour stops short of serious physical violence, but amounts to extreme psychological and emotional abuse. Perpetrators can now be brought to justice. The offence can carry a maximum of 5 years imprisonment, a fine or both. Modern Slavery is high on the agenda for the Milton Keynes safeguarding board and so again this is a positive step that we have highlighted case where there were none reported the previous year.

The increasing variety of categories of abuse reported is reflecting the success of safeguarding awareness and the evidence that people know how to report.

3.3 Alerts Raised by MKUHFT against MKUHFT

We have seen a reduction in the raising of safeguarding alerts against ourselves with 3 raised in 2017 / 2018 compared to 19 in the previous year.

Chart 8 Safeguarding Alerts made by MKUH against MKUH by Category 2017-2018



Neglect, physical and sexual abuse are the 3 categories where MKUH raised safeguarding alerts against themselves.

- Neglect- relates to pressure ulcer development. The raising of safeguarding alerts in relation to pressure ulcers (grade 3 and above) is continued to be embedded with the safeguarding lead working closely the Tissue Viability nurses. The incident reporting system, Datix, was been revised last year so the question is asked early, to the reporter, whether a safeguarding alert has been completed. This enables the safeguarding lead and Tissue Viability to alerted and follow up. This is an ongoing training process which will continue to be monitored. It is worth noting that the Trust has seen a reduction in hospital acquired grade 3 pressure ulcers which can be attributed to the early prevention of pressure ulcers through essential skills and ad-hoc, bespoke training as well as the embedding of pressure ulcer summit process used as a learning mechanism for all grade 2 pressure ulcers. This process is aimed to be developed further in 2018/19 improve its governance structure and ensure a multi-disciplinary team approach is evident to demonstrate shared learning.
- Physical – relates to a patient who was defending a nurse as they were being physically approached by another patient. In the incident the defending patient hit the abusive patient across the face. This was ascertained as an accident. Both relatives were informed and no further action was instigated. Both patients were agreeable to remaining on the same ward.
- Sexual – relates to a patient accusing an acuity health care assistant of running his hand up and down his leg. This was discussed with the medical matron and escalated to the hospital police officer at the patient's request. A fact finding investigation was conducted by police and no further escalation or action was taken.

MKUHFT is transparent in our safeguarding reporting, if it is conveyed to staff that an act of abuse has allegedly taken place a safeguarding investigation will happen immediately and an alert will be raised against us. A thorough investigation will be carried out which will involve the patient, family, carer, and advocate as appropriate. There is no hesitation to contact the police if a crime is suspected to have occurred.

MKUHFT has a resident police officer from Thames Valley Police who MKUHFT safeguarding team work closely with. There is always the opportunity to discuss any concerns that safeguarding may have that does not reach the threshold of a call to 101, but does require a discussion with the police. On occasions such as this the police officer has raised an Adult Protection Order (safeguarding) to log the concern in the Thames Valley Police system. The Safeguarding Team have a good working relationship also with the Domestic Abuse Unit in Milton Keynes who are able to be contacted via a non-urgent landline for advice, support and to follow up any cases that require further information gathering or sharing under safeguarding.

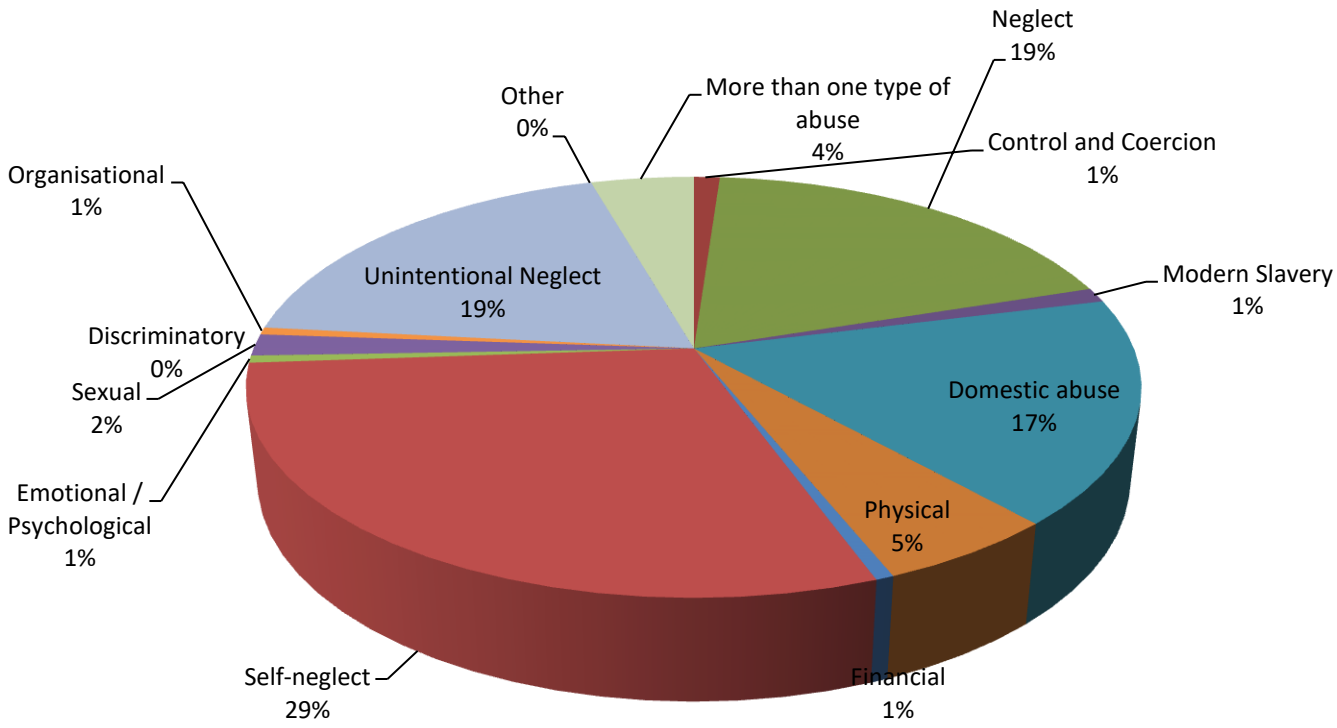
MKUHFT safeguarding team prides itself in these professional relationships which strengthen the transparency of abuse to be reported and support for our patients.

3.4 Alerts Raised by MKUHFT against external parties

Year on year we are seeing an increase is safeguarding alerts raised by MKUHFT against external parties. This is reassuring that staff are identifying concerns and appropriately raising them with the safeguarding adults lead. This aligns with the adult safeguarding training compliance and so achieved safeguarding awareness over periods of staff leaving and recruitment.

MKUHFT staff also raised a larger variety of safeguarding than last year, which again evidences that they are more aware and understand what requires reporting. Chart 6 shows a breakdown of the alerts made regarding external sources by MKUHFT staff.

Chart 9 Safeguarding Alerts made by MKUH against external agencies by Category 2017-2018



Not all safeguarding alerts that have been raised against MKUHFT reach the threshold of adult safeguarding; these are often complaints or concerns. The concern raised continues to be investigated as lessons must be learnt if substantiated. The Milton Keynes Quality Sub Group are discussing the number of inappropriate alerts that have been received across the area and the group have confirmed there is further learning in regards to what to report via safeguarding. This includes guidance as to when to contact the ward or hospital directly to discuss an omission or a complaint. The safeguarding lead will continue to feedback to the supervisory body of inappropriate alerts and also to redirect through to complaints if more appropriate.

Of the above, neglect and unintentional neglect are the largest categories. Many relate to discharge or information not effectively or accurately communicated to the community from the ward. It has proved difficult to determine a number of allegations due to delay in allegation being raised and poor documentation. Unless it is documented in the patient health records the safeguarding lead is not able to clarify whether an omission occurred or not.

Examples of the allegations made are:

- *Patient being discharged home and no care package organised*
- *Patient being discharged home and District Nursing team unaware of requirement to visit*
- *Patient being discharged home without medication and the medication being delivered at a later time*

The main themes from these alerts are:

- a breakdown in communication when planning discharge and
- Pressure ulcers that we had already raised as hospital acquired

There were no serious alerts raised by external that required external investigator or police involvement.

The safeguarding Adult lead will work closely with the Trust Discharge Lead to review safeguarding alerts related to discharge and will also liaise with the CCG to provide assurance.

3.5 Mental Capacity Act and Deprivation of Liberty Safeguards

The Trust has policies and processes in place to ensure that the Mental Capacity Act and the Deprivation of Liberty Safeguards are followed and embedded into practice. The Mental Capacity and Deprivation of Liberty Safeguarding Policy was reviewed and revised during this year, completed the ratification process and now available to all staff via the intranet.

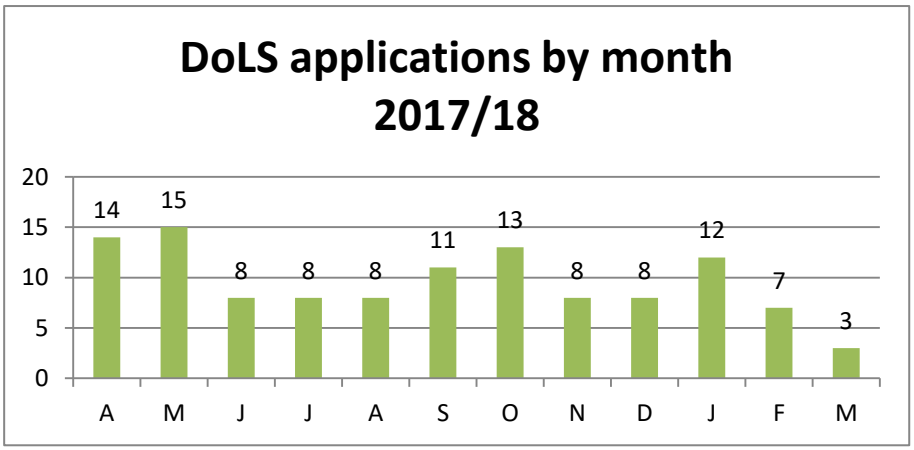
During 2017/18 the Trust has seen a slight decrease in the number of Deprivation of Liberty Safeguarding's requested. During this period 115 applications were made which is a which is a reduction of 21 referrals on the previous year. Deprivations of Liberty Safeguards (DoLS) are reported to the Safeguarding Adults Lead Nurse or the Clinical Site Manager to be approved and signed prior to being sent to the Supervisory Body, (the appropriate council where the patient is a resident or the council that is funding the care in the community).

The Adult Safeguarding Lead and the wards work closely with the councils DoLS teams in reviewing each DoLS to stay within the legal limitations of the Mental Capacity Act and legislative timescales that this involves. The safeguarding adults lead liaises regularly with the councils to review current practice and review of practice that may require addressing.

The Safeguarding Adults Lead attends the Milton Keynes Safeguarding Adults Board MCA & DoLS sub-group meeting where Milton Keynes DoLS are discussed.

The Deprivation of Liberty Safeguarding documents are no longer forwarded by Milton Keynes Council if they are required to go to the appropriate council in relation to the address of the patient or the location of the council funding the care. The Safeguarding Lead has updated the Trust Intranet site to include a guide of which council to send DOLs forms too. This process has been positively adopted within the Trust. The safeguarding administration team in the Trust are supporting overseeing this process to provide assurance to the Board.

Chart 10 DOLS applications by month



Domestic abuse has been fairly consistent in its reporting which is encouraging, with Modern slavery a rare reported category also having two reported (the same as last year).

3.6 Alerts Raised by External parties against MKUHFT

MKUHFT have received a number of safeguarding alerts raised by external parties. The Trust investigates these. The breakdown of the theme of allegation is seen in table 9 below.

Table 11 Safeguarding Alerts made by MKUH against external agencies by Category 2016/17 and 2017/18

Theme	2016/17	2017/18
Neglect	79%	67%
More than one type of abuse	4%	4%
Other	2%	0
Unintentional neglect	7%	25%
Physical	4%	4%
Emotional/ Psychological	2%	0
Financial	2%	0

3.7 Dementia

The Dementia Team has continued to promote awareness across the Trust in terms of recognising symptoms and the promotion of management strategies.

Training has been provided both through an essential skills programme and bespoke ad-hoc frameworks, face to face training from the Dementia Lead and Dementia Nurse through Trust induction and scheduled presentation sessions open to all staff.

An electronic Dementia Awareness workbook has been designed and is being promoted via the Safeguarding and Quality Intranet page for all non-clinical staff to access.

MKUHFT continues to host their own Dementia Café once a month where on average 5-6 patients attend. The café has been operating for a year and continues to provides a relaxed friendly atmosphere for patients, relatives, and carers to enjoy conversation, exchange ideas and offer support to each other. The Dementia team are also in attendance to provide any support, information or signposting.

Quiet zones have continued to be promoted by the team not only for patients with a diagnosis of dementia but those with any cognitive impairment. Ward 19 has worked to improve the current day room to incorporate a comfy sofa, dining table, television, wall art and books. Ward 14 have created a quiet/activity area where patients can complete puzzles and play games.

All ward area have dining tables, with the aim of encouraging patients to move from their bed side to socialise, sit together, undertake activities, and eat meals. This is in line with the Trust's promotion of the national initiative #endPJParalysis.

Communication resource boxes are now in all clinical areas, theatres and outpatient departments. These boxes contain both practical and social items such as hearing aid batteries, magnifying glass, colouring sheets, reminiscence folders and twiddle muffs. The Trusts enhanced observers are encouraged to use these boxes to engage with the patients they are caring for as a tool to aid stimulate conversation and engagement as well as distraction therapy.

As a Trust we have implemented John's Campaign which provides a framework for staff to enable relatives and carers to remain with a patient outside of the routine visiting hours. This encourages communication between professional and carer enabling the provision of compassionate, supportive care. This has also been extended across the Trust for patients with learning disabilities, mental health diagnosis of anxiety, depression as well as a dementia diagnosis.

3.8 Learning Disability

People with learning disabilities can find it challenging to come into hospital for many reasons, including diagnostic overshadowing, verbal and oral communication including signage.

The requirements for meeting the needs of patients with a learning disability have continued to grow in the trust. We continue to liaise with the patients and their families for our patients to get the best possible care. The Vulnerable Adults Nurse takes the lead on supporting these patients and their families and will routinely visit and support the patients and families when on the ward and to support the staff with any concerns they may have. They also aim to enhance effective communication between patients, families and staff and support to facilitate discharge, by signposting extra help in the community if required. The Vulnerable Adults Nurse role supports MKUHFT care for patients, their families and carers on a daily basis by co-ordinating activity, support risk assessments, developing and implement appropriate care pathways.

Within the Safeguarding Committee learning from incidents and complaints has been prioritised and has a lower threshold for investigation when patients with learning disabilities have been involved to ensure this group of vulnerable people are safeguarded

3.9 Safeguarding Children Activity

The Safeguarding Children's Team monitors all new referrals to Children's Social Care (CSC) on a monthly basis. In line with CQC requirements the lead continues to monitor an outcome for each case. The Safeguarding Children's Team maintain a database of contacts and this demonstrates

that the number of contacts with the service has remained fairly constant over the past 2 years with around 2780 contacts made. This does not reflect the increasingly complex cases that are being dealt with on a daily basis by the team as staff become more competent and confident in addressing basic safeguarding concerns.

The Multi Agency Safeguarding Hub (MASH) is a collection of multi professionals including Social Workers, Health staff and Police who work together to review and agree actions following concerns referred to them. Most of the referrals made by MKUHFT are taken up by CSC and acted upon some requiring a section 47 investigation or Section 17 Child in Need Plan set up. Some are sent on to Early Support and taken up by Child and Family Practice workers who work with these vulnerable families to support them and provide them with basic life skills. A breakdown of the referrals made by the hospital can be seen in the table 5, for 2017/18.

Table 12 Referrals and Outcomes by month

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL
Number of referrals taken up by MASH	67	65	55	60	60	37	60	52	50	54	57	36	653
Number of referrals sent to CFP.	8	11	11	14	7	6	6	5	8	4	5	5	90
Number of Referrals actioned by MASH with no further action taken.	33	44	37	39	46	19	24	25	18	38	44	28	395
Number of referrals closed with no action taken	25	10	6	7	7	10	23	12	14	11	8	3	136
CP Medicals	3	1	0	5	3	4	2	8	3	1	1	1	32

The MASH (Multi Agency Safeguarding Hub) has had a consistent number of referrals from MKUH, April 2016-March 2017. Overall the annual number of safeguarding referrals has increased marginally since last year by 147.

Further breakdown of the actions taken by the MASH identifies that of the number of referrals made with no action taken are higher than the previous year.

Reviewing the data we can see that over the course of the year we have completed 32 Child Protection Medicals which has decreased from the previous year where there were 46 undertaken within the Trust. These medicals take place in the acute ward areas and due to capacity, children often have to wait while emergency patients are prioritised and which can add to the distress and anxiety of the difficult situation. These concerns continue to be shared with the CCG and discussions are ongoing regarding the most appropriate place for these medicals to be completed. We now have a Consultant Paediatrician who is working with both MKUHFT and CCG to review this pathway.

Using the data from the referrals made we can categorise the principle theme for the referral, seen in chart 3, below. The current system does not allow for a more detailed breakdown of themes which prevents reporting directly on which categories the referrals fall under. On review, the number of maternity referrals remains the second highest from last year whilst the parental mental

health and domestic violence themes continue to reduce. Aside from maternity the support theme remains the largest percentage of referrals which again would reflect the work that has been done within training on early help.

Chart 13 Referrals by Theme

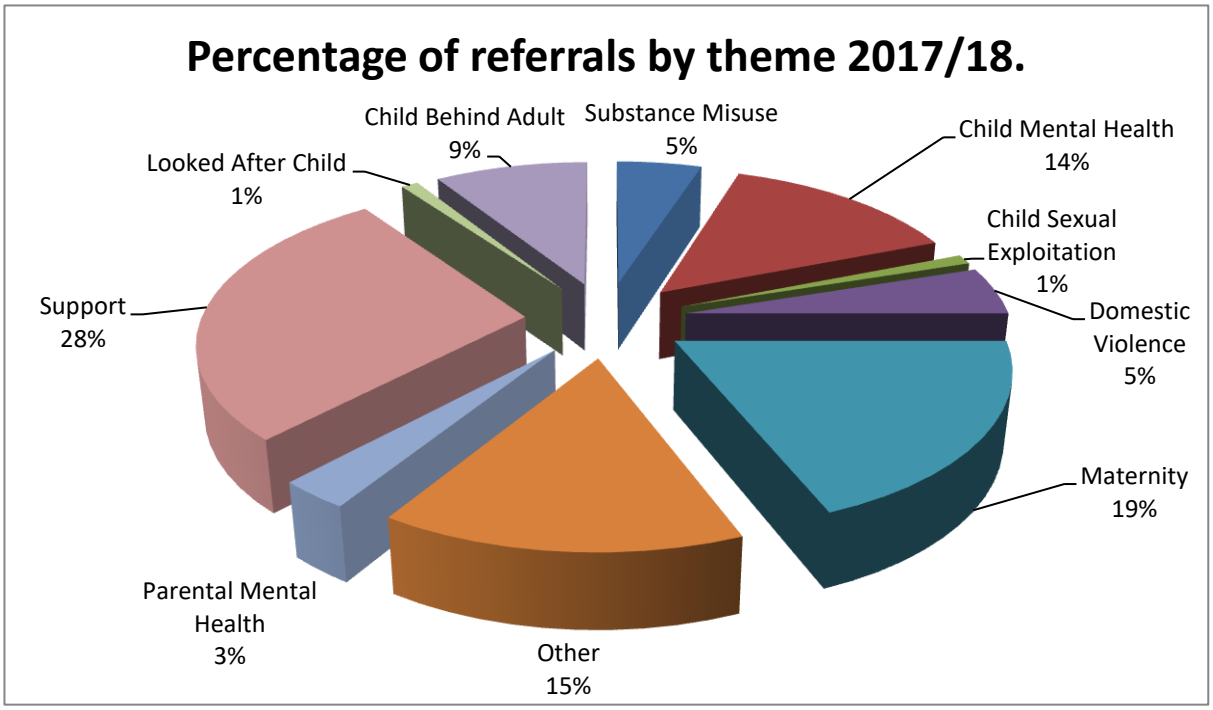


Table 14 Referrals by theme comparison between 2015/16 and 2016/17

Theme	2015/16	2016/17	2017/18
Child behind the adult	8%	8%	9 %
Substance misuse	8%	8%	5 %
Child Mental Health	18%	11%	14 %
Child Sexual Exploitation	5%	4%	1 %
Domestic Violence	13%	8%	5 %
Maternity	7%	24%	19 %
Other	10%	10%	15 %
Parental Mental Health	8%	4%	3 %
Support	22%	21%	28%
Looked After Child	1%	2%	1%

3.10 Child Deaths

The Named Doctor sits on the local Child Death Overview Panel (CDOP). The trust has a Communicating the Death of a Child Policy that is available to all staff and should be followed in all deaths up to the age of 18 years.

Table 15 Number of child deaths reported in Milton Keynes by Month 2017/18

Month 2016/17	Number of child deaths recorded
April	1
May	1
June	0
July	0
August	3
September	1
October	0
November	1
December	2
January	4
February	1
March	1

4. Safeguarding Maternity Activity

4.1 Lead Midwife Vulnerable Families & Named Midwife Safeguarding

As of Mid-February 2018 the Lead and Named Midwife Roles have merged into one role. The post continues to provide antenatal and postnatal care for those clients with complex social factors such as high risk domestic abuse, current significant substance and/or alcohol misuse, women already involved with Children's Social Care or a Looked after Child. This also includes attending any Strategy meeting, Child Protection Meetings and Corse Group Meetings for the family.

Monthly safeguarding training is provided to Maternity Staff as part of the Protected Tim training. This role now also supports all activities to ensure that the organisation meets its responsibility to safeguard and protect children and young people in order to promote best professional practice and provide advice and expertise to fellow professionals, and ensuring robust safeguarding practice is in place. The Named Midwife works closely with the Trust Child and Adult Safeguarding Team and the Multi Agency team through regular meetings, attending FGM panel and MARAC.

4.2 Lead Midwife Teenage Pregnancy

In the last 15 years since the government Teenage Pregnancy Strategy the under-18 conception rate has dropped by 60 per cent. However, the teenage pregnancy rate still remains higher than a number of western European countries. Teenage Pregnancy is a cause and consequence of heath inequalities and the majority of teenage parents have complex social issue and require additional support. The role of the Lead Midwife for Teenage Pregnancy is to caseload pregnant teenagers who are 17 years of age or under at pregnancy booking and work with agencies and departments to improve outcomes and services for teenage parents.

In 2017/18 the Lead Midwife's caseload included 51 pregnancy bookings to mothers under 18 years of age. The pregnancy booking, as well as routine antenatal and postnatal care is completed at home. Of these 51 young mothers, 46 had a history of mental illness. 36 had current or previous involvement with Children Social Care. Other Social Concerns included Substance abuse, Smoking, Domestic abuse and housing issues.

The Lead Midwife for teenage pregnancy attends all Core Group meeting, Family Support Meetings, strategy meetings and Child Protection Conferences in relation to the clients on her caseload.

Additional activity includes:

- Setting up antenatal parent education classes for young parents held twice a month at Moorlands Children Centre.
- Attending the young parents group at moorlands twice a month
- Holding a drop in clinic at Brook every week.
- Working closely with the Brook outreach nurse to improve postnatal contraception
- Meeting regularly with the staff at Springfield House, the local Mother and Baby Unit, to discuss referrals.
- Attend the Young Parents Provider Forum every three months.

The Lead Midwife has also undertaken work with Milton Keynes Youth Faculty and Youth Advice and Guidance to provide young parents with support for education and training and benefits advice. The majority of young parents are not in education and training and suffer education inequalities.

4.3 Lead Midwife Perinatal Mental Health

The role of the Lead Midwife for Perinatal Mental Health is to caseload women with clinically diagnosed severe mental health issues, as well as work with agencies and departments to improve the perinatal mental health services.

The 2017/18 caseload for Lead Midwife's for Perinatal Mental Health was 49 women with severe mental health issues. This includes collaborative working with the perinatal mental health team; Multi-disciplinary team meetings, joint visiting with the Community Psychiatric Nurses, Specialist Psychologist and Consultant Psychiatrist. Many of these women have complex social issues and therefore close working with other services is essential. Two women received support from Children and Family Practices; eleven women involved with Children's Social Care and two babies were placed in foster care following the birth.

The Lead Midwife for Perinatal Mental Health has undertaken Perinatal Mental Health Champion training – Perinatal mental health champions provide a one day multiagency perinatal mental health training for health and social care professionals and support workers (including mental health nurses, Doctors and consultants, midwives, maternity care workers, health visitors, social workers and children's centre staff). This is a training programme that has been commissioned by joint commissioners from MKCCG and MKC and is run on a monthly basis which the Lead Midwife is a Champion for and is regularly required to lead a training day.

Chart 16 Incidence of mental health disorders on caseload for 2017/18

Mental Health disorder	Number of women
Personality disorder	24
Bi-polar	7
Previous traumatic abuse - PTSD	7
Previous postnatal depression	2
Anxiety/depression	16
Schizophrenia	1
Previous postnatal psychosis	1
Previous psychosis	4
Severe OCD	1
Eating disorder	2

4.4 Confidential Communiques

The Maternity Unit has an electronic Confidential Communique (CC) which assists midwives in identifying those women and unborn babies that may have additional needs, and improve the communication between the Maternity Services and Health Visiting to ensure collaborative working . With the implementation of e-Care within maternity services an interim process is currently in place which requires the document to be printed, scanned and emailed to the Health Visiting Team. Ongoing monitoring of this process will be undertaken to ensure safeguarding practice is robust and provides assurances .Many of these women will have more than one issue that requires assistance and support during the pregnancy and therefore the midwife will need to liaise with a number of professionals to ensure that the family are able to care for their new baby. Some staff may only identify and indicate one issue on the CC however as they work with the woman and other professionals it often becomes apparent that there are multiple problems.

4.5 FGM

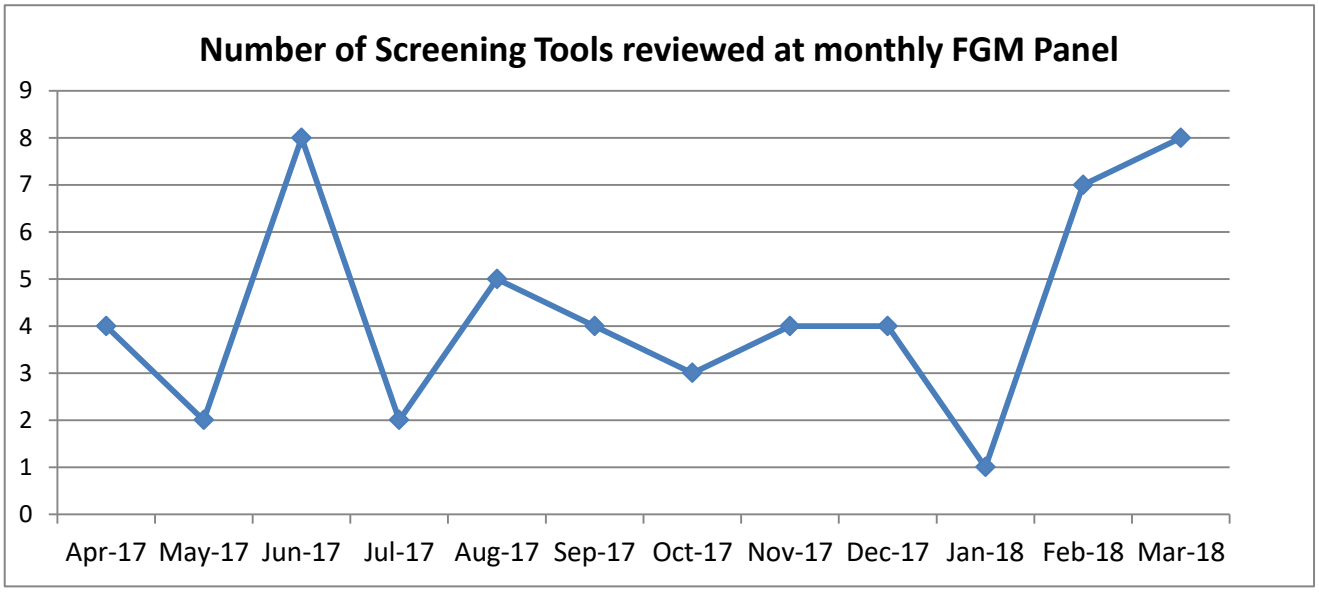
FGM refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. It is an act perpetrated by parents and extended family members upon young girls entrusted to their care.
FGM is an extremely harmful practice and responding to it cannot be left to personal choice. FGM is a human rights violation and a form of child abuse, breaching the United Nations Convention on the Rights of the Child (1989) and is a severe form of violence against women and girls and has severe short and long-term physical and psychological consequences.

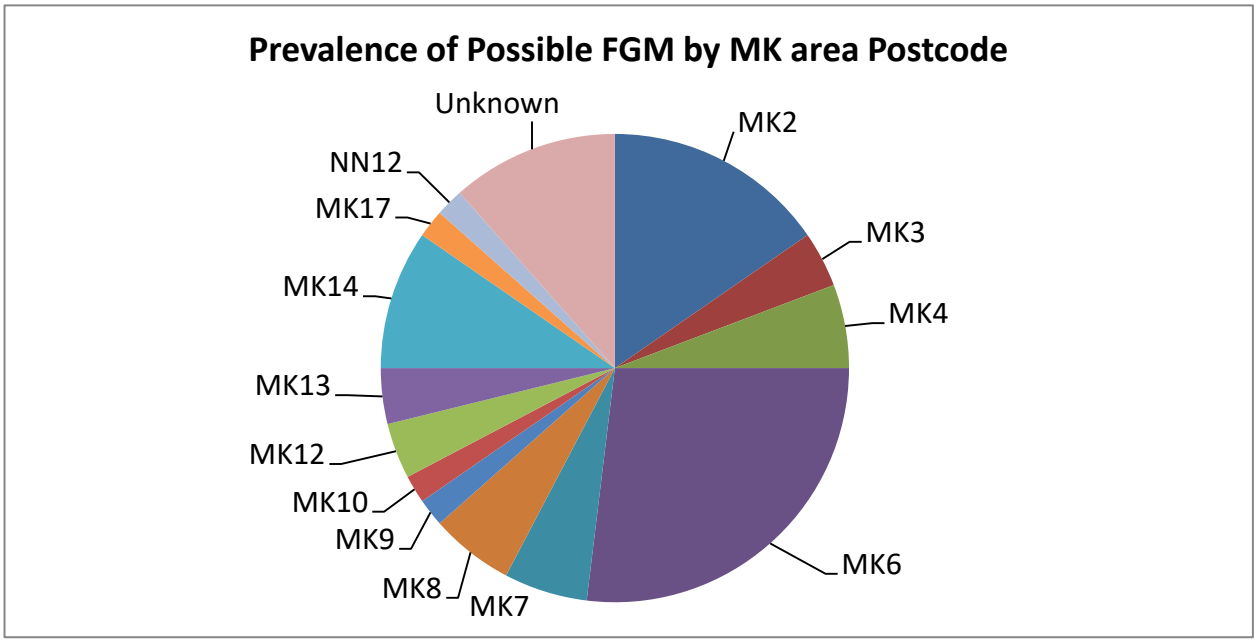
In 2012, the United Nations General Assembly adopted a mile in 2012; the United Nations General Assembly adopted a milestone resolution calling on the international community to intensify efforts to end the practice. More recently, in September 2015, the global community agreed to a new set of development goals – the Sustainable Development Goals (SDGs) – which includes a target under Goal 5 to eliminate all harmful practices, such as child, early and forced marriage and FGM/C, by the year 2030.

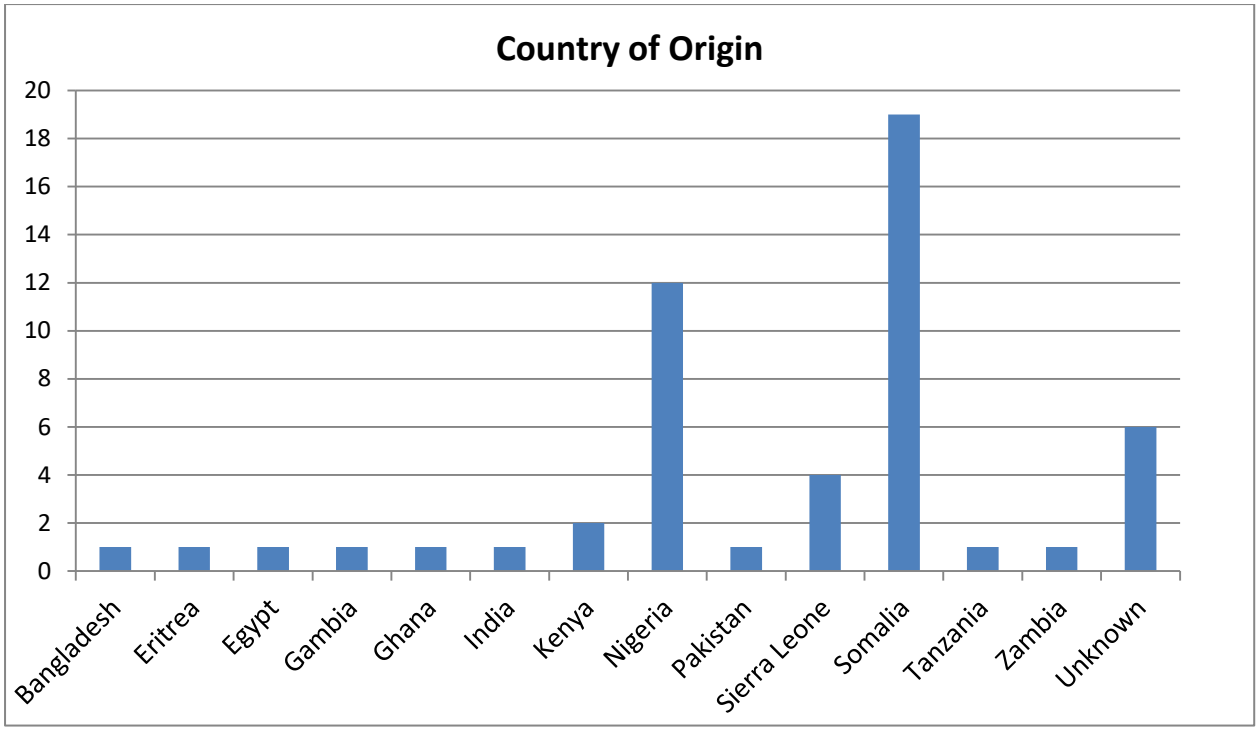
All health professionals are now required to report any child under 18 years that discloses FGM, or observes that she has had FGM to Children's Social Care and the Police. The Trust is also required

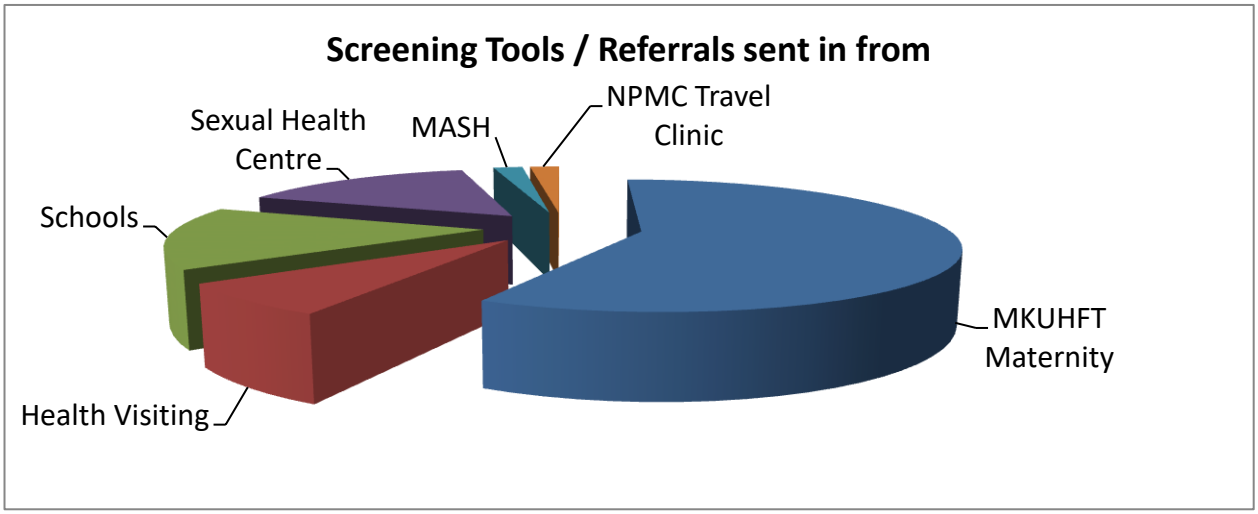
to report all cases of FGM using Datix and MKSCB FGM screening tool. These cases are discussed at a monthly Multi-Agency FGM Panel.

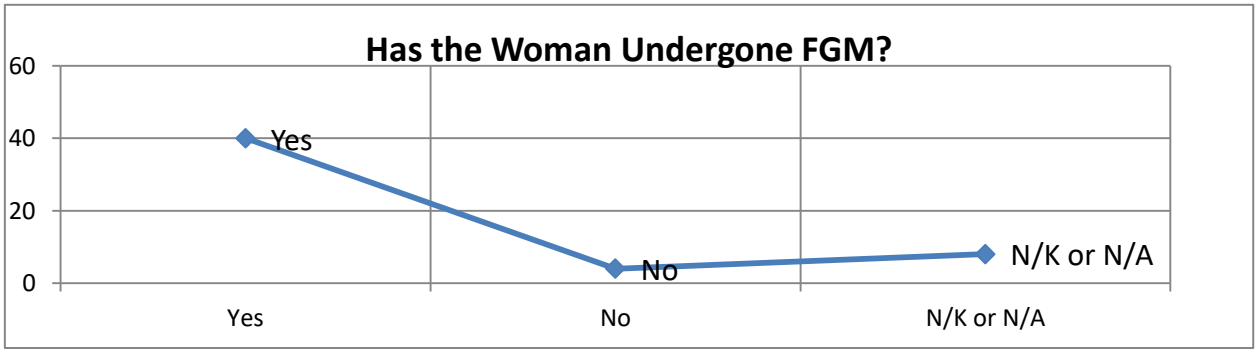
Graph 17Number of screening tools reviewed at monthly FGM panel

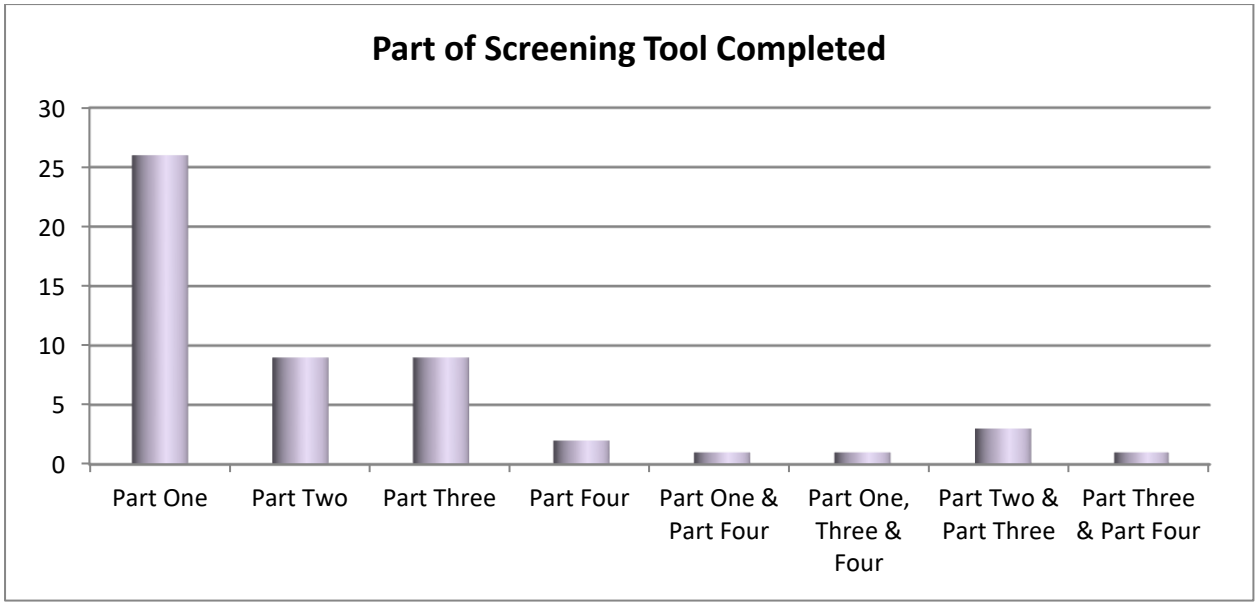





Country of Origin
20
18
16
14
12
10
8
6
4
2
0
Bangladesh
Eritrea
Egypt
Gambia
Ghana
India
Kenya
Nigeria
Pakistan
Sierra Leone
Somalia
Tanzania
Zambia
Unknown


Screening Tools / Referrals sent in from
Sexual Health Centre
MASH
NPMC Travel Clinic
Schools
MKUHFT Maternity
Health Visiting


Has the Woman Undergone FGM?
60
40
20
0
Yes
No
N/K or N/A
Yes
No
N/K or N/A



5. Future Developments for 2018/19

5.1 Adults

The Adult Safeguarding Team will continue to work towards aligning training to *The Safeguarding Adults: Roles and competencies for health care staff – Intercollegiate Document 2016* when the final document is settled. The document is alleged to be agreed in principle; however we await the official published paper.

Safeguarding Adults and Safeguarding Children will continue to look at collaborating children's and adults training together. The aim of bringing adults and children's training together is to encourage staff to think of 'safeguarding the family' and not singularly the adult or the child; Child behind the adult, adult behind the child.

Prevent e-learning is available via the library; it is government designed and so not indigenous to the trust, therefore does require localising and an assessment of learning at the end. Capacity issues within the team have delayed the progression of this training and will be completed by the Safeguarding Adults Lead Nurse and the Library E-Learning Services Manager. The Prevent initiative 'Run, Hide & Tell' continues to be discussed during every Safeguarding training session (level 1 and 2) Bespoke PREVENT training for areas such as Emergency Department, Medical Assessment areas to be discussed at safeguarding Leads forum and a proposal produced.

Last year we implemented the National Learning and Disability Mortality Review Programme (LeDeR). The LeDeR reviews all deaths to improve care for patients who have a Learning Disability and ensures that any factors that are modifiable will not be repeated to improve the care that our patients have when they enter hospital. The LeDeR annual report December 2017 has recently been shared with MKUHFT and the Vulnerable Adults post holder will be looking at the recommendations given in this report and developing and associated action plan. A learning disability workbook and e-learning educational tool will be developed meaning that all staff can access and complete the training.

The Vulnerable Adults Nurse will be providing more bespoke Learning Disability Awareness training in MKUHFT and will look at supporting children with a learning disability who are transitioning into adult services within MKUHFT.

For Dementia education we have contributed to the development of an Open University Dementia course that will commence in October 2018 for a cohort of 25 staff.

Our electronic patient records system e-Care was launched in May 2018 allowing us to review the assessment of pain in patients with dementia, with a possible implementation of The Abbey Pain assessment tool which is specifically designed for dementia patients in collaboration with the Pain team.

We are in the process of recruiting volunteers to assist with the implantation of Pets As Therapy (PAT) dogs in the Trust. Pets as Therapy animals and their handlers provide therapeutic visits to hospitals, hospices, residential and nursing homes. Patients often feel isolated and anxious in hospitals and PAT dogs can reduce anxiousness and enhance hospital experience. Research has shown a reduction in anxiety, improvement in cardiovascular system and appetite as well as reducing agitation and aggression.

We will continue to promote John's campaign within the Trust and review the effectiveness and experience for families and carers.

Within the Dementia clinical service unit we are currently developing a Dementia strategy for the Trust, incorporating the vision that "Every patient with a diagnosed dementia admitted to MKUHFT is recognised, treated with respect and dignity by all staff who demonstrate awareness, understanding, and the skill appropriate to their own role and involvement with that person who has dementia including their relative or carer"

The Vulnerable Adult post holder left the trust in April 2018 and a successful recruitment campaign has secured a replacement who is due to commence post in July 2018. There will be an a gap in the service for 3 months period which the Safeguarding and Quality team will cover to mitigate the risk for vulnerable adults.

- Continue to review and adaptation of the training programme to embed learning from local and national incidents to improve care.
- Essential Skills registered nurse training to be reviewed as it has been in place for over 2 years. New scenarios to be designed and the accompanying booklet to evidence practice to be updated to reflect the new content.
- Redesigned Safeguarding intranet will be embedded to give staff the resources and tools they require for raising adult safeguarding alerts and deprivation of liberty safeguarding to the appropriate council in an easy to access facility.
- MKUHFT safeguarding adults and Mental Capacity Act & Deprivation of Liberty Safeguarding information leaflets to be circulated

5.2 Children

Multi-agency safeguarding training is recommended within the Intercollegiate Document (2014) and although not statutory, the advantages of interagency training in widely seen to improve professional relationships and understanding of roles in relation to safeguarding children. The MK Safeguarding Board and MKUH are collaboratively planning to deliver multi-agency training at the

hospital later in the year to allow staff the opportunity to attend onsite and will be offered to other agencies. Additional dates will be set for 2018.

The MK Safeguarding Children's Board (MKSCB) & MK Safeguarding Adults Board (MKSAB) are planning to merge in the future. Available training has been reduced and specialist training will now incur a charge to attend.

There is a plan to review the way MKUHFT delivers safeguarding level 3 training, with a proposal aimed to be agreed at the quarterly Safeguarding Committee by September 2018.

The Safeguarding Children's team continues to work towards delivering a number of developments within the context of the current capacity.

The welfare of 16 to 18 year olds in the Trust remains a priority and the safeguarding team attend the Trusts daily safety huddle where information is shared if any adolescents are in the hospital to prioritise any additional support required to ensure the young person's welfare is protected.

There has been considerable collaborative work undertaken between MKHUFT and Oakhill Secure Training Centre to agree a memorandum of understanding to improve the communication and safeguarding of young people attending the trust and will be in operation by September 2018.

5.3 Maternity

- The Children's Social Care birth plans have been reviewed and renamed. They are now called Maternity plans and include more detailed information regarding concerns, which friends and family are able to visit, required level of supervision and the plan for discharge.
- Work is in place to develop 'best practice' when babies are taken into the care of a family member or the local authority to help support the family and staff in this difficult time.
- The Named Midwife is working with the St Frances' Children's Society to provide input from a maternity point of view regarding the care for in pregnancy and for a newborn to a mother with a Substance Misuse issue.
- Work is in place to provide safeguarding Supervision to Maternity Staff. There are currently 2 trained members of staff and plans to also train a 3rd. Work around a policy and guideline will be developed shortly in collaboration with the trust safeguarding team.
- The safeguarding training has been refined in line with the new 3 day Protected Time session. 'Safeguarding Everyone"' is now provided yearly in a 3.5 hour session. This considers the adults around the child and the child behind the adult and the cross overs that can cause a concern. Staff are also required to complete DoLs and MCA training as a mandatory every 3 years.

  Support is being developed for Community Midwives in working with a Common Assessment Framework alongside the Community Health Visiting Team.
- Review of level 3 safeguarding training
- To develop and improve links with COMPASS drug and alcohol services. There is no current mental health provision for substance users as there is no psychiatrist that specialise in this subject
- A review of the need for Confidential Communiques will be completed once eCARE maternity IT system is implemented as it is envisaged that this would complete the purpose of the Confidential Communique
- Audit of Routine Enquiry Standard Operating Procedure

5.4 Audits planned for 2018/19

- Safeguarding knowledge (children and adults)
- Serious Case Reviews, Lessons Learnt
- Mental Capacity knowledge
- Writing a good Multi Agency Referral Form
- Writing a good Safeguarding Adult Alert Form (SABR1)
- Use of the FGM screening tool
- Use of the Neglect/FII toolkit
- Attendance of adolescents from Oakhill Secure Training Centre

Overall it was agreed that MKUHFT had continued to sustain robust arrangements for safeguarding adults and it was noted there was evidence of strong leadership and robust governance through the MKUHFT safeguarding committee.

Meeting title	Board of Directors	Date: 6 July 2018
Report title:	Infection Prevention and Control Annual Report	**Agenda item:** 6.6
Lead director	**Name:** Lisa Knight	Title: Director of Patient Care and Chief Nurse
Report author	**Name:** Angie Legate	Title: Assistant Director of Infection Prevention and Control
FoI status:	Public Meeting	

Report summary	To receive and consider the Infection Prevention and Control Annual Report			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [x]	**Decision** [ ]
Recommendation	That the Report be received and noted.			

Strategic objectives links	1. Improve patient experience 2. Improve patient safety 3. Improve clinical effectiveness
Board Assurance Framework links	None
CQC regulations	Regulation 12 – Safe care and treatment
Identified risks and risk management actions	None
Resource implications	None
Legal implications including equality and diversity assessment	None

Report history	Information Prevention Control Committee, Management Board, Quality and Clinical Risk Committee
Next steps	
Appendices	

Infection Prevention and Control Annual Report

April 2017 – March 2018

Authors:

Angela Legate, Assistant Director Infection Prevention

Graphics by Martin Parker, Data Analyst – Infection Prevention

Contents

Welcome to the 2017/2018 Infection Prevention and Control Annual Report.

This is the statutory report for the Trust on Infection Prevention and Control, written by the Assistant Director of Infection Prevention and Control (ADIPC) for the period 1 April 2017 to 31 March 2018.

The format, altered last year to pay due regard to those elements where significant achievement was made and to highlight the rapidly increasing problem of antimicrobial resistance (AMR) has changed again to offer clinical and non-clinical staff, our patients and public a greater understanding of why our united approach to reducing avoidable infection is moving towards a critical stage .

The work of the Infection Prevention and Control Team and the IPC Committee focuses on the preventing and control of infection through effective communication, education, audit, surveillance, risk assessment, quality improvement and development of policies and procedures.

All those involved in delivery (and receipt – where appropriate) of healthcare are encouraged to participate in the activities identified in this report as resulting in the reduction of infection associated with healthcare in our hospital and community.

Each and every one of us employed by the Milton Keynes Hospital has infection prevention and control responsibilities.

Wash your hands with soap and water - it’s the best way to prevent infections.

Executive Summary and overview of infection control activities in the Trust - April 2016- March 2017

As before, this account serves as a reference for anyone looking for information about the Milton Keynes University Hospital Health Care Associated Infection (HCAI) prevention progress. The style of the report reflects similar language used in publications by the World Health Organisation (WHO) the Hospital Infection Society, the Health and Social Care Act and NICE guidance.

The IPCT consists of Dr Poonam Kapila as the designated Infection Control Doctor, Lisa Knight, Chief Nurse as Director of Infection Prevention, Angela Legate as Assistant Director (band 8B & Lead nurse), and Sharon Burns (band 7). Further recruitment is planned for the new financial year. The team is to be supported by a data analyst/administrator from May 2018.

The year has seen 3 MRSA bacteraemia which were associated with the hospital, one of which was attributed to lapse in care. Please see main report for discussion.

Thirteen cases of post-72 hour Clostridium difficile Infection (CDI) positive cases were apportioned to the Trust against an internal threshold of 22. The Department of Health set the threshold at 39.

All cases of CDI post-72 hours go through a meticulous root cause analysis (RCA) process as do the incidents where MRSA is found in the bloodstream.

Quality improvements continued to feature across the year with a focus on the education of staff to enable them to tackle infection prevention and control issues in their own clinical areas as well as raising the profile of and the accessibility of the IPCT.

Weekly and monthly reports provide information on the distribution of HCAI's across the Trust and provides a baseline framework for Divisions to target their high risk areas.

From April 2017, pseudomonas aeruginosa and Klebsiella in blood cultures were added to the current list of organisms reported via the mandatory surveillance system:

• MRSA bacteraemia • MSSA bacteraemia • E coli bacteraemia and CDI.

As all blood cultures are taken within the hospital (both in the admitting areas and the in-patient wards) and 80% of reportable bacteraemia are associated with the community, this represents a significant increase in the amount of data gathering, data entry and subsequent reporting by the IPCT.

Key Achievements

1. The Trust is registered as “Good” with the Care Quality Commission (CQC) which encompasses having appropriate arrangements in place for the prevention and control of infections.

2. Low incidence of mandatory reportable healthcare associated infection.

3. Lower number of outbreaks of diarrhoea and vomiting, and successful management of confirmed Norovirus and Influenza type A and B.

4. Significant input from the Infection Prevention and Control team (IPCT) to this year’s influenza campaign with improved numbers of peer vaccinators to facilitate vaccination of staff. The percentage of staff receiving the vaccination increased this year breaking through the ceiling of 75% set by the Department of Health.

5. The Trust continues to improve its drive to achieve and sustain its ambition for hand hygiene compliance. Improved auditing this year has included enhancing the audit tool and altering the format in which the results are shared across the hospital.

6. Continued education of staff on key infection prevention and control issues, at induction, ward based training, medical staff training, and the new academic centre.

7. Reduction in Gram negative blood stream infection (GNBSI), particularly E. coli bacteraemia attributed to our hospital – see P12 for Gram staining information.

Healthcare-associated infections (HCAIs) and related issues

Each year I write of our meeting thresholds and the multidisciplinary work done to achieve those “targets”. The “alert” organisms are always featured but what does that term mean?
Alert organisms are microorganisms that have the potential to cause harm and disease in individuals and which can cause an outbreak of infection in any healthcare environment. They are identified by our microbiology laboratory and referred to the infection prevention and control (IPCT) team for assessment of possible hospital associated acquisition and to identify any possible environmental/equipment sources.
Pseudomonas aeruginosa, Klebsiella, MRSA, MSSA and E coli in blood cultures and Clostridium difficile are all considered as “alert” organisms and therefore reportable nationally.

Of interest, the MKUH had a case of a **borderline-resistant strain of *S. aureus*** (BORSA). Reports show that BORSA can be associated with both nosocomial (hospital) and community-acquired infections and have been isolated from various sites, including skin swabs, surgical wounds, respiratory samples, abscesses, and blood. BORSA is treated in the same way as MRSA.

Clostridium difficile

Antimicrobial resistance continues to play an important role in driving the current numbers of *Clostridium difficile* and the emergence of new types. *Clostridium difficile* although greatly reduced in terms of the numbers of cases seen at the MKUH, should still be recognised as a major cause of healthcare antimicrobial associated diarrhoea.

The MKUH CDI multidisciplinary team closely monitor therapy in support of tempering the inflammatory response preventing severe infection and resultant poor outcome.

The Department of Health threshold is 39 cases; our internal is set at 22.

As of 12.03.2018, 13 cases of CDI have been reported as attributed to the MKUH, which equates to 8.91 per 100,000 bed days. Patients reported have an age range of 78 – 92 years, 10 female, 3 male – the majority of cases are within medicine, all have chronic co-morbidities. The definition of hospital associated CDI is those patients that test positive at 72 hours following admission.

None of these cases have been classified as due to lapse in care by our local C. *difficile* investigation panel within the Milton Keynes Clinical Commissioning Group (MK CCG). The CCG employ the Public Health England criteria to assess each case.

Please note the trajectory set by the Department of Health is reduced by one case as per the previous year. The Trust continues with our community health partners to drive down the incidence of avoidable Clostridium difficile.

Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia.

Of the three MRSA bacteraemia apportioned to our hospital, one was identified as due to lapse in care and proved significant in terms of the learning outcomes derived from the investigation.

MRSA colonisation eradication and repeat screening in high risk patients is vital if we are to reduce the potential for MRSA to enter the patient blood stream. There is a safety requisite to verify observation of medical device insertion sites and for peripheral cannula, in particular to be removed if signs of phlebitis are present or the patient reports the entry site as uncomfortable, feeling warm or of a “stinging” sensation. Diabetic patients are more at risk of infection, bloodstream or otherwise.

Investigation was unable to evidence the frequency of the visual inspection for phlebitis (VIP) being maintained for this diabetic patient requiring intravenous antimicrobials and or glucose and insulin during the patient stay in hospital. Interviews with nursing staff and medical teams made evident the challenges in cannulating the patient but documentation did not support this across a four week period.

Unable to exclude two necrotic areas on the patient forearm as being the direct result of cannula insertion, the assumption was that MRSA identified from the blood culture was device related and therefore preventable.

Points of review/further action

Given the seriousness of the incident, a number of efforts were explored, advocated, and in the main implemented on suspicion of the culture being MRSA positive.

The level and frequency of device insertion and post management training for doctors and nurse teams has been discussed at the Divisional Unit meeting Chaired by one of the Senior Consultants and Clinical Service Unit Lead.

a) Assurance was sought from the Trust in respect of this safety element of patient care being met and maintained through a robust programme of clinical skills teaching that is delivered in-house.

b) A “shared” learning has been implemented to highlight incidents within the division in support of all members of the care teams being aware of quality issues discussed that indicate a personal and professional review of practice.

c) The IPCT has provided assistance to the Senior Sister with the re-integration of the value of using the VIP score in clinical practice. Included in this have been the origins of infusion phlebitis and the potential loss of reputation to the Trust and litigation associated with phlebitic incidents. The VIP score empowers healthcare workers so that IV catheters can be removed at the first indication of

phlebitis and is recommended by the Department of Health (UK) and Royal College of Nurses (UK) and enforced by the hospital.

d) Compliance with hand hygiene was met through a targeted programme of increased observation with immediate feedback to those staff breaching safe clean care. Disciplinary action was to be taken where applicable.

e) Nurse in Charge reviews electronic bed board daily to ensure all patients with a Biohazard flag have the appropriate screening/treatment in place. This is confirmed through update of nurse handover sheet and review of subsequent screening results.

f) All Ward staff (nursing and medical) have received a safety awareness briefing to share the incident, understand and act on the learning in practice obligation as per the GMC & NMC accountabilities.

g) “Message of the Week” by Senior Sister reinforced device management

From July 2017 – all disciplines of nursing staff received additional briefing from small group workshops, focusing on nursing documentation; this was led by the senior nursing team.

Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia.

Most strains of S. aureus are sensitive to the more regularly used antimicrobials, and infections can be effectively treated. However, in comparison with MRSA patients, MSSA patients are more likely to have bacteraemia, endocarditis, or sepsis and to be adult.

Staphylococcus aureus is easily the most important species of the staphylococci.
It is found in the environment and is frequently seen as normal flora bacteria in humans, and is estimated to be present in 20 to 40 percent of adults.

Whilst it is recognised as a bacterium found on human skin or mucosa and not causing any issues, it is widely known as being capable of causing skin and soft tissue infections (SSTIs), bloodstream infections, osteomyelitis, infections of the heart valves (endocarditis), pneumonia, septic arthritis, and device-related infections if the bacteria enter the body.

The microscopic appearance of Staphylococcus aureus (S. aureus) is round and resembles that of a sphere (cocci). In Greek, staphylococcus means “clusters of grapes.”
The use of a common bacteriological stain, the Gram stain, helps us to identify S. aureus. The organism appears purple using this staining technique and is therefore

classed as gram-positive.

Whilst the national focus sits firmly with the gram negative bacteraemia reductive programme, it is important to include MSSA, a gram positive, as part of our plan when looking to reduce infection.

Public health England (PHE) report 7.7% increase in the numbers of bacteraemia caused by S. aureus from 2015/16 against the rate of all MRSA cases per 100,000 population, per year having fallen from 8.6 in 2007/08 to 1.5 in 2016/17.

Diagnostic evaluation — In general, blood cultures positive for *S. aureus* are respected as a clinically significant finding that prompts clinical re-evaluation and initiation/review of empiric therapy.

The clinical approach to *S. aureus* bacteraemia consists of careful history and physical examination with support from the consultant microbiologists and or infectious disease consultation, and diagnostic evaluation including echocardiography and additional imaging as needed.

For circumstances in which the source of bacteraemia is uncertain, patients are questioned carefully regarding potential portals of entry including recent skin or soft tissue infection and presence of indwelling prosthetic devices (including intravascular catheters, orthopaedic hardware, and cardiac devices).

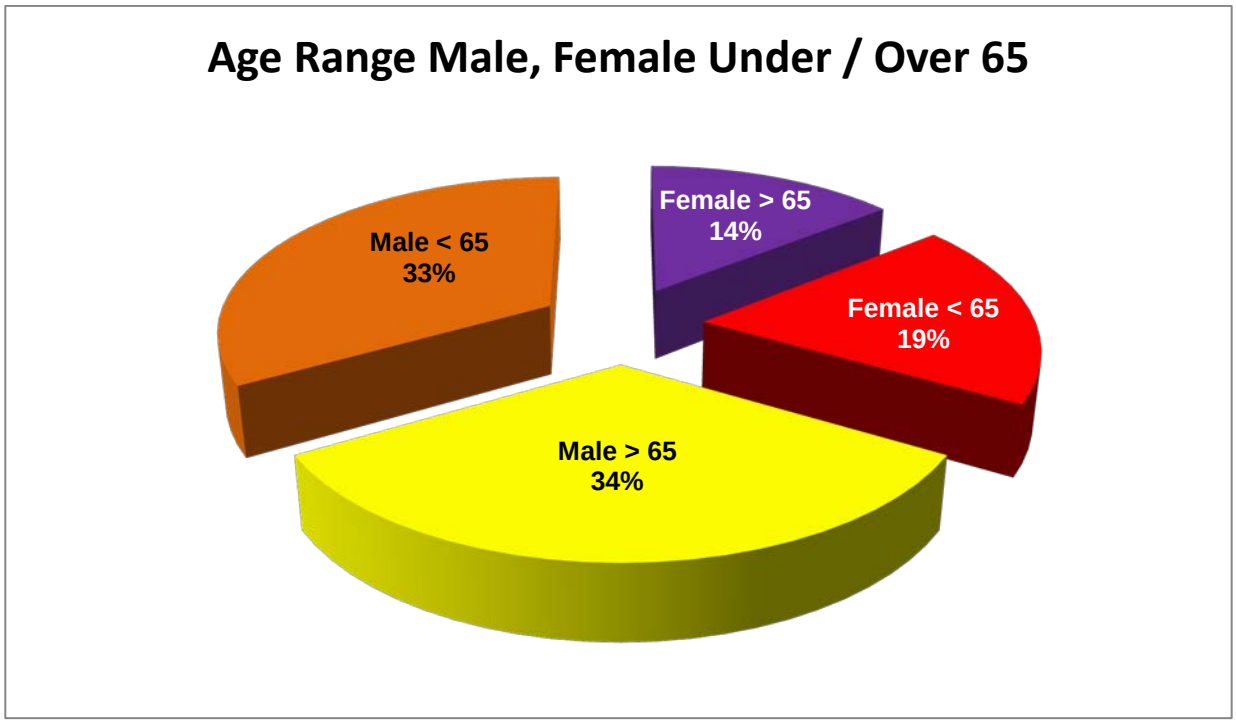
Patients are also questioned regarding symptoms that may reflect metastatic (spread from original site to other areas of the body) infection, which can occur in up to 30 percent of cases. These include bone or joint pain (particularly back pain, suggesting vertebral osteomyelitis, discitis, and/or epidural abscess), protracted fever and/or sweats (suggestive of endocarditis), abdominal pain (particularly left upper quadrant pain, which may reflect splenic infarction), costovertebral angle tenderness (which may reflect renal infarction or psoas abscess), and headache (which may reflect septic emboli).

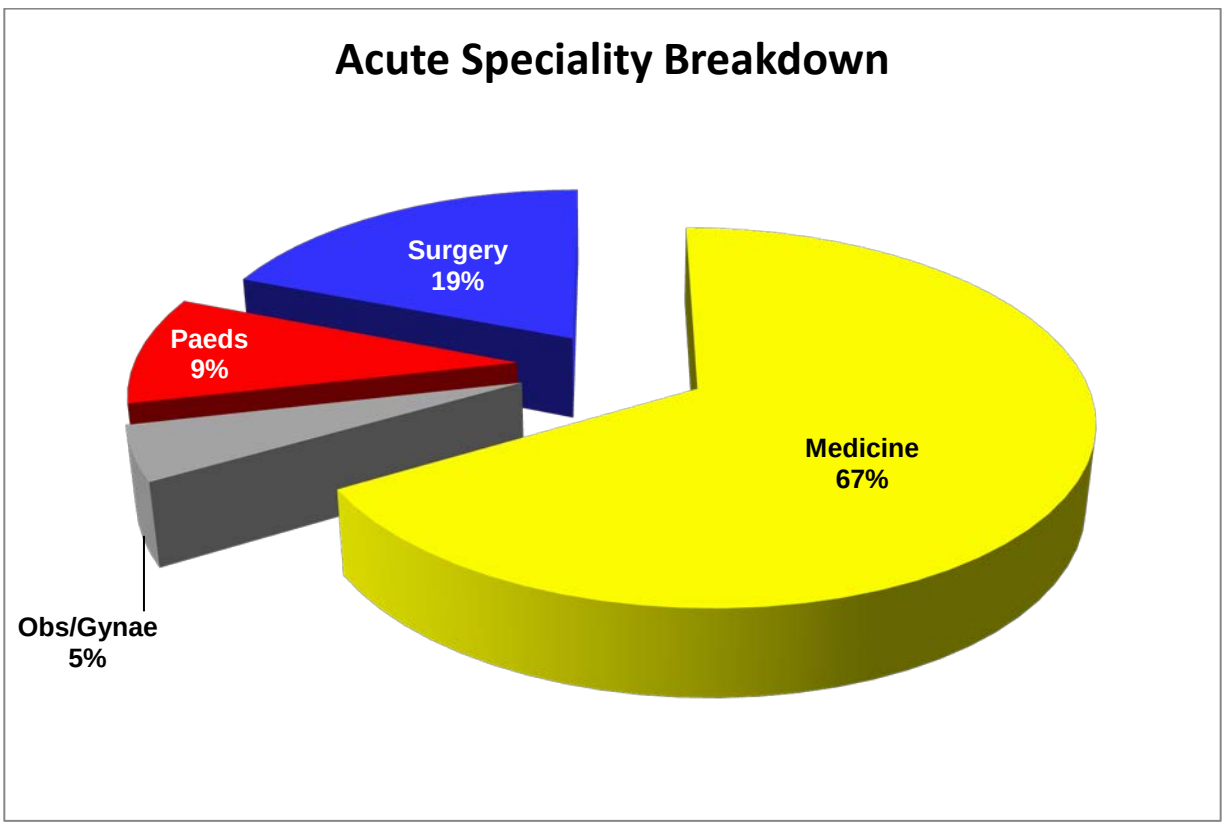
Research has shown Consultation by an infectious diseases specialist and or Consultant Microbiologist is associated with better outcomes including fewer deaths, fewer relapses, and lower readmission rates.

There were twenty one cases apportioned to our hospital and a further one hundred and twenty eight to the community.

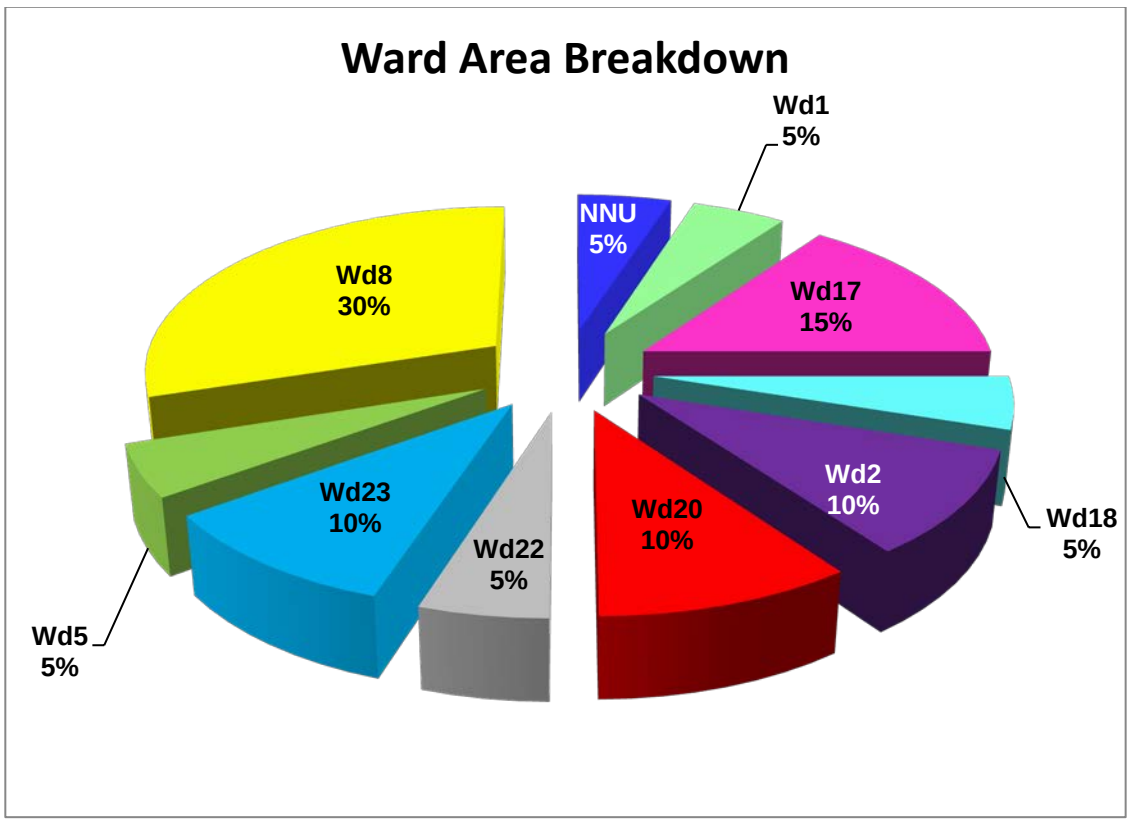
Graphs detailing MSSA cases are on the following pages 10 and 11.

Please see break down of MKUH MSSA cases and trend analysis below.





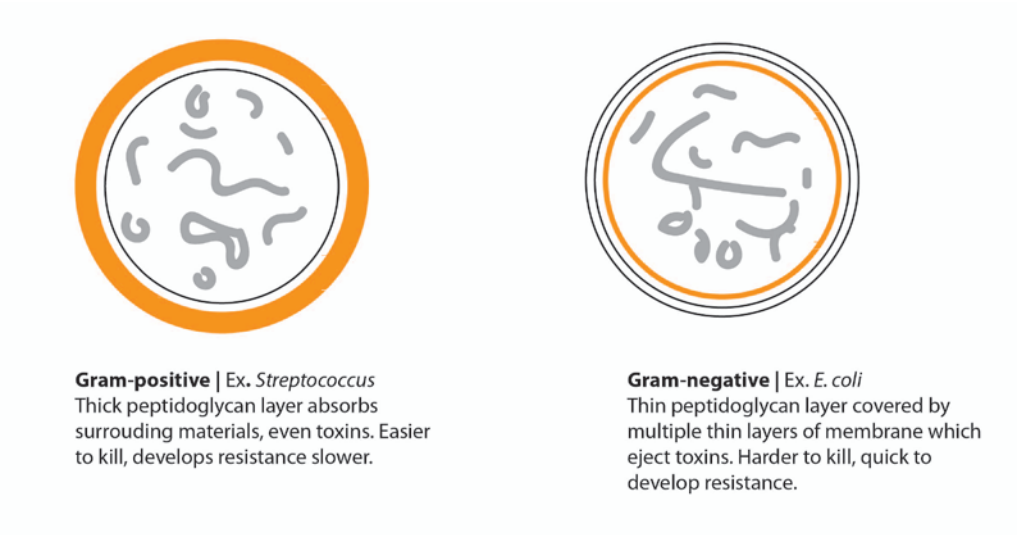
MSSA cases per ward.



Gram-positive vs. Gram-negative Bacteria (Both can be pathogenic – capable of causing disease)

A Danish scientist Hans Christian Gram devised a method to differentiate two types of bacteria based on the structural differences in their cell walls. In his test, bacteria that retain a crystal violet dye do so because of a thick layer of peptidoglycan and are called **Gram-positive bacteria**. Peptidoglycan is vitally important for the way antimicrobials work as the role of a bacterial cell wall is defensive. The wall is there for the same reason our skin is on us, to keep the insides in and the outsides out and it does this by physically limiting the size and shape of the cell.

In contrast, **Gram-negative bacteria** do not retain the violet dye and are coloured red or pink. Compared with Gram-positive bacteria, Gram-negative bacteria are more resistant to antimicrobials because the outer membrane of the cell wall comprises a complex layer. See example next page (12).



***Escherichia coli* (E coli) bacteraemia**

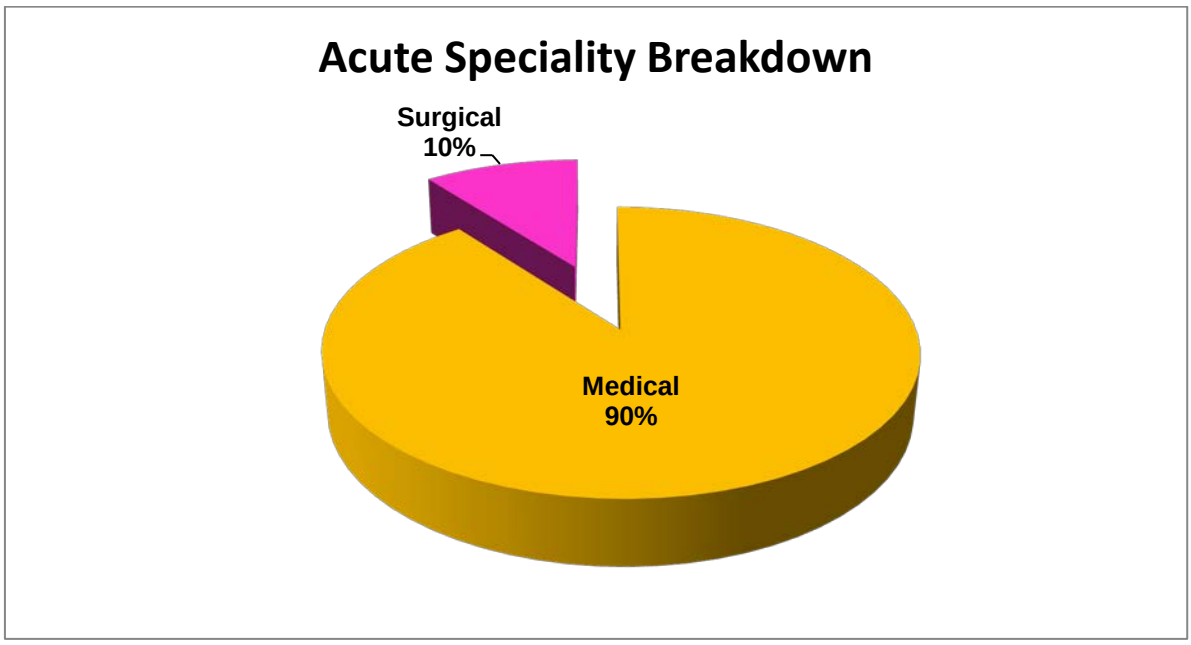
E. coli infections have increased by a fifth in the last 5 years and as a result, in 2017, the National Health Service Improvement (NHSi) set a 10% reduction target for *Escherichia coli* bacteraemia to be realised by 2018, followed by a 50% reduction in healthcare-associated Gram-negative bacteraemia by 2022. We have met the 10% reduction.

E.coli remains one of the most frequent causes of many common bacterial infections, including cholecystitis, bacteraemia, cholangitis, urinary tract infection (UTI), traveller's diarrhoea, and other clinical infections such as neonatal meningitis and pneumonia.

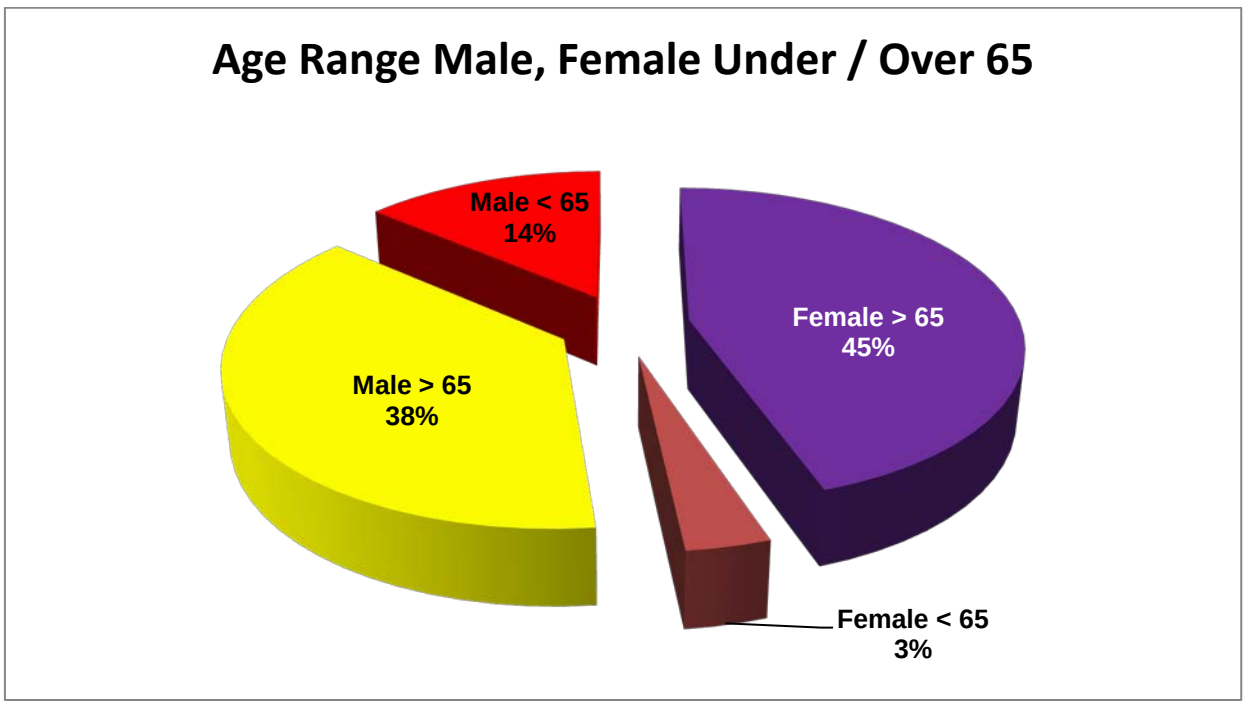
Urinary tract infection in catheterised and non-catheterised patients as a contributor to the number of bacteraemia reported nationally remains significant with E.coli associated with hepatobiliary disease now cited as being the second most prevalent.

A percentage of E. coli bacteraemia related to urosepsis may be avoided by better empirical treatment and targeted prophylaxis. Urinary catheter quality improvement programmes also contribute to a further reduction. For patients undergoing high-risk urinary or biliary tract procedures or device manipulation

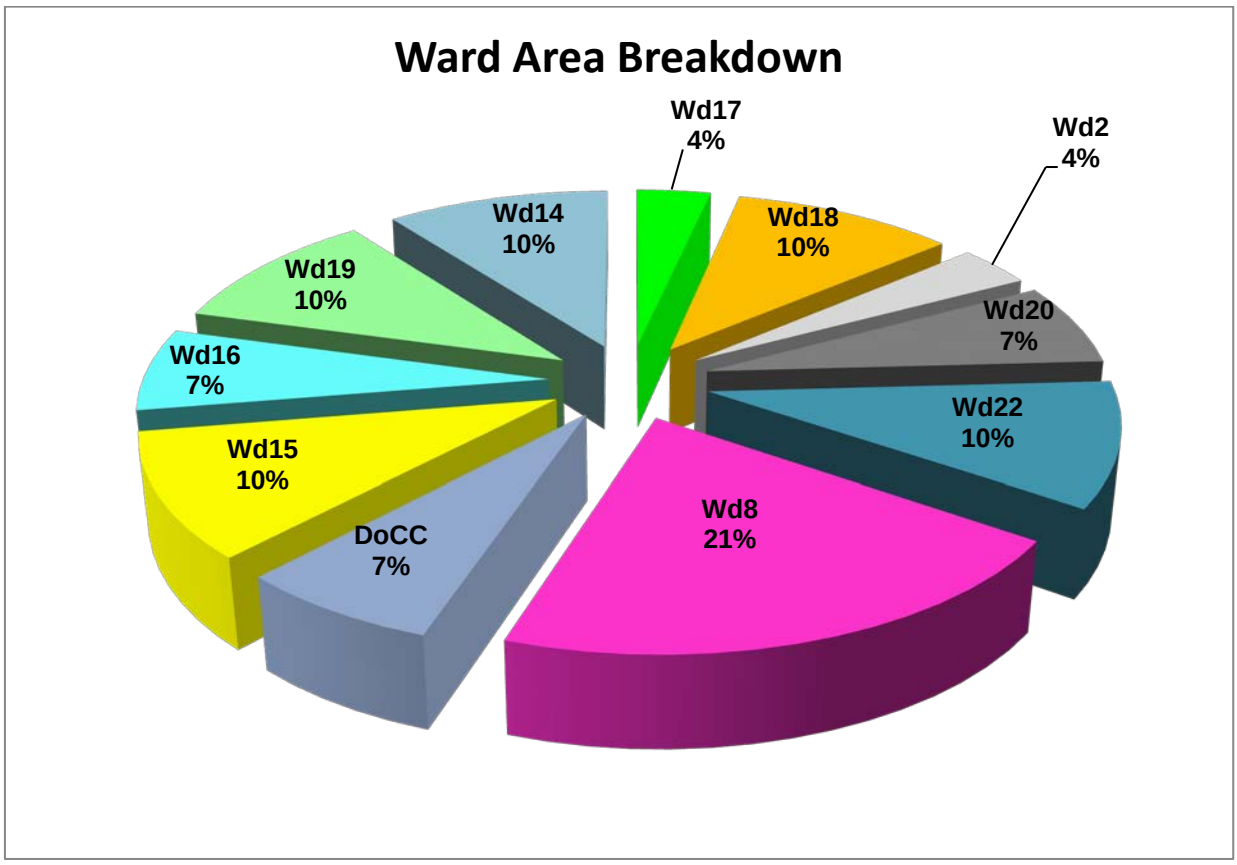
Twenty nine cases, two of which were repeat positives were apportioned to the Acute Trust against one hundred and sixty six to the community.



E.coli cases for the acute Trust 2017/18



Please see following page (14) for ward/area breakdown of E.coli bacteraemia cases



Surveillance, Monitoring and Progress

Key Issues

The microbiology laboratory plays a vital role in the surveillance, treatment, control and prevention of health care associated infections. The Consultant microbiologists are permanent and active members of the Infection Prevention and Control Committee (IPCC) and the Antimicrobial Stewardship Group (ASG).

The first task of the microbiology laboratory is to accurately, consistently and rapidly identify the responsible agents to species level and identify their antimicrobial resistance patterns. A number of our analysers offering traditional microbiologic methods are now considered suboptimal in providing rapid identification and susceptibility testing.

Surveillance and research, reduction of the incidence of infection and optimisation of the use of antimicrobials are among the strategic objectives of the World Health Organisation global action plan to combat antimicrobial resistance. The microbiology laboratory in our hospital plays an important role in antimicrobial stewardship, which aims to optimise antibiotic prescribing to improve patient outcomes, minimise potential toxicity, prevent emergence of resistance and reduce healthcare costs.

The microbiology laboratory is responsible for the early detection of clusters of microorganisms with the same phenotypic characteristics. Laboratory and epidemiological studies of suspected outbreaks are conducted in parallel. During outbreaks the microbiology laboratory collaborates with the IPC to elaborate case definitions, choose the specimens to collect, the isolates to fingerprint, and the relevant isolates to store. Microbial fingerprinting methods differentiate microorganisms or groups of microorganisms based on unique characteristics. As the challenges in healthcare continue to escalate, our need for investment remains critical if we are to deliver a quality, life- saving service to our patients.

Blood culture qualifies as one of the most important functions of the microbiology laboratory. The number of cultures received by our hospital laboratory increases year on year and there is an urgent need to replace or upgrade the systems that critically supports accurate testing with high performance, ease of use and media quality if we are to continue to meet patient safety obligation.

Audit

Infection Prevention and Control environmental audits are a requirement of the Code of Practice for the prevention of healthcare-associated infection (Health and Social Care Act 2008-updated 2015) and are to become an integral part of the Matron portfolio.

The standards used in the audit use the most up to date guidance and incorporate the latest standards and guidelines as well as incorporating the Infection Prevention Society's Quality Improvement Tools.(2015)

Hand hygiene

Each year the SAVE LIVES: Clean Your Hands campaign aims to progress the goal of maintaining a global profile on the importance of hand hygiene in health care and to 'bring people together' in support of hand hygiene improvement.

The focus of the 5 May 2017 campaign is that hand hygiene remains at the core of effective infection prevention and control (IPC) to combat antimicrobial resistance.

Good hand hygiene is essential to protect patients from antimicrobial resistant infections such as carbapenemase producing organisms (CPOs), meticillin resistant *S. aureus* (MRSA) and vancomycin resistant enterococci (VREs).

These types of bacteria are resistant to a wide range of antimicrobials and infections caused by them and are difficult to treat. Practicing good hand hygiene prevents the spread of these multi-drug resistant organisms, stops the spread of resistance and

preserves antimicrobials for patients who require them to combat infection(s), and for life saving intervention.

Hand hygiene is a preventative strategy that is simple to perform; yet health care worker compliance is often low. Studies have estimated a wide range of compliance, with an average of roughly 40% according to World Health Organisation (WHO) analysis.

Monitoring and feedback is essential to improve compliance and we have altered our reporting system across the year in an attempt to better understand where and how we might drive compliance. Traditional monitoring has been direct observation, but this strategy is limited by high resource requirements, low number of observations, and the Hawthorne Effect.

Strategies to improve hand hygiene are agreed and monitored through the infection prevention and control committee. Different approaches have been explored where data collection became a challenge, we moved from reporting exceptions to audit and will re-examine the entire process again in June 2018.

At every level of our health care system, from “those on the ground” to the executive teams, there is the opportunity to influence safer, quality care through effective hand hygiene. Stay part of the solution…….challenge poor practice when you see it!

Surgical Site Infection Surveillance Service (SSISS)

The resignation of the SSISS co-ordinator in March 2017 resulted in our suspending our SSISS portfolio. The compulsory requirement to conduct surveillance of orthopaedic surgical site infections utilising the Public Health England (PHE) Surgical Site Infection Surveillance Service has been met across the year.

A data analyst/administrator will join the IPCT in May 2018 and following the obligatory training delivered by Public Health England (June 2018) on SSISS data gathering/reporting, our surveillance will recommence. Of note: the continued exploration of E.coli bacteraemia has identified hepatobiliary as being high on the list, urinary tract infection remains top. The gastroenterology team are to be invited to take part in the SSISS criterion that captures intervention associated with the hepatobiliary tract.

Facilities – Cleaning and Catering

The cleaning of all Trust properties is provided by a combination of in house services and external contracts. All of the services are managed and monitored by the corporate Facilities team. The cleaning services provided are invaluable to maintain and promote an appropriate level of cleanliness across the Trust in an ever changing environment.

Catering is also provided both in-house and externally. The Trust’s in-house catering

team supply all of our inpatient facilities and ensures our patients are served with healthy meals using sustainably sourced products.

Infection Prevention and Control Activities

The Infection Prevention and Control Team (IPCT) supported national initiatives to raise awareness and engage staff, patients and visitors. This included the World Health Organisations Save Lives: Clean Your Hands Campaign in May 2017, the Infection Prevention Control awareness week in October 2017, the SEPSIS 6 campaign.
All events were successful with positive feedback from staff and visitors.

Induction and Mandatory Training

All new staff receive infection prevention and control training on induction to the Trust. In addition, e-learning modules and or work books on infection prevention and control are for available for all disciplines of staff in support of mandatory update timeframes being met. This allows the Trust to meet the requirements of the Hygiene Code for in-patient staff. The IPCT have delivered locality based sessions for in-patient unit staff where a change in service has necessitated. The learning and development team populate the business intelligence software that allows managers to view levels of compliance and for any areas with low compliance to be emailed to ensure out of date staff book a session. A system of on-line booking has led to improved attendance. A concern that the change to shift times within in-patient services may reduce opportunities for locality based training has not raised any issues.

Compliance for IPC mandatory education update at the time of writing = 97% for Level 1 (non-clinical staff) and 83% for Level 2 (clinical).

It should be noted that informal training occurs in many other ways e.g. via visits to areas by the IPCT, telephone consultation with patients, staff and visitors.

Education and updates for the Infection Prevention and Control Nurses (IPCN`s) is provided internally and externally. The Lead ICN supports the objective structured clinical assessor examination (OSCE) used in health sciences to test clinical skill performance for the Bucks Medical School in addition to the health and safety lectures.

Medical students have been included in an “in-house” IPC training programme directed by the infectious disease consultant from April 2017.

Building and Refurbishment Guidance

To engage and integrate clinical expertise into the planning and design of our immediate health care environment, the IPCT have been involved in advising on new

building or refurbishment projects within the Trust to provide advice according to national guidance: Infection Control in the built environment (DH 2013) as well as other relevant building notes.

The IPCT have attended planning and snagging meetings and have advised on IPC issues where appropriate. The Head of Estates and Facilities is represented at the Trust's Infection Prevention and Control Committee. The IPCT have regular contact and meetings with Estates to discuss recommendations regarding the environment in relation to infection control requirements.

Outbreaks

Influenza Outbreak investigation is generated by 2 or more patients exhibiting same symptoms linked by time and space.

Influenza like illness (ILI)
The latest Public Health England (PHE) report published in March 2018 shows that seasonal flu continues to circulate across the UK, with signs that activity has peaked.
The statistics show:

- a 37% decrease in the GP consultation rate with flu-like illness
- a 31% decrease in the flu hospitalisation rate
- a 26% reduction in the flu intensive care admission rate

The main strains circulating continue to be flu A (H3N2) and flu B. The MKUH uses an in-house quick test using a PCR method. Flu A, B and respiratory syncytial virus can all be detected.

PCR stands for "polymerase chain reaction" – a biochemical method of searching samples for the tiniest traces of genetic material belonging to disease-causing organisms, and then amplifying them to a point where they can be easily detected. PCR tests are highly sensitive, so only a small sample is required.

A respiratory sample is taken using a swab. The swab is simply touched against the back of the nasal cavity, placed into a small plastic tube containing 2ml of preservative, and can be tested right away. The sample takes 65 minutes to process (patient sample to lab, process and result to clinician).

Like all other hospitals, we experienced an unprecedented rise in the number of people admitted and confirmed as having flu as a stand-alone diagnosis, with many more suffering flu in addition to an acute episode of a chronic condition.

The NHS confederation claim the number of flu and norovirus patients at its highest point in acute hospitals was around 5000, enough to fill 10 acute trusts.

The acute Trusts were obligated with 7 day reporting of Flu until the end of April 2018 which resulted in the two infection control nurses working 1 in 12 from the first week in January to meet this.

Viral Gastroenteritis including Norovirus

In January and February this year, 2 wards were closed in full, with one other needing partial closure due to Norovirus. Genotype 2 was identified as the circulating strain. The majority of patients sampled as positive were admitted with diarrhoea and or vomiting and screened in the assessment/admitting areas. A small number of patients became symptomatic within 48 hours of admission. Heightened surveillance is in place from September – end of March each year.

Financial Implications

As indicated in the previous report there is now direct financial implication in discharging the Trust's duties in that additional investment to the microbiology laboratory equipment is sought and an increase in the nurse team numbers is required.

Assurance

The Healthcare Infection Society (HIS) launched their Director of Infection Prevention and Control (DIPC) Network and Development Programme, directed at current or aspiring DIPCs and Assistant DIPCs in 2017.
Delivered as single day programmes, they offer speaker presentations, discussion sessions and a networking opportunity in order to:

- Allow the sharing of experience and knowledge
- Act as a forum for bringing together DIPCs who are both microbiologists and non-microbiologists
- Facilitate future research and collaboration
- Narrow the knowledge gap for those with differing clinical backgrounds

The ADIPC belongs to this forum in support of her own learning, that of the IPCT and that of the Trust assurance being met year on year. IPC competencies set by the Infection Prevention Society (IPC) are those that underpin the 2 infection control nurse portfolios in relationship to fitness to practice as subject matter experts.

The Infection Prevention and Control Committee will continue to monitor progress made against the Infection Control Work programme.

Key Plans for 2018/19

- Provide support to the Trust 'Flu Lead in co-ordinating the Trust Influenza campaign to again meet the national target of vaccinating 75% of frontline staff and ensuring that staff are fully briefed on the prevention, detection and management of Influenza.
- Provide support to clinical teams in collaboration with Medicines Optimisation to improve on uptake of influenza vaccine to at risk people using our services.
- Collaborate with the healthcare community to reduce the risk of E.coli and other gram negative bacteraemia.
- Continue to promote knowledge and compliance with hand hygiene practice and other standard infection control precautions through education and audit activity.
- Work alongside the SEPSIS group/ lead on the correct detection, reporting and management of sepsis.
- Risk assessment and planned action in relation to environmental or cleanliness issues.
- Continued input into refurbishment projects as required, together with infection prevention and control advice
- Continue to support education on the standards relating to antimicrobial use and re-audit to monitor compliance with national antimicrobial stewardship guidance.

Conclusion

Our overall improvement in HCAI performance continues to be recognised by our commissioners. However, as the nature of the infection prevention and control challenge evolves, so too must our collective approach to meeting it, with a number of solutions focusing on ease of use for busy clinicians, in a very busy environment.

References:

Abraham J, Mansour C, Veledar E, et al. Staphylococcus aureus bacteraemia and endocarditis: the Grady Memorial Hospital experience with methicillin-sensitive S aureus and methicillin-resistant S aureus bacteraemia. Am Heart J 2004; 147:536.

Acute trust toolkit for the early detection, management and control of Carbapenemase-Producing Enterobacteriacaea (Dec 2013)

Care Quality Commission registration Standards http://www.cqc.org.uk/organisations-we-regulate/registered-services/essential-standards

Chambers HF, Deleo FR. 2009. Waves of resistance: Staphylococcus aureus in the antibiotic era. Nat Rev Microbiology 7:629 –641. http://dx.doi .org/10.1038/nrmicro2200.

Clostridium difficile infection objectives for NHS organisations in 2015/16 and guidance on sanction implementation (including Annex A, Annex B, Annex D and objectives in Annex E)

Clostridium difficile and Acinetobacter species. Am J Infect Control 2010 Jun; 38(5: Suppl1): Suppl-33.

Clostridium difficile Infection: How to Deal with the Problem http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1232006607827

Danner RL, Hartman BJ. Update on spinal epidural abscess: 35 cases and review of the literature. Rev Infect Dis 1987; 9:265.

Darouiche RO, Hamill RJ, Greenberg SB, et al. Bacterial spinal epidural abscess. Review of 43 cases and literature survey. Medicine (Baltimore) 1992; 71:369.

Department of Health – Managing Pseudomonas aeruginosa in healthcare Settings https://www.gov.uk/government/publications/addendum-to-guidance-for-healthcare-providers-on-managing-pseudomonas-published

http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1317140378529

EPIC 3 National evidence based guidelines for preventing HCAIshttp://www.journalofhospitalinfection.com/article/S0195-6701(13)60012-2/fulltext

Essential steps to safe, clean care: reducing healthcare-associated infection. The delivery programme to reduce Healthcare associated infections (HCAI) Including MRSA: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4136212

Fowler VG, Jr, Miro JM, Hoen B, Cabell CH, Abrutyn E, Rubinstein E, Corey GR, Spelman D, Bradley SF, Barsic B, Pappas PA, Anstrom KJ, Wray D, Fortes CQ,

Anguera I, Athan E, Jones P, van der Meer JT, Elliott TS, Levine DP, Bayer AS. 2005. Staphylococcus aureus endocarditis: a consequence of medical progress. JAMA 293:3012–3021. http: //dx.doi.org/10.1001/jama.293.24.3012.

Health and SFowler VG Jr, Li J, Corey GR, et al. Role of echocardiography in evaluation of patients with Staphylococcus aureus bacteraemia: experience in 103 patients. J Am Coll Cardiol 1997; 30:1072.

https://www.gov.uk/government/publications/advisory-committee-on-antimicrobial-resistance-and-healthcare-associated-infections-annual-reports

Huslage K, Rutala WA, Sickbert-Bennett E, Weber DJ. A quantitative approach to defining "high-touch" surfaces in hospitals. Infection Control & Hospital Epidemiology2010 Aug; 31(8):850-3.

Ing MB, Baddour LM, Bayer AS. Bacteraemia and infective endocarditis: Pathogenesis, diagnosis, and complications. In: The Staphylococci in Human Disease, Crossley KB, Archer GL (Eds), Churchill Livingstone, New York 1997. p.331.

Investigation of Blood Cultures (for Organisms other than Mycobacterium species) Bacteriology | B 37 | Issue no: 8 | Issue date: 04.11.14 | Page: 10 of 51 UK Standards for Microbiology Investigations | Issued by the Standards Unit, Public Health England

Jensen AG, Espersen F, Skinhøj P, Frimodt-Møller N. Bactereamic Staphylococcus aureus spondylitis. Arch Intern Med 1998; 158:509.

Louie T J, Miller M A, Mullane K M. et al**.** Fidaxomicin versus vancomycin for Clostridium difficile infection. N England J Med. 2011; 364 (5):422–431.

Loveday HP, Wilson JA, Pratt RJ, Golsorkhi M, Tingle A, Bak A, et al. epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. Journal of Hospital Infection 2014 Jan; 86: Suppl-S70

NICE (2011): Prevention and Control of Healthcare-associated Infections http://publications.nice.org.uk/prevention-and-control-of-healthcare-associated-infections-ph36

NICE (2012) Infection Prevention and Control of healthcare-associated infections in primary and community care http://publications.nice.org.uk/infection-cg139

Otter JA, Yezli S, Salkeld JAG, French GL. Evidence that contaminated surfaces contribute to the transmission of hospital pathogens and an overview of strategies to address contaminated surfaces in hospital settings. Am J Infect Control 2013; 41

Public Health England (2014) Surgical Site Infection Surveillance System [Online] Available from: https://www.gov.uk/government/collections/surgical-site-infection-ssi-

guidance-data-and-analysis [Accessed 04.04.17].

Public Health England (2012) Guidelines for the management of Norovirus outbreaks in acute and community health and social care settings [Online] Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322943/Guidance_f or_managing_norovirus_outbreaks_in_healthcare_settings.pdf [Accessed 04.04.17].SUPPL.): May.

Rasmussen RV, Høst U, Arpi M, et al. Prevalence of infective endocarditis in patients with Staphylococcus aureus bacteraemia: the value of screening with echocardiography. Eur J Echocardiogram 2011; 12:414.

Rosen AB, Fowler VG Jr, Corey GR, et al. Cost-effectiveness of transoesophageal echocardiography to determine the duration of therapy for intravascular catheter-associated Staphylococcus aureus bacteraemia. Ann Intern Med 1999; 130:810.

Safety Thermometer Tool
http://www.ic.nhs.uk/services/nhs-safety-thermometer

Saving Lives: A delivery programme to reduce Healthcare Associated Infection (HAI) including
MRSA. http://webarchive.nationalarchives.gov.uk/20120118164404/http://hcai.dh.gov.uk/

Showler A, Burry L, Bai AD, et al. Use of Transthoracic Echocardiography in the Management of Low-Risk Staphylococcus aureus Bacteraemia: Results from a Retrospective Multicentre Cohort Study. JACC Cardiovascular Imaging 2015; 8:924.
Khandheria BK, Seward JB, Tajik AJ. Transoesophageal echocardiography. Mayo Clin Proc 1994; 69:856.

Social Care Act 2008: Code of Practice for the Prevention and Control of Infections and related
Guidance http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122604

Sullenberger AL, Avedissian LS, Kent SM. Importance of transoesophageal echocardiography in the evaluation of Staphylococcus aureus bacteraemia. J Heart Valve Dis 2005; 14:23.

Wang W J, Gray S, Sison C. et al. Low vitamin D level is an independent predictor of poor outcomes in Clostridium difficile-associated diarrhoea. Therapy Adv. Gastroenterology. 2014; 7(1):14–19.

Wertheim HF, Melles DC, Vos MC, van Leeuwen W, van Belkum A, Verbrugh HA, Nouwen JL. 2005. The role of nasal carriage in Staphylococcus aureus infections. Lancet Infect Dis 5:751–762. http://dx.doi.org /10.1016/S1473-3099 (05)70295-4

Weber DJ, Rutala WA, Miller MB, Huslage K, Sickbert-Bennett E. Role of hospital surfaces in the transmission of emerging health care-associated pathogens: norovirus,

WHO. Global plan to combat antimicrobial resistance. Available at http://www.wpro.who.int/entity/drug_resistance/resources/global_action_plan_eng.p df. Accessed 2 February 2018.

2012/13 report from the Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI).

End of references.

Meeting title	Board of Directors	**Date: 6 July 2018**
Report title:	Health & Safety Update	**Agenda item: 6.7**
Report author(s)	Kate Jarman Marion Fowler Tina Worth	Director of Corporate Affairs Health & Safety Advisor Head of Risk & Clinical Governance

Report summary	This report provides information in relation to health, safety and welfare activity undertaken within the Trust from 13th March 2018 (date of previous escalation report) to 21 May 2018 and subsequently reported at the Health and Safety Committee meeting held 21 May 2018. It includes a summary of concerns and positive achievements during the period in order to provide assurance in relation to health and safety management compliance.			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** [x]	**Decision** ☐
Recommendation	Board are asked to note the contents of the report and make comments and recommendations as appropriate			

Strategic objectives links	1. Improve Patient Safety 4. Deliver Key Targets 7. Become Well-Governed and Financially Viable 8. Improve workforce effectiveness 9. Make best use of the estate
Board Assurance Framework links	N/A
CQC outcome/ regulation links	Regulation 12 – Safe Care and Treatment Regulation 15 – Premises and equipment Regulation 17 – Good governance Regulation 18 - staffing
Identified risks and risk management actions	Staff, patient, third party injury Personal injury claims Failure to meet duties under health and safety legislation Enforcement action, formal notices, prosecution Poor patient experience Media interest/adverse publicity
Resource implications	Personal injury claims
Legal implications including equality and diversity assessment	Failure to meet statutory and regulatory duties of health and safety legislation. Failure to provide safe place of work, safe working practices and equipment and failure to provide competent advice in relation to manual handling.

Report history	The information provided is extracted from the Health & Safety Committee meetings held on 21st May 2018.
Next steps	Ongoing monitoring at Health & Safety Committee

1. Purpose of the Report

This report highlights health, safety and welfare activity across the Trust in the period 13th March 2018 (date of last upward escalation report to Management Board) to 21st May 2018; and upward reports information discussed at the Trust Health & Safety Committee meeting held on 21st May 2018. The report covers incidents, concerns and other relevant health and safety information. Information provided is in relation to health and safety.

2. Overview

- **Multi storey car park – perimeter fencing/self-harm risk**

72 hour report in relation to web58127 was discussed having been referred by the Serious Incident Review Group. This report is in relation to an individual who scaled the perimeter fencing of the top floor and was reportedly sitting on the ledge of the structure overlooking the redway and threatening to jump but made no attempt. This is the 9th such incident reported onto DATIX since 2012 (the structure was completed in 2007 – a search of DATIX was undertaken from 1 January 2007) (nine incidents are recorded relating to a total of four individuals – one individual twice over a two consecutive days in 2012, one individual recorded five times, with four times over consecutive days in 2015 and one further report in 2016. The two other incidents are recorded in 2017 and on 30 April 2018) and raise concerns in relation to whether further structural work should be undertaken to mitigate risks of attempts to scale the perimeter fencing. The Trust has a legal and moral duty to ensure the safety of all individuals and must take reasonable steps to ensure their safety. This would include the prevention of such attempts; whether they be purposeful or accidental. Additional safety measures and costings are being explored.

- **Patient safety**

Concerns were raised during Q4 in relation to escalation areas and whether these had been appropriately risk assessed taking into account patient dependency; equipment and facilities. Concerns were also raised in relation to Ward 14, bay 5, where 4 incidents have been recorded since March 2018 where patients have desaturated or experienced difficulties requiring oxygen and/or suction. In this bay there is reportedly no piped oxygen or suction and staff are relying on the resus trolley to provide back up. This raises a significant risk to patient safety and vulnerability. The ward have been asked to provide risk assessment and assurance that the area is safe with adequate controls in place and the Divisional Triumvirate made aware of the concerns for patient safety.

- **Manual Handling Advisor Vacancy**

Post remains vacant. The banding has now been reviewed and agreed (band 7) and will be discussed at the next vacancy control panel. Training and expert advice for specific projects is being provided by an external advisor. The absence of a full time advisor remains a risk to the safety of staff and others and leaves the Trust vulnerable to non-compliance with legal duties.

Manual handling is managed by Staff Health & Wellbeing – the concern has been placed on the risk register entry number 2520.

- **Quarterly Health & Safety Inspection Checklists**

These assist in gauging compliance with legislation and Trust policy and allow for action planning of future work plan/streams to fill gaps identified. Performance in relation to health and safety compliance was discussed. It was noted that a drop in returns of health and safety checklists during Q4 was seen and the target of 70% was not achieved. Capacity in the hospital may have affected the responses. A drive for Q1 2018/19 is required and the importance of checklist returns is to be reiterated.

- **Incident reporting**

204 health and safety related incidents reported during Q4, 118 identified under the categories of violence and abuse. Violence and abuse continues to be the highest reported incident in relation to staff safety and was mentioned in the staff survey results. In this quarter increased reporting in relation to staff on staff incidents was noted. The Health & Safety Committee agreed action needs to be taken in supporting staff post incident and to highlight what actions can and are being taken to address perpetrators. A pilot scheme of localised promotion is to take place initially in some targeted areas where there is a known high risk of violence and abuse.

- **Fire Safety**

Audible Alarm Testing – a programme of audible alarm testing has been identified and will take place on the last Wednesday of each month.

Fire Warden Training - an external provider is now booked and an ongoing programme in place. 14 fire wardens have been trained to date with another 22 due for training in June. e

Fire Training (mandatory) – workbooks and presentations have been reviewed and are in the final stages of approval before being adopted.

Fire Extinguishing equipment - review and inspections has commenced. Red tags are being placed on all extinguishers already inspected.

- **Risk Assessment Process**

The Health & Safety Risk Assessment process has been rolled out amongst managers. This process meets with the regulatory duty under the Management of Health & Safety at Work Regulations 1999. Managers have been asked to ensure their departments and activities have been appropriately risk assessed in line with this guidance. Compliance will be picked up as part of health and safety inspection checklists.

4. Recommendations

Management Board is asked to note the contents of this report, make comment and recommendation as appropriate.

MEETINGS OF THE FINANCE AND INVESTMENT COMMITTEE HELD ON 30 April and 25 May 2018

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- At the 30 April meeting, the Committee approved the Trust's control total for 2018/19 and agreed to the submission of the 2018/19 annual plan.
- At the 25 May meeting, the Committee approved, in principle, the Electro Biomedical Engineering (EBME) contract, and the process for revenue costs compilation
-

Matters referred to the Board for final approval:

- The EBME contract was referred to the Board for ratification in view of its value.

Matters considered at the meeting (30 April):

1. Annual Plan 2018/19

   i. The control total for 2018/19 is £15.8m deficit which includes £3m of Provider Sustainability Fund (PSF) funding.
   ii. The Trust will be required to deliver £10.1m (3.9% of turnover) in this year's Cost Improvement Plan (CIP) of 3.9% of turnover (compared to a national average of 4.2%). The Executive are confident that this is deliverable.
   iii. The Trust does not at this stage intend to sign up to an STP-wide control total, as the PSF could be at risk if this total is not met.
   iv. There is an expectation of increased non-elective activity between November and January and the budget has been adjusted to reflect this. Overall, it is expected that there will be a 4.7% growth in clinical income.
   v. eCARE remains the Trust biggest current risk and its implementation could adversely affect performance in the short term

2. Performance Dashboard:

The Committee noted:

   I. The RTT position has deteriorated over the last few months.
   II. The Trust must have no increase in the number of incomplete pathways, and it is also required to reduce the number of patients who have been waiting for 52 weeks or more by half by the end of the year. Most of these patients are orthopaedic patients.
   III. There is currently good capacity within the hospital and at the moment, elective performance is good. However, this requires continuous focus. The divisional recovery plans need some more work.
   IV. The number of 30 day readmissions continues to grow, but the financial consequences have been renegotiated with the CCG.

3. Finance Report:

The Committee noted that:

I. At this point in the year, the Trust's control total deficit is £3m better than expected. The deficit is now half of what it was 3 years ago.
II. The bad debt provision was reduced in month 12.
III. There was an audit risk around the revaluation of the estate, but agreement was reached with the valuer, with the effect that the impact for 2018/19 was reduced from £1m to £600k.
IV. A debt of £840k had been owed by one of the local NHS partners and conversations are to be held by the respective directors of finance to seek to resolve the issue.

4. Agency update

i. Overall, agency spending reduced significantly during the year from £20m to £11m, although the Trust remains an outlier nationally. The Trust remains well within nits ceiling for the year.
ii. For 2018/19, the Trust is confident that it would be able to stay within its ceiling, although there are risks in some specialities.
iii. As more staff move from agency to bank, it is likely that the reporting requirements for the latter will increase. Attempts are being made to reduce bank rates in some areas, and this has not had an adverse effect on bank usage.

5. Transformation Programme Month 12 update

The following points were highlighted:

I. The Trust was £1.5m short of the target for the year, but a number of one-off payments as well as non-elective over-performance enabled the Trust to meet its control total. There will be a more focused approach to delivery in 2018/19.
II. Just under £8m of schemes have already been identified, of which £3m has been rated green, and another £1m rated amber.
III. A different, more financial focus is to be taken to CQUIN and procurement.

6. Timeline for strategic capital projects

i. The Trust came in slightly below expectations but no capital funding was lost as a result of this underspend.
ii. More work is being done to agree the Guaranteed Maximum Price for the Cancer Centre project.

25 May

7. Elector Biomedical Engineering (EBME) contract
   i. A 6 year EBME contract has been procured jointly with Bedford Hospital. It is expected that this will generate significant savings.
   ii. As a result of a potential legal challenge from one of the other bidders, the standstill period has been extended.

8. 2017/18 reference costs and PLICS submissions
   There is a gradual move away from reference costs to patient level information with the Trust submitting both returns this year.
   PLICS will provide more detailed costing information, which will allow for better comparison to other trusts.

9. Risks highlighted during meeting for consideration to CRR/BAF
   - RTT operational risk
   - Year-end revaluation
   - Potential procurement challenge

Workforce and Development Committee Summary Report

1. Introduction

The Workforce and Development Committee met on 30 April 2018. A summary of key issues discussed is provided below.

2. Workforce

2.1 Staff Story – The Chief Registrar attended to provide the staff story. He is the first holder of this post at MKUH. A diabetologist participating in the on call and medical rotation, the scheme allows him to also work on strategic projects. He had previously trained at the hospital, and he has been well supported, being able to negotiate a slight reduction in his clinical commitments to focus on other aspects of the role.

He has been encouraged to help get junior doctors more engaged while they are at the Trust, and there is now junior doctor representation on the Sepsis and Medicines Safety Committees. The recent Event in the Tent was also more relevant for doctors. He acknowledged that historically, doctors have not sought to be involved in healthcare management, but noted that this is beginning to change, as medical training has developed. There was decision about junior doctors possibly being invited to attend board committee meetings.

The Chief Registrar was optimistic about the positive impact that eCARE could have on patient CARE, nothing the extent to which staff are prepared to embrace new technology, particularly where it helps to enhance patient safety.

While the Chief Registrar acknowledged that it will take some time for the ill feeling generated as a result of the way that the junior doctor contract was introduced, he noted that the new contract had brought about improvements in job planning, for example.

2.2 National staff survey 2017 – results and action plan and Staff Friends and Family Test Q4

Results from the National Staff survey were mixed. The Trust has maintained a relatively good response rate for the survey, and overall, staff would recommend the hospital. There have also been improvements in some functional results within the survey. Nevertheless, it was acknowledged that there has been no tangible improvement in the overall engagement of staff despite the efforts that have been made in the last year. MKUH remains “middle of the pack” on staff engagement among acute hospitals. It was acknowledged that improving staff engagement was a pre-requisite for becoming an outstanding hospital. Worryingly, it was noted that the Trust is an outlier with regard to the number of staff experiencing violence. The Committee were clear that they wanted to see an improvement in the level of staff engagement, and asked that this should be discussed at the next Board Development session. It was felt that a different approach to that adopted following previous surveys would be necessary. The results of local engagement activities across the divisions are to be shared with this Committee.

It was noted that this year's Event in the Tent is to focus on staff health and wellbeing and it was agreed that this would be an opportunity to review what has changed over the last year to help inform the workforce strategy that is being drafted.

2.3 **Workforce Information Quarterly Report** – The number of staff in post has increased by 150 posts, with the highest growth in scientific and technical posts, allied health professionals and medical and dental. There has been a slight reduction in the vacancy rate. The Trust is involved in an NHS Improvement programme to help improve retention. Statutory and mandatory training is reported at 90% and appraisals at 86%; the introduction of eCARE has had an impact on this.

2.4 **Agency controls and usage** – The ceiling for 2018/19 is expected to be similar to 2017/18, and the Trust expects to achieve this.

2.5 **Staff health and wellbeing report** – The full CQUIN for health and wellbeing was not achieved in 2017/18, despite significant improvements in year – an action plan is now in place. The Trust once again met the flu campaign target, but the suggestion of moving to compulsory injections was not considered a good idea. A two day mental health first aid course has been introduced and has generated a significant amount of interest.

2.6 **We Care update** – The introduction of eCARE has been a very good opportunity to embed good values and behaviours within staff groups. This has fostered a proactive approach to highlighting and resolving. Long service awards are to be presented on day 2 of Event in the Tent.

3. Education

3.1 **Apprenticeships update –** Although there is an interest in apprenticeships, most training providers are still developing their programmes. The Trust aims to spend as much of the levy as possible, but there are some barriers, including the requirement release the apprentice for 20% of the time for off-the-job training.

3.2 **Education Update** – Work continues to be done with local schools, particularly at years 9 and 11. The coaching service continues to grow, with 7 active coaches in place and another 6 coming through by the end of the year. The Trust has submitted expressions of interest for placements on the NHS Graduate Management Scheme.

3.3 **Medical Education update –** Cardiology trainee posts have now been reinstated. A number of training and development opportunities for consultants and medical leaders have been well received.

4.1 Board Assurance Framework –

- Risk 8.1 – the target risk score of 6 is to be increased to 12 to reflect the difficulties around nurse retention and overseas doctor recruitment

4.2 Workforce Risk Register – Three more risks are to be added this register – eCARE training and readiness, gender pay gap and education funding.

The Board is asked to note the summary report.

Charitable Funds Committee Summary Report

1. Introduction

The Charitable Funds Committee met on 4 May 2018.

2. Key matters

The following items were presented to the Committee:

Matters arising –

- Steps are being taken to obtain separate public and trustees' liability insurance for the charity. Work is also continuing on overhauling the charity's governance arrangements.

Charitable Fund requests

- A bid was received from the Women's and Children's division for additional specialised physiotherapy support for the neonatal unit. This is to cover an additional 4 hours a week as well as staff training to provide support and advice to parents on the therapeutic handling of babies so as to prevent developmental delays later. The Committee expressed their support for the bid, but noted that the charity's objectives do not currently allow for employment costs to be funded.
- A further funding request, also from Women's and Children's was received. This was to fund a play therapist to help keep children occupied and distracted before surgery. Again, while the Committee agreed that this is a good initiative, they were unable to approve the bid as it contravenes the charity's objectives. It was agreed that these will be reviewed in due course. It was also noted that both bids would make good subjects for fundraising.

Charitable Funds Finance Report

- The charity's running costs for 2018/19 include additional costs around the cancer centre appeal. A detailed forecast of these costs is to be provided at the next meeting. Further discussions are to be held as to how the cancer centre appeal is to be administered in the short to medium term.
- There was a discussion as to whether charitable funds should be withheld temporarily, but it was agreed that this would be very unpopular among fundholders.

Other business

- A question was raised about fundraising opportunities in the Main Entrance. The lease agreement will be checked to ascertain what activities could be hosted there.

3. Risks highlighted during the meeting for consideration on BAF/SRR

None