Board of Directors

Public Meeting Agenda

Meeting to be held at 10.00 am on Friday 11 January 2019 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 9 November 2019	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 November 2018	Receive	Pages 17-22	Chairman
2.2	Chairman's Report	Receive and Discuss	Verbal	Chairman
2.3	Chief Executive's Report	Receive and discuss	Verbal	Chief Executive
2.4	Sustainability and Transformation Partnership	Note	Verbal	Chief Executive
3. Quality				
3.1	Patient Story	Receive and Discuss	Presentation	Director of Patient Care and Chief Nurse
3.2	Nursing staffing update	Receive and Discuss	Pages 23-34	Director of Patient Care and Chief Nurse
3.3	Mortality update report	Receive and Discuss	Pages 35-44	Medical Director
3.4	Safety of Nasogastric Feeding	Note	Pages 45-52	Medical Director
4. Performance and Finance				
4.1	Performance report Month 8	Note	Pages 53-66	Deputy Chief Executive
4.2	Finance update report Month 8	Receive and Discuss	Pages 67-74	Director of Finance
4.3	Workforce update report Month 8	Receive and Discuss	Pages 75-78	Director of Workforce
5. Governance				
5.1	Freedom to Speak Up Framework	Receive and Discuss	Pages 79-102	Director of Workforce
5.2	Fit and Proper Person Test Policy	Note	Pages 103-132	Director of Workforce

Item No.	Title	Purpose	Type and Ref.	Lead
5.3	Amended Board Committee Terms of Reference	Note	Pages 133-160	Director of Corporate Affairs
6. Assurance and Statutory Items				
6.1	Board Assurance Framework	Receive and Discuss	Pages 161-168	Director of Corporate Affairs
6.2	Use of Trust Seal	Note	Pages 169-170	Director of Corporate Affairs
6.3	(Summary Report) Audit Committee – 13 December 2018	Note	Pages 171-172	Chair of Committee
6.4	(Summary Report) Finance and Investment Committee – 5 November 2018	Note	Pages 173-174	Chair of Committee
6.5	(Summary Report) Quality and Clinical Risk Committee – 29 October 2018	Note	Pages 175-176	Chair of Committee
6.6	(Summary Report) Workforce and Development Assurance Committee – 5 November 2018	Note	Pages 177-180	Chair of Committee
6.7	(Summary Report) Charitable Funds Committee – 5 November 2018	Note	Pages 181-182	Chair of Committee
7. Administration and closing				
7.1	Questions from Members of the Public	Receive and Respond	Verbal	Chairman
7.2	Motion to Close the Meeting	Receive	Verbal	Chairman
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 business: *"That representatives of the press and members of the public be excluded from the remainder of this meeting having regard to*	Chairman

Item No.	Title	Purpose	Type and Ref.	Lead
			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 9 November 2018 in Room 6, Postgraduate Centre, Milton Keynes University Hospital

Present:

Robert Green	Vice 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
Caroline Hutton	Director of Clinical Services
Mike Keech	Director of Finance
Lisa Knight	Director of Patient Care and Chief Nurse
Tony Nolan	Non-executive Director (Chair of Workforce and Development Assurance Committee)
Danielle Petch	Director of Workforce
Ian Reckless	Medical Director
Heidi Travis	Non-executive Director (Chair of Finance and Investment Committee)

In Attendance:

Kate Jarman	Director of Corporate Affairs
Ade Kadiri	Company Secretary
Karen Rice	Neonatal Unit Manager (item 3.1)
Kate Swailes	Neonatal Lead Nurse (item 3.1)

2018/11/01	**Welcome**
1.1	The Chairman welcomed all present to the meeting.
2018/11/02	**Apologies**
2.1	Apologies for this meeting were received from Simon Lloyd and Helen Smart.
2018/11/03	**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.
2018/11/04	**Minutes of the meeting held on 7 September 2018**

4.1	The minutes of the public Board meeting held on 7 September 2018 were accepted as an accurate record of that meeting, with the exception that the comment at paragraph 14.8 on the experience of A&E patients is to be removed.
2018/11/05	**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>359 Performance Report Month 4</u> Andrew Blakeman and the Deputy Chief Executive have discussed the issue and shared some helpful ideas about how to alert the Board that confidence levels are outside the normal boundaries. Closed.
2018/11/06	**Chairman's Report**
6.1	There was no update from the Vice Chairman.
2018/11/07	**Chief Executive's Report**
7.1	The Chief Executive informed the Board of the "signing the steel" event that had taken place in relation to the cancer centre development. A number of major donors had been in attendance and the event was positively received. One of the local radio stations had covered the event. The Board stressed the importance of maintaining the momentum of the appeal.
7.2	The staff awards ceremony is taking place today. This will be the largest ever such event for the Trust with the highest number of nominations.
7.3	66% of staff have now been vaccinated for the flu, well ahead of where the Trust was at the same time last year.
7.4	The Trust will be running a series of events to commemorate Remembrance Sunday. **Resolved**: The Board **noted** the Chief Executive's Report.
2018/11/08	**Sustainability and Transformation Partnership**
8.1	The Chief Executive reported that discussions are ongoing as to whether the Milton Keynes system stays within the BLMK STP or joins Buckinghamshire, Oxfordshire and Berkshire West (BOB). A formal process for reaching the decision is to be communicated by letter today. Milton Keynes Council is now more persuaded of the benefits and clinical synergies of moving to BOB. In response to a question as to how long the process will take, the Chief Executive indicated the expectation that the issue would be resolved before the end of this calendar year. The support of the CCG and the Council would be important to the decision making.

8.2	The Chief Nurse raised a question about the MK Place work, and in response, the Chief Executive made the point that the decision around BLMK/BOB will influence its development. However, cognisance would need to be taken of the intention to centralise the commissioning function in BLMK. The future provision of community services within MK is also up for consideration in conjunction with the Council. **Resolved**: The Board **noted** the Sustainability and Transformation Partnership update.
2018/11/09	**Patient's Story**
9.1	Karen Rice, the neonatal unit manager, and Kate Swailes attended to demonstrate some new technology being used on the unit in the form of an app that enables families to retain contact with their babies while they are still being cared for, thereby helping to improve the patient and family experience. The Board were shown a clip of baby Oakley whose patents' consent had been obtained.
9.2	Ms Rice set out the background to the development of the system, stating that in an attempt to give patients more electronic access to their babies, the unit had initially relied on FaceTime, but this had raised confidentiality issues. An alternative was therefore required, and contact was made with the charity Emily Star which agreed to fund the introduction of the vCreate app, making MKUH the first hospital within the Thames Valley area to introduce it. The app is available for the use of all NNU parents and they are able to keep the videos as a permanent record of their babies' first few weeks. The local BBC was in attendance when the app was launched. As a result of Emily's Star's sponsorship, there is no cost for the introduction of the technology to the Trust.
9.3	The Board recorded their thanks to the charity for their support in providing this amazing service for parents at such an emotional time. **Resolved**: The Board resolved to **note** the Patient's Story.
2018/11/10	**Nursing staffing report**
10.1	The Director of Patient Care and Chief Nurse presented this report. She made reference to the new Safer Care Nursing Tool which had been run on every ward in the hospital for the first time in September over a 20 day period. The audit has been carried out 4 times and as the Trust now has 4 years of data, the tool is more useful in helping to determine what the nursing establishment should be. However, the SCNT does not capture assessment units – a separate tool is being developed for them.
10.2	With regard to ward 5, it was noted that the SCNT has developed a new tool for paediatrics, and it tends to take wards a few attempts to understand the data. It was also noted that the tool indicates that ward 8 has 7 nurses too many – the Chief Nurse confirmed that this is not the case. She stated that the position regarding the other wards is just about right.
10.3	The Director of Finance noted the trend towards a reduction in the establishment as

	the years have passed. The Chief Nurse acknowledged this, but made the point that levels of dependency have tended to fluctuate.
10.4	The Chief Nurse informed the board that levels of recruitment and vacancies continue to move in the right direction, and the overall vacancy rate will fall to 10%. With regard to student recruitment, it was confirmed that the September intake has provided the Trust with most of its nursing requirements, but that only 6 student midwives were recruited. The universities are confident that this shortfall will be made up in the March intake. The Chief Nurse explained that on average the Trust takes in 20 student midwives each year and should have had 10 in September. As to what this would mean down the line, the Chief Nurse explained that there would only be 15 qualified midwives rather than 20 when they graduate, and the shortfall would have to be made up through open recruitment which is more difficult.
10.5	The Board were informed that the 2nd cohort of 28 nursing associate apprentices have started their training – 20 for the Trust and 8 for CNWL. The 1st cohort are due to qualify in March. National guidance has now been received as to how to fit them into nursing posts, and this will be brought back to the next Board meeting. **Action: Chief Nurse**
10.6	In terms of the colour of their uniforms, nursing associate apprentices will wear white with orange piping, but it is not yet clear what they will wear once they qualify. It was also noted that two of the current apprentices have been shortlisted for the student of the year award. The Chief Nurse acknowledged that as a group, the apprentices, who are all current trust employees, have brought much energy to their training. In response to a question from Parmjit Dhanda as to whether there is any tension surrounding the role, the Chief Nurse explained that the tension mainly exists at national level as the academic nursing community is concerned that the introduction of the nursing associate role has had the effect of downgrading nursing. For this Trust, the nursing associates will help to fill the gaps in hard to fill areas.
10.7	In the course of a discussion about other possible routes into nursing, Andrew Blakeman raised the question whether the Trust could use its apprenticeship levy for this purpose. The Chief Nurse referenced the complexity of the education climate, and explained that following discussions at the Nursing and Midwifery Board, the Trust had decided to focus on the nursing associate role in the short term while other options are evaluated. Parmjit Dhanda acknowledged the point about the current complexities, but asked that the use of the apprenticeship levy be kept under consideration. The Director of Finance offered to assess the cost benefit implications.
10.8	The Chief Nurse indicated that more Filipino nurses are joining the Trust as part of the original recruitment exercise – 3 have just arrived and another 3 are expected. The main issue continues to be getting them through their English tests.
10.9	In response to a question from Bob Green about ward refurbishment, the Chief Executive made the point that compared to other hospitals, MKUH has a relatively low maintenance backlog. Ward 2 has now been refurbished, but ward 7 has yet to be done. The problem is that the Trust does not have decant wards and is therefore carrying out the refurbishment on a bay by bay basis. Common areas are harder to get to as this needs the ward to be empty, and there had not been enough of a lull

	over summer. However enough work has been done such that this is not an issue, and the Trust is able to keep on top of it. **Resolved**: The Board resolved to **note** the nursing staffing report.
2018/11/11	**Mortality update report**
11.1	The Medical Director presented this routine report setting out the Trust's current position on mortality. He made reference to the latest HSMR figure, which indicates that the Trust is within the "lower than expected" range. There is one significant outlier – 'other perinatal conditions', but this is likely to be a coding issue and is being investigated.
11.2	The Medical Director also drew the Board's attention to the qualitative reviews of death. He is concerned that for Q2 of 2018/19 it had been determined that there were no avoidable deaths. He takes the view that this means that the team may not have been looking hard enough. If this trend continues, the whole process would need to be revisited. **Resolved**: The Board resolved to **note** the mortality update report.
2018/11/12	**Patient Experience Strategy Development Update**
12.1	The Director of Corporate Affairs provided this update on the work being done to develop a patient experience strategy. A full strategy document will be brought back to the Board in January 2019.
12.2	In response to a question as to how the strategy would be funded, the Chief Executive explained that the Trust is about to go through the planning round for 2019/20, and any funding requirement would need to be cross referenced to risk. He noted that the majority of complaints from patients are to do with communication, and highlighted the need to embed patient experience within job descriptions.
12.3	The point was made that the Trust has known for some time that its scores on the Friends and Family Test have tended to be more positive than for the Patients' Survey. While there may be reasons for this, it was noted that all other trusts use the same methodology. In response to a question from Tony Nolan about the main priority for action, the Chief Executive stressed that customer care training is essential, but he acknowledged that the issues around communication would be the most difficult to address. **Resolved**: The Board resolved to **approve** the direction of the proposed patient experience strategy
2018/11/13	**Performance Report Month 6**
13.1	The Deputy Chief Executive introduced this routine report and highlighted the following points:

	• The Trust's RTT performance is at 86.9%, confirming the continuation of the journey towards improvement. • However, there are 24 patients who have been waiting 52 weeks for treatment. This is an alarming figure and there is much focus and effort on addressing this. It is expected that the number would have fallen to the low to mid teens by the time next month's figures are presented. • A&E performance has been difficult. The Trust achieved 91% for the month which is lower than the Trust's NHS Improvement trajectory, and also lower than the performance at the same time last year. The point was made that there are significant financial benefits to doing better than last year. • Cancer targets were achieved in Q2, but Q3 has got off to a difficult start. • Moving into winter, delayed discharges are low. However, there are 107 "super- stranded" patients in the hospital, and it would be important to reduce this figure. Bed occupancy and re-admission rates are going up.
13.2	Heidi Travis enquired as to what had changed with regard to the 52 week waits, and in response, the director of Clinical Services indicated that in August and September a number of patients had exercised their choice to delay treatment, but more recently the Trust has introduced a new access policy which limits the extent to which such choice can be exercised. The Trust also has a revised overall plan which focuses on detailed management of patients within this category. The forward plan appears more positive and work is being done further down the waiting list to address delays at an earlier point.
13.3	The Chief Executive made the point that the Trust is going in the right direction with regard to 52 week waits compared to much of the rest of the country. The Board reiterated its commitment to reducing the number to 0 as having patients waiting 52 weeks for treatment is unacceptable.
13.4	John Clapham raised a question about NICE breaches. In response, the Medical Director explained that NICE issues a large amount of information of various categories, including technology appraisals and quality guidelines, and the required response to each varies. The definition 'NICE breach' is an internal one for the Trust. It was noted that many of the breaches relate to the Medicine division, and a new clinical governance coordinator has just been appointed to support them. **Resolved**: The Board resolved to note the Month 6 Performance Report.
2018/11/14	**Finance Report Month 6**
14.1	The Director of Finance presented this regular report. He highlighted the following points: • The Trust met its control total for month 6 and achieved all of the financial PSF. • It is expected that pay will continue to rise as the Trust has not been fully compensated for the Agenda for Change pay rises. • The Trust will receive the part of performance PSF relating to A&E performance for the quarter as a result of a rule change meaning that the year to date performance is taken into account. The same rule will be used in

	assessing Q3 performance, but for Q4 the Trust would need to achieve 95% and the level of funding at that stage is significantly higher. • The Trust's agency spend is now below 6.5% of overall pay spend. This was previously 12%, even with bank staffing. • The transformation programme is still £2m short of the £10.1m target, although £9.3m has been identified. The rate of identification and validation of schemes needs to be accelerated.
14.2	Parmjit Dhanda enquired as to where the Trust sat on the league table of agency spending. The Director of Finance explained that it would not be possible to give an accurate figure, but he made the point that the Trust is now doing better than most of its neighbouring trusts. **Resolved**: The Board **noted** the month 6 Finance Report.
2018/11/15	**Workforce Report month 6**
15.1	The Director of Workforce presented this report and highlighted the following: • The Trust's headcount continues to rise, but vacancy rates for medical and dental and nursing and midwifery are at 18% and 17.6% respectively. • The use of temporary staffing continues to move in the right direction. • The sickness absence rate remains slightly above 4%. The new sickness absence policy was launched recently, but there is recognition of the potential impact of winter. Under-reporting of the reasons for absence remains an issue, but it is hoped that the new process introduced by the policy will help to address this. • The turnover rate has fallen, in part as a consequence of the retention programme with NHS Improvement. • Statutory and mandatory training compliance has fallen by 1%. All staff will shortly receive letters explaining the link that has now been established between compliance in this area and movement through the Agenda for Change incremental steps. The training and development team have anticipated the additional activity that this new rule will introduce. It was confirmed that long term sickness would be taken into account in the event of non-compliance. • Appraisal compliance is 5% short of the target. Again, it is expected that the new pay deal will help to improve this rate.
15.2	In response to a question from Andrew Blakeman as to how members of Management Board score on statutory and mandatory training, the Chief Executive confirmed that this is taken seriously by all senior managers, and that the executive team is at full compliance. **Resolved:** The Board **noted** the Month 6 Workforce Report.
2018/11/16	**Introduction to the UK Corporate Governance Code 2018**
16.1	The Director of Corporate Affairs introduced this item for noting, informing the Board that as Monitor's Foundation Trust Code of Governance is based on the UK Code, it

	is likely that the former will shortly be updated to take account of the changes to that document. She highlighted some of the main changes introduced by the new Code, including an added focus on board development and wider stakeholder engagement. On the issue of board development, there was agreement that consideration needs to be given to more productive use of the 6 development sessions during the year. **Resolved**: The Board **noted** the introduction to the UK Corporate Governance Code 2018
2018/11/17	**Board Assurance Framework**
17.1	The Director of Corporate Affairs presented the latest iteration of the BAF. She informed the Board that the risks relating to eCare have been updated.
17.2	Bob Green reiterated the point that had been made at Audit Committee, that there needs to be a renewed focus on getting the scores down. The Board agreed that all the risk owners should have action plans to achieve this. He also informed the Board that the Committee had had sight of the updated risk management framework which will be presented to the Board following consideration by Management Board.
17.3	It was noted that the oversight of risk 9-1 around the neonatal unit is to be transferred to the Quality and Clinical Risk Committee from Finance and Investment.
17.4	Tony Nolan questioned whether the rating of risk 5-2 around the failure to adequately safeguard against cyber-attacks is high enough at 9. In response, the Deputy Chief Executive made reference to the effectiveness of the measures that have been put in place to mitigate against the risk. He also informed the Board of NHS Digital's intention to visit the Trust to speak to the Board about this subject.
17.5	The Chief Executive stressed the need for the Board to focus on the highest rated risks. It was noted that risk 7-1 around agency staffing is to be taken off the BAF. **Resolved**: The Board **noted** the contents of the Board Assurance Framework.
2018/11/18	**Terms of Reference Review**
18.1	The Director of Corporate Affairs introduced the annual review of the terms of reference of the Board and its Committees.
18.2	With regard to the Board's terms, the question was raised in relation to meeting frequency as to the necessity for private sessions in between all public meetings. It was noted that there is now a tendency to hold private Board meetings on those dates, when in fact those sessions should be devoted principally to development. Andrew Blakeman also referenced conversations that he had had with the Chairman about holding fewer meetings. The Chief Executive made the point, in the context of an organisation that is in financial deficit, that the Board should be seen to be providing appropriate scrutiny to those areas of risk. It was agreed that paragraph 8.1 would be re-drafted to indicate that the Board will meet in public 6 times during the year, and once in private to sign off the annual report and accounts. Private

	meetings will then take place as required. Paragraph 8.2 is to be deleted.
18.3	With regard to the Audit Committee, it was agreed that the Medical Director would be removed from the membership, but he may be invited to attend on occasion. The appendices to the Finance and Investment Committee terms of reference are to be amended to reflect the updated Standing Financial Instructions.
18.4	The Chief Nurse commented on the apparent lack of transparency, as far as front line staff are concerned, about the criteria for applying for charitable funding. Parmjit Dhanda in response stressed the need for the charity's objectives to be defined through the Committee's terms of reference and indicated that these will be reconsidered at the Committee's next meeting, in light of advice that has been received on the subject.
18.5	The Board agreed that the duty to maintain oversight of the work of the University of Buckingham Medical School, which had been removed from the Workforce and Development Assurance Committee's terms of reference, should be restored. **Resolved**: The Board **approved** the changes to the terms of reference of the Board and its Committees, subject to the inclusion of the further amendments that had been agreed
2018/11/19	**Board Register of Interests**
19.1	The Director of Corporate Affairs presented the updated Board Register of Interests for noting in advance of publication on the Trust website. She asked any that any amendments to the register be forwarded to the Trust Secretary. **Resolved**: The Board **noted** the updated Register of Interests
2018/11/20	**Use of the Trust Seal**
20.1	The Director of Corporate Affairs confirmed that the Trust Seal had been used in relation to the settlement of the grant agreement between the Trust and Milton Keynes Council. **Resolved**: The Board **noted** the use of the Trust Seal.
2018/11/21	**Management Board upwards report**
21.1	The Board **noted** the Chief Executive's upwards report from the Management Board meeting of 3 October 2018.
2018/11/22	**Board Committee summary reports**
22.1	The Board noted the contents of the summary reports of recent Board Committee meetings as follows: • Audit Committee meeting held on 29 October 2018 • Finance and Investment Committee meetings held on 3 September and 1

	October 2018 • Quality and Clinical Risk Committee meeting held on 29 October 2018.
2018/11/23	**Questions from members of the public**
23.1	There were no questions from members of the public
2018/11/24	**Any other business**
24.1	There was no other business.

	All					**Action log – All items**				
	Public/ Private	**Action item**	**Mtg date**	**Agenda item**		**Action**	**Owner**	**Due date**	**Status**	**Comments/Update**
Board of Directors	Public	359	7 Sept 2018	14.5	Performance Report Month 4	Clarification to be provided as to why the upper and lower control limits within the report have not all been set at SD3	John Blakesley	2 Nov 2018	Closed	Helpful ideas have been shared as to how to alert the Board that confidence levels are outside the normal boundaries
Board of Directors	Public	360	9 Nov 2018	10.5	Nursing staffing report	The national guidance on how to fit nursing associates into nursing posts is to be presented at the next Board meeting	Lisa Knight	11 Jan 2019	Closing	Included within paper 3.2

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 2.30pm on Thursday 22nd November 2018, in the Conference Room in the new Academic Centre

Present:
Simon Lloyd - Chairman

Public Constituency Members:
Alan Hancock (AHa)
Alan Hastings (AH)
Peter Skingley (PS)
Akin Soetan (AS)
Barry Linton (BL)
Clive Darnell (CD)

Appointed Members:
Andrew Buckley(AB) - Milton Keynes Council

Staff Constituency Members:
Michaela Tait (MT)
Kim Weston (KW)

Executive Directors
Danielle Petch (DP) - Director of Workforce
Daphne Thomas (DT) - Deputy Director of Finance

Non-Executive Directors
Helen Smart (HS)
Heidi Travis (HT)
Parmjit Dhanda (PD)

Sofia Gallo - Executive Assistant

1.	**WELCOME & ANNOUNCEMENTS**
	The Chairman extended a warm welcome to everyone present at the meeting.
1.1	**APOLOGIES**
	Apologies for absence were received from
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 11 September 2018.** The draft minutes of the meeting held on the 11 September were considered. **Resolved: That the draft minutes of the meeting held on the 11 September 2018 be agreed, noting that Helen Smart had given her apologies for that meeting.**
(b)	**MATTERS ARISING / ACTION LOG**
2	**CHAIRMAN AND CHIEF EXECUTIVE REPORTS**
(a)	**Chairman's Report**
	The Chairman gave an update on the inquest currently taking place into the death of the lady who fell from the top of the multi-storey car park. It was noted that much of the proceedings had been focused on the management of mental health. The inquest is scheduled to conclude tomorrow. There will clearly be lessons to be learned and these will be disseminated across the system. Update on the Cancer Centre. The construction work has started. A couple of weeks ago a 'Sign the Steel' event was held, during which a number of key local partners and stakeholders signed a steel beam that will eventually become a part of the structure. The Chairman also announced the appointment of a Patron for the Cancer Centre appeal, who will support activities to raise funds. The identity of the Patron will be announced publicly in due course. The campaign "Be Seen in Green" has also been launched the Garfield Weston Foundation has made a donation of £200k. The Big Give Christmas challenge will start on 27 November and run for a week. Everyone is welcome to visit the Big Give website and donate. The minimum donation is £5 and the Big Give company will match the total amount raised. The Chairman agreed to check whether it is possible to donate via PayPal and get back to AHa. It was noted that the Trust's policy around the use of charitable funds is being revised with a view to simplifying accessibility. The Chairman has been appointed a trustee of Arts for Health having taken over from John Blakesley. The Chairman attended the NHSI regional meeting on 24 October which focused mainly on improving the CQC assessment process specifically in relation to GP access and mental health, as well as making Well Led more consistent and transparent. NED recruitment – A meeting was held on Tuesday to shortlist those applicants who are to be appointed for interview. There were 17 applicants in total, many with NHS and/or NED experience. The 5 who have been shortlisted will be interviewed on 12 December. **Resolved: That the Chairman's report be received and accepted.**
3.	**Sustainability and Transformation Partnership (STP)**
	AHa enquired about the decision making as to whether the Milton Keynes system stays within BLMK. The Chairman confirmed that the process is ongoing, but was unable to

	provide a timeframe within which a decision would be reached. **<u>Resolved:</u> That the Sustainability and Transformation Partnership update be received.**
4.	**Update on Estate Development**
	The Chairman's update included: • Cancer Centre – construction work is ongoing; • The remedial work on the older multi-storey car park is continuing, with some drilling to take place to check its foundations; • DP gave an initial presentation of the New Pathway Unit currently in discussion. This will be aimed at patients who do not necessarily require A&E attendance or admission. The unit will incorporate several specialties, and JB will be writing a proposal in due course. AH made the point involving the patients at an early stage would be beneficial. A query was also raised as to whether GP referrals are tracked. DP agreed to check with the Director of Clinical Services whether this is currently done. **Action: Director of Workforce** **<u>Resolved:</u> That the Update on Estate Development be received.**
4.1	**(Summary Report from) Finance and Investment Committee 3 September and 1 October 2018**
	Heidi Travis presented the summary report for the Finance and Investment Committee meetings held on 25 June and 6 August 2018. She highlighted the focus on supporting the organisation to achieve the further £2m worth of savings required to meet its CIP target for the year. **<u>Resolved</u> That the Summary Report from) Finance and Investment Committee 3 September and 1 October 2018 be received**
4.2	**(Summary Report from) Audit Committee 29 October 2018**
	Bob Green not present. The report taken as read. **<u>Resolved:</u> That the Summary Report from the Audit Committee 29 October 2018 be received.**
4.3	**(Summary Report from) the Quality and Clinical Risk Committee 29 October 2018**
	The written report for the Quality and Clinical Risk Committee meeting held on 29 October 2018 was received and considered. In the course of the discussion the following issues were highlighted: • Changes are to be made to the way that pressure ulcers are measured and recorded; • Proposals are to be put forward for the development of robotic surgery within the Trust. The governors asked to be kept updated on progress; • HS commented favourably on her attendance at the Serious Incident Review Group, noting how the Trust positively challenges and supports members of staff involved in incidents.

	<u>Resolved:</u> That the Summary Report from the Quality and Clinical Risk Committee 29 October 2018 be received
4.4	**Summary Report from Management Board 3 October 2018**
	DP presented the report, and gave an update on the current state of the flu vaccination programme – the Trust's position is better than it was at the same time last year. The target is 75% which looks achievable. With regard to the staff survey, the Trust is taking a number of steps to help secure a higher response rate than last year, including providing incentives. There was discussion around the Freedom to Speak Up agenda. The next stage in this process is the appointment of Ambassadors from across the organisation who would be able to more readily support colleagues wishing to raise a concern. With regard to eCare, governors questioned whether a safety alert could be integrated into the system. DP agreed to check this with the Director Clinical Services, and also in relation to a question raised about incident reporting – whether Datix could be integrated into eCARE. **Action: Director of Workforce** **<u>Resolved:</u> That the Summary Report from Management Board 3 October 2018 be received**
5.1	**Healthwatch Milton Keynes Update**
	The written update from Healthwatch Milton Keynes was received and considered. **<u>Resolved:</u> That the Healthwatch Milton Keynes Update be noted**
5.2	**Engagement Group Update**
	The written update from the Engagement Group Update was received and considered. **<u>Resolved:</u> That the Engagement Group Update be noted**
6.1	**Integrated Performance Report Month 6**
	The Integrated Performance Report for Month 6 was received and considered. **<u>Resolved:</u> That the Integrated Performance Report Month 6 be received**
6.2	**Finance Report Month 6**
	The Deputy Director of Finance presented the Finance Report for Month 6. **<u>Resolved:</u> That the Finance Report Month 4 be received.**
7.1	**Motions and Questions from Council of Governors**
	There was none.
7.6	**Any other Business**
	The Chairman announced that he had received a letter from NHS Improvement praising the Trust on its performance and track record on Infection Prevention and Control. HS mentioned her recent '15 steps' visit to Ward 3 and reflected on what was a very positive experience.

7.3	**Date and Time of next meeting** The next scheduled informal meeting is on 12 December, but this would need to be re-scheduled as a result of the NED interviews. A new date will be announced in due course.

Sofia Gallo
Interim Executive Assistant
22 November 2018

Meeting title	Board Of Directors			**Date:** 11 January 2019	
Report title:	Nursing Staffing Report			**Agenda item: 3.2**	
Lead director **Report author Sponsor(s)**	**Name:** Lisa Knight **Name:** Matthew Sandham			**Title:** Director of Patient Care/Chief Nurse **Title:** Associate Chief Nurse	
FoI status:					
Report summary					
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [x]	**Decision** [ ]	
Recommendation	That the Board receive the Nursing Staffing Report.				

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

Report history	To every Public Board
Next steps	
Appendices	Appendices 1 and 2

Board of Directors Report on Nursing and Midwifery staffing levels Amalgamated report for October and November 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
October	14099	5.1	3.5	8.6
November	13710	5.2	3.4	8.5

Hospital Monthly Average Fill Rates for October 2018 and November 2018

Month	RN/RM Day % Fill Rate	HCA/MCA Day % Fill Rate	RN/RM Night % Fill Rate	HCA/MCA Night % Fill Rate
October	84.9%	114.9%	99.6%	139.2%
November	85.8%	103.0%	98.1%	137.7%

A Ward by Ward breakdown of fill rates for the two months has been included in the Appendix 1.

The CHPPD hours have remained static over the past two months.

3. Areas with notable fill rates

Wards 2 and 15 remain with a high fill rate on nights and review of enhanced observers will need to be under taken in the next two months.

4. Nursing Associate

The nursing associate (NA) role is designed to bridge the skills gap between the health care support worker and more senior registered professional and provide a new route into the registered nurse (RN) pathway. The more senior registered professional will continue to be the primary assessors and prescribers of care while NAs deliver and adapt care, contributing to assessment within agreed parameters. NA's have gained a Foundation Degree of higher education. NA's are a new profession, accountable for their practice and due for deployment in early April 2019. They are registered with the Nursing, Midwifery Council.
The National Quality Board guidance "An improvement resource for the deployment of nursing associates in secondary care" is the tool we have used to ensure safe deployment of NA's. Jobs on wards 3,14,18,19, (elderly care and rehab) outpatients, theatres, endoscopy and the emergency department has been agreed with the ward managers. Please see the completed tool below and a quality impact assessment is also completed in Appendix 2.

No.	Question	Action
1	Use an evidence-informed decision-support tool triangulated with professional judgement and comparison with relevant peers before deployment.	Deployment has been agreed by the Chief Nurse following the review of the following information. • Monthly CHPPD • Quarterly department performance meetings • Chief Nurses professional judgement
2	Discuss the deployment of NA's with wider senior registered multi-professional team.	NA's role has been discussed and agreed at Nursing, Midwifery and Allied Health professionals board meeting.
3	Consider safer staffing requirements and workforce productivity as an integral part of the deployment process.	A full review of all departments using the Shelford Group nursing acuity tool "Safer Nursing Care Tool" has been undertaken in September 2018, prior to deployment of NA's
4	Use a local dashboard to assure stakeholders about safe and sustainable staffing. The dashboard should include quality indicators to support decision-making.	All clinical departments record monthly safer staffing figures and CHPPD and nursing fill rates. Quality indicators are displayed on the department metrics and are triangulated and monitored at quartile department performance meetings.
5	Ensure that the organisation is familiarised with NMC standards of proficiency and with individual nursing associate competencies.	Prior to placement of the NA's the ward managers will be met with by the practice development team to ensure the clinical team have a clear understanding of the NMC standards and the competencies of each NA.
6	Ensure there is an appropriate escalation process in cases where issues arise as result of deployment.	All NA,s will be supported with 1 years preceptorship and will have clinical supervision supported by the practice development team.
7	Investigate staffing-related incidents, the impact on staff and patients and ensure action and feedback.	Staffing incidents will be investigated via the datix system and monitored through Workforce Board.
8	Develop guidelines to ensure that existing staff are aware of the rationale for deployment, the risks and benefits of the role, and process for escalation of concerns.	Guidelines being developed by the practice development team on the role of the NA and how to raise a concern.
9	Complete a full quality impact assessment (QIA) before there is any substantial skill mix change or deployment of a new role	Full QIA completed (Appendix 2)

5. Recruitment

Qualified Staff Vacancies

Division	wte vacancies now	% vacancy now	Post recruited to	Residual wte vacancy	Residual % vacancy
Women's & Children	25.4wte	9.5%	6wte	19.4wte	7%
Medicine	69wte	16%	21wte	49wte	11%
Surgery	34wte	12%	13wte	21wte	7.6%

Total vacancy rate for the trust for qualified nurses' once new staff in post approx. **9.1%.**

HealthCare Assistant Vacancies

Division	wte vacancies now	% vacancy now	Post recruited to	Residual wte vacancy	Residual % vacancy
Women's & Children	8wte	6%	2.14wte	5.86wte	5%
Medicine	33wte	15.7%	20wte	14wte	6%
Surgery	17wte	15%	9.4wte	7.6wte	9%

Total Trust vacancy rate for HCA once new staff in post approx.**7%**

Please note that these figures are dynamic and so are changing on a daily basis – and recruited to posts will still be subject to drop outs.
Within these figures the areas of most concern remain – operating theatres, wards 14, 15, and.20.

6. Controlling Premium Cost

Agency nursing expenditure continues to stabilise. The focus over the next 3 months is to reduce the number of agency Health Care Assistant's, and to continue work on maximising the productivity of our e roster system with planned bi-monthly "Check and challenge "meetings with the Matrons. The meeting will focus on the efficiency of the planned rota. A review of booking agency nurses/ midwives is to been untaken by Associate Chief Nurse and to be reported back to Workforce Board.

Fill rates for Nursing, Midwifery and Care Staff October 2018

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
AMU	78.8%	112.1%	103.2%	118.7%	726	5.9	2.5	8.3
MAU 2	85.6%	108.8%	103.3%	166.6%	687	3.9	3.8	7.7
Phoenix Unit	84.2%	115.8%	97.8%	130.6%	678	3.3	4.0	7.3
Ward 15	80.8%	163.4%	99.2%	183.8%	857	3.4	4.0	7.4
Ward 16	79.0%	109.5%	97.6%	132.2%	850	3.5	2.8	6.3
Ward 17	83.4%	148.6%	100.8%	156.5%	765	4.2	3.1	7.3
Ward 18	86.8%	112.2%	98.9%	150.4%	829	3.5	4.3	7.8
Ward 19	77.5%	120.4%	94.9%	167.7%	874	2.9	4.4	7.3
Ward 20	79.8%	128.3%	101.7%	128.8%	758	4.0	3.3	7.3
Ward 21	80.5%	89.5%	100.0%	129.5%	686	3.7	2.4	6.2
Ward 22	88.6%	131.3%	100.6%	150.0%	625	4.1	3.5	7.6
Ward 23	86.4%	146.1%	102.4%	136.3%	1063	3.7	4.5	8.3
Ward 24	88.9%	99.0%	96.8%	-	509	4.6	1.1	5.8
Ward 3	90.4%	98.8%	98.9%	124.7%	837	3.3	3.6	6.9
Ward 5	78.1%	77.6%	113.4%	89.6%	562	6.7	1.5	8.2
Ward 7	86.6%	111.4%	104.8%	130.3%	719	3.8	4.6	8.4
Ward 8	82.2%	115.4%	104.3%	146.6%	735	3.7	3.5	7.2
DOCC	86.4%	97.5%	86.2%	-	188	26.7	2.2	28.9
Labour Ward								
Ward 9	78.1%	77.4%	91.6%	93.5%	795	3.6	0.8	4.4
Ward 10	96.8%	93.5%	109.7%	-	264	6.1	2.8	9.0
NNU	98.2%	75.7%	103.9%	109.7%	92	40.4	7.6	48.0

Fill rates for Nursing, Midwifery and Care Staff November 2018

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
AMU	86.4%	106.6%	103.2%	118.7%	698	5.5	2.5	8.0
MAU 2	92.0%	118.5%	103.3%	166.6%	780	3.6	3.5	7.1
Phoenix Unit	88.0%	111.7%	97.8%	130.6%	691	3.4	3.8	7.2
Ward 15	95.8%	111.5%	99.2%	183.8%	812	4.0	3.4	7.4
Ward 16	77.9%	109.5%	97.6%	132.2%	861	3.3	2.7	6.1
Ward 17	82.4%	121.1%	100.8%	156.5%	739	4.5	2.9	7.4
Ward 18	87.4%	102.3%	98.9%	150.4%	806	3.4	4.2	7.6
Ward 19	83.4%	118.1%	94.9%	167.7%	857	3.0	4.5	7.5
Ward 20	81.3%	90.5%	101.7%	128.8%	729	4.0	2.9	7.0
Ward 21	84.3%	92.4%	100.0%	129.5%	699	3.8	2.4	6.2
Ward 22	91.3%	87.8%	100.6%	150.0%	615	4.4	2.9	7.4
Ward 23	90.0%	95.6%	102.4%	136.3%	1064	3.7	3.9	7.7
Ward 24	91.5%	99.2%	96.8%	-	448	5.2	1.3	6.5
Ward 3	87.5%	84.2%	98.9%	124.7%	831	3.3	3.3	6.6
Ward 5	83.2%	151.6%	113.4%	89.6%	634	6.2	1.6	7.8
Ward 7	80.6%	107.1%	104.8%	130.3%	710	3.7	4.6	8.2
Ward 8	82.2%	101.1%	104.3%	146.6%	737	3.6	3.2	6.8
DOCC	82.6%	98.5%	85.7%	-	185	26.5	2.1	28.6
Labour Ward								
Ward 9	64.4%	60.0%	79.4%	76.7%	539	4.3	0.9	5.2
Ward 10	80.0%	71.7%	80.0%	-	199	6.2	2.8	9.0
NNU	97.6%	98.7%	98.3%	100.0%	76	48.7	9.0	57.8

Appendix 2

Milton Keynes University Hospital NHS Foundation Trust

Summary PID for cross cutting schemes FY2018-19

Overview:	
Executive Lead:	Lisa Knight
Deputy Lead:	Matthew Sandham
Clinical Lead:	Nicky Burns-Muir
Finance Lead:	Not Required
Operational Lead:	Jon White
Transformation Lead:	Not Required
Full year net benefit £000	Nil (Vacancies filled at band 5)
Rationale: (why are we doing this?)	Deployment of nursing associates
Summary of scheme: (how are we doing this?)	Nursing associates are a new profession, accountable for their practice. The roles played by nursing associates will vary from setting to setting, depending on local clinical frameworks, and clinical settings. The nursing associates will be interviewed as part the Trust recruitment process and will be deployed to risked accessed clinical areas agreed by the Chief Nurse.
Objectives: (what we are going to achieve?)	Nursing associates are members of the nursing team, who have gained a Foundation Degree, typically involving two years of higher education. Nursing associates will provide care for people of all ages and from different backgrounds, cultures and beliefs. They will provide care for people who have , physical, cognitive and behavioural care needs, those living with dementia, the elderly and for people at the end of their life. They work in the context of continual change, challenging environments, different models of care delivery, shifting demographics, innovation and rapidly evolving technologies.
Links to other workstreams:	Workforce plans and trust Care Hours Per Patient Per Day

Summary PID for cross cutting schemes FY2018-19

Scheme name:

Overview:	
Delivery timescales for key milestones:	Nursing associates to be deployed in M1 April 2019
Key considerations during scheme development:	Key considerations are as follows: • Consider safer staffing requirements and workforce productivity as an integral part of the deployment process. • Ensure that the organisation is familiarised with NMC standards of proficiency and with individual nursing associate competencies. • Investigate staffing-related incidents in-regards deployment the impact on staff and patients and ensure actions are feedback. • Develop guidelines to ensure that existing staff are aware of the rationale for deployment, the risks and benefits of the role, and process for escalation of concerns.
Impacts of other divisions: (please list which divisions this scheme is likely to impact on and how this has been agreed with the respective GM)	All divisions
KPIs (SMART):	Reduction in nursing vacancies at band 5 level and a reduction in bank/ agency cost.
Tracker methodology (please list the methodology which will be used for tracking delivery of savings for this scheme each month)	Not Required
Is this scheme linked to a business case? (Y/N) Is yes please attach	No

Summary PID for cross cutting schemes FY2018-19

Scheme name:

Cost reduction or income
Cost Reduction Not Required

Financial benefits (est)										
2018-19	Recurrent **Medicine**	Non Recurrent **Medicine**	Recurrent **Surgery**	Non Recurrent **Surgery**	Recurrent **Core Clinical**	Non Recurrent **Core Clinical**	Recurrent **W&C**	Non Recurrent **W&C**	Recurrent **Corporate**	Non recurrent **Corporate**
Cost £000										
Benefit £000										
Net Benefit £000										
Divisional totals										

Scheme	Scheme name:	Executive Lead:	Completed by:
Associate Nurses	Deployment of Associate Nurses	Lisa Knight	Matthew Sandham

How the proposed scheme will adversely impact quality AFTER delivery /implementation

Dimension	Will the proposal adversely impact:	Description of impact	Mitigation strategy	Issues that cannot be mitigated
Patient experience	Personalised, compassionate care	Nursing associates play a role in supporting people to improve and maintain their mental, physical, behavioural health and wellbeing and are new to the nursing workforce.	They are actively involved in the prevention of and protection against disease and ill health, and engage in public health, community development, and in the reduction of health inequalities.	
	Dignity and respect in care	Nursing associates will provide compassionate, safe and effective care and support to people in a range of care settings.	They monitor the condition and health needs of people within their care on a continual basis in partnership with people, families, and carers. They contribute to ongoing assessment and can recognise when it is necessary to refer to others for reassessment.	Speciality areas with complex nursing assessments and interventions would not currently be an area for deployment of NA,s.
	Communication with multi-disciplinary teams about patient care.	Nursing associates will need to ensure good communication and escalation in-regards patients care requirements.	Nursing associates play an active role as members of interdisciplinary teams, collaborating and communicating effectively with nurses, a range of other health and care professionals and lay carers.	

Overall Risk Rating				
Quality Risk		**Likelihood (1-5)**	**Impact (1-5)**	**Risk rating (x/25)**
Patient safety	Safeguarding young people and adults	2	2	4
	Risk of healthcare acquired infection	2	2	4
	Risk of preventable harm	2	2	4
Clinical outcomes	Workforce capability and skills	Deployment of new workforce Nursing associates contribute to the provision of care for people, including those with complex needs.	They understand the roles of a range of professionals and carers from other organisations and settings who may be participating in the care of a person and their family, and their responsibilities in relation to communication and collaboration..	
	Effectiveness of care/ treatment	Nursing associates improve the quality of care by contributing to the continuous monitoring of people's experience of care.	They identify risks to safety or experience and take appropriate action, putting the best interests, needs and preferences of people first.	
	Other (please state)			
Equality	Access to or experience of health services on the basis of race, gender, age, sexual orientation, religion or belief, gender re-assignment, pregnancy and maternity (includes staff)			

APPROVAL (name, signature & date)

Scheme name:

	Print name:	Signature:	Date:
Executive Lead			
Divisional Lead			
Clinical Lead			
Operational Lead			
Financial Lead			
Chief Nurse			
Medical Director			

Approved by Quality Group date:	Programme Board review date:

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Trust Board**	**Date: 11 January 2019**
Report title:	**Mortality update report**	**Agenda item: 3.3**
Lead director **Report author** **Sponsor(s)**	**Dr Ian Reckless** **Dr James Bursell**	**Medical Director** **Associate Medical Director**
FoI status:	**Publically 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	Risk register ID reference 616
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	Regular update
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 and morbidity (M&M) meeting framework.

The last Mortality Review Group (MRG) meeting was held on 14th November 2018. The next is scheduled for 23rd January 2019. Dr Bursell has stepped down from his role as Associate Medical Director leading on clinical risk and mortality work (to take up the role of Divisional Director, Women's and Children's), and Miss Bina Parmar takes up this role from 1st February 2019.

The Trust's current HSMR and SHMI are both statistically 'as expected'. Dr Foster, when analysing the Trust's data, previously identified an HSMR negative outlying diagnostic group of 'other perinatal conditions'. This continued to 'alert' (for statistical significance) for some months. This alert has now ceased but it should be noted (as a 12 month rolling dataset) that this may well reappear. There are currently no specific outlying diagnostic group alerts.

The Trust continues to implement National Quality Board guidance regarding Learning from Deaths. This includes quarterly publishing of qualitiative and quantative data on deaths at Trust Public Board meetings. The Trust has trained more than 20 multidisciplinary Trust staff members in the use of Royal College of Physicians (RCP) methodology for Structured Judgement Review (SJR) case note review. Changes have been made to the structure and running of Trust Mortality and Morbidity meetings to incorporate the new methodology. Changes to the Trust Mortality – Learning from Deaths policy have been made in line with regional classification terminology and classification of deaths.

Definitions

Out of hours – Nights/weekends and bank holidays

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

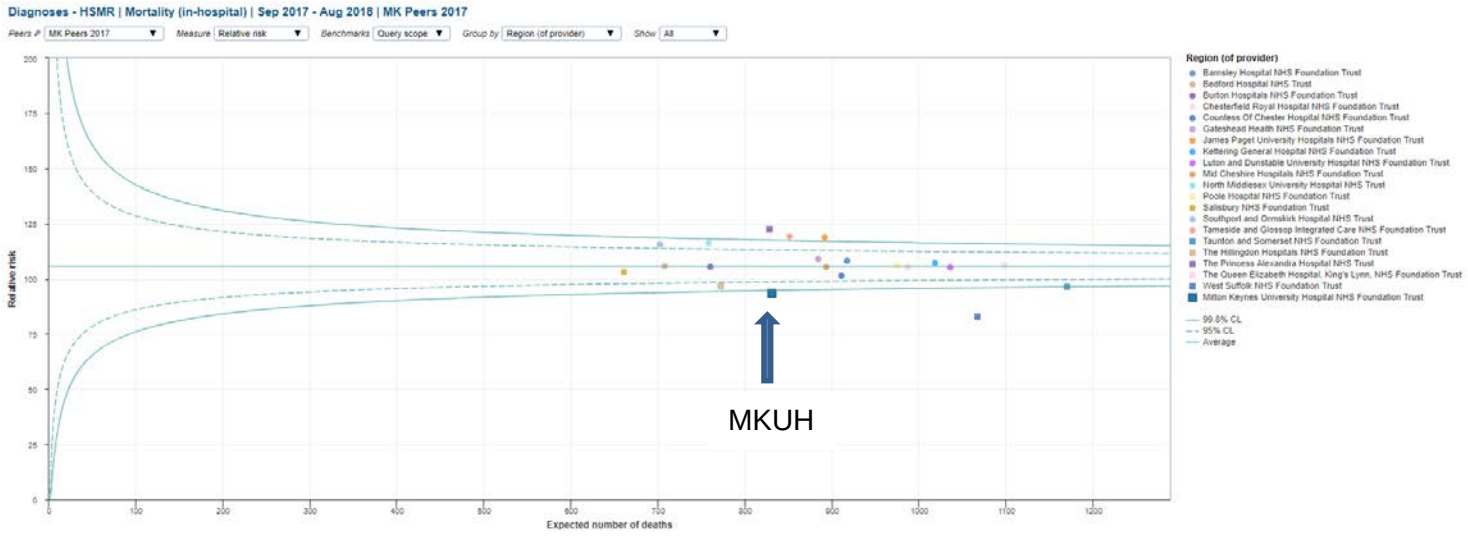
Data period: September 2017 – August 2018

Key Highlights:

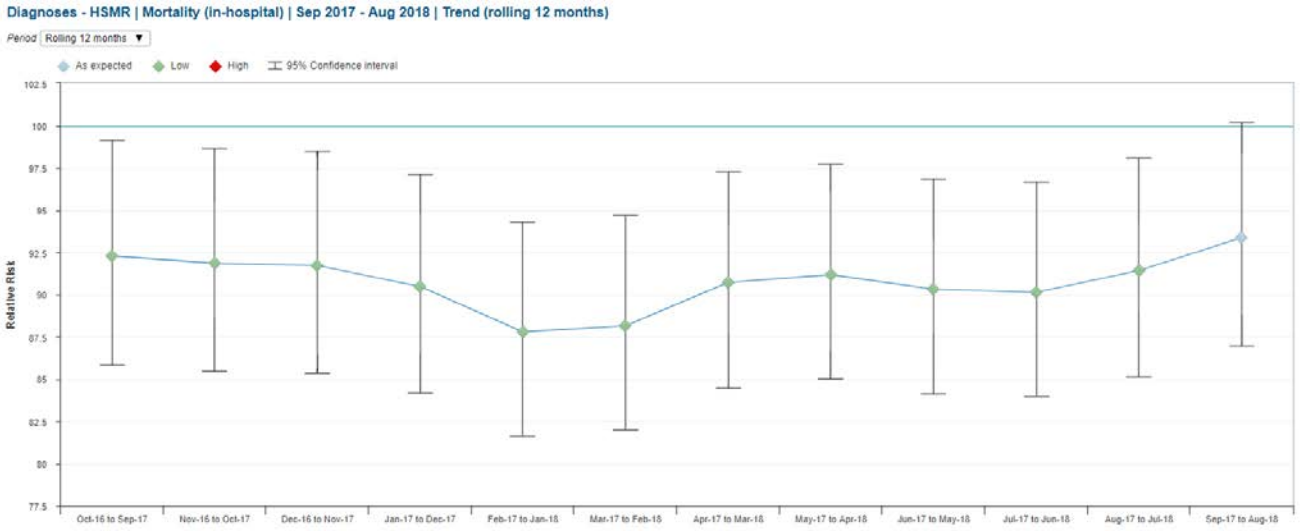
- HSMR relative risk for 12 month period = 93.4 ‘as expected’ range
- The Trust has moved bandings from ‘lower than expected’ to ‘as expected’.
- Crude mortality rate within HSMR basket = **3.3%** (MKUH local acute peer group rate = 4.0%)
- 0 outliers were identified within the HSMR basket for this period.

The Trust currently ranks 2nd (2nd lowest HSMR relative risk value) against its MKUH peer group and 38th lowest (best) against national peers.

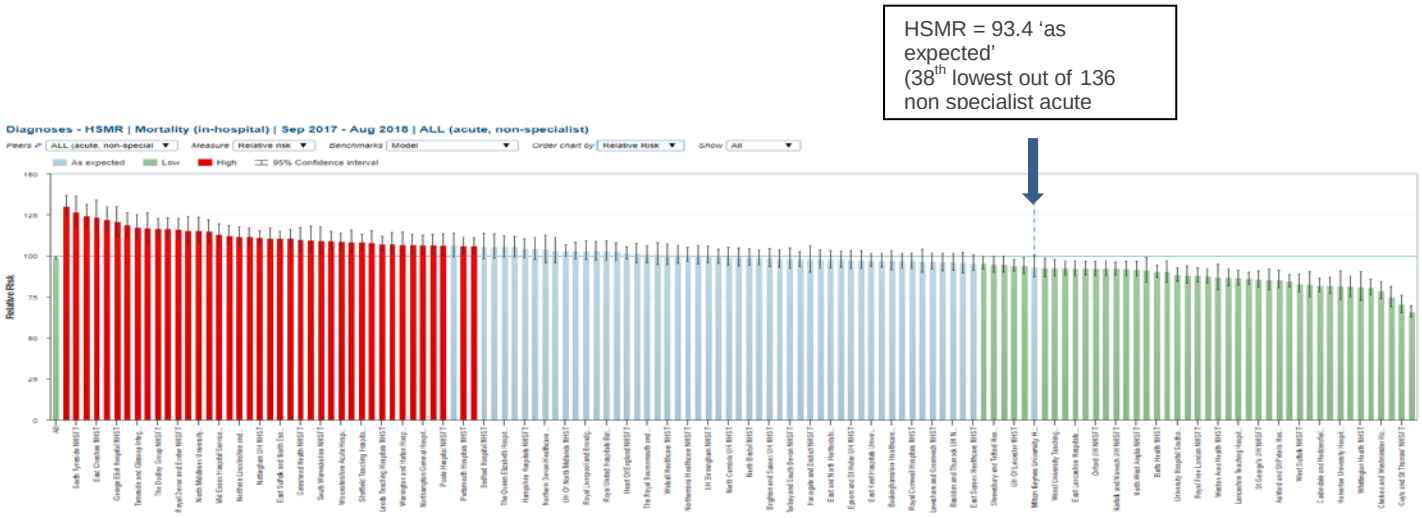
HSMR Funnel Plot – Trust vs. MKUH peer group (September 2017 – August 2018)



Trust level HSMR monthly performance for rolling year (September 2017 – August 2018*)*



HSMR position vs. national acute peers: September 2017 – August 2018



HSMR relative risk = 93.4 'as expected' (38th lowest out of 136 non-specialist acute). 1st lowest ranking indicates the trust with the lowest (best) HSMR relative risk.

HSMR by diagnosis group:

HSMR basket 'Other perinatal conditions' – no longer alerting in December 2018 report

This HSMR diagnostic group alerted as being a negative outlier in the March 2018 Dr Foster report that covered the period December 2016 to November 2017 and had alerted in subsequent monthly reports. This alert has been discussed at the Mortality Review Groups held in April, May, June and July and the Trust response to the alert outlined in the Quality and Clinical Risk Committee Board paper in September 2018.

'Other perinatal conditions' – rolling 12 month trend

An action from the November 2018 Mortality Review Group was to put together a working group to review any negative effect that inaccurate or imprecise coding or documentation may be having on the HSMR basket for 'other perinatal conditions'.

Divisional HSMR performance for rolling year (September 2017 – August 2018)

Divisional HSMR relative risk (RR) scores have been developed by attributing deaths in the Dr Foster basket of 56 diagnostic groups to the most appropriate division. A significant caveat must be provided when the data are dis-aggregated in this way. This is intended for information / screening purposes only, rather than purporting to provide any significant assurance in any direction.

Medical Division RR = 93.2 'as expected'. There were 0 outlying diagnosis groups (significantly higher than expected deaths).

Surgical Division RR = 91.4 'as expected'. There were 0 outlying diagnosis groups (significantly higher than expected deaths).

Women's and Children's Division RR = 132.4 'as expected'. There were 0 outlying diagnosis groups (significantly higher than expected deaths).

SHMI

Data period: April 2017 – March 2018 (most up to date data available)

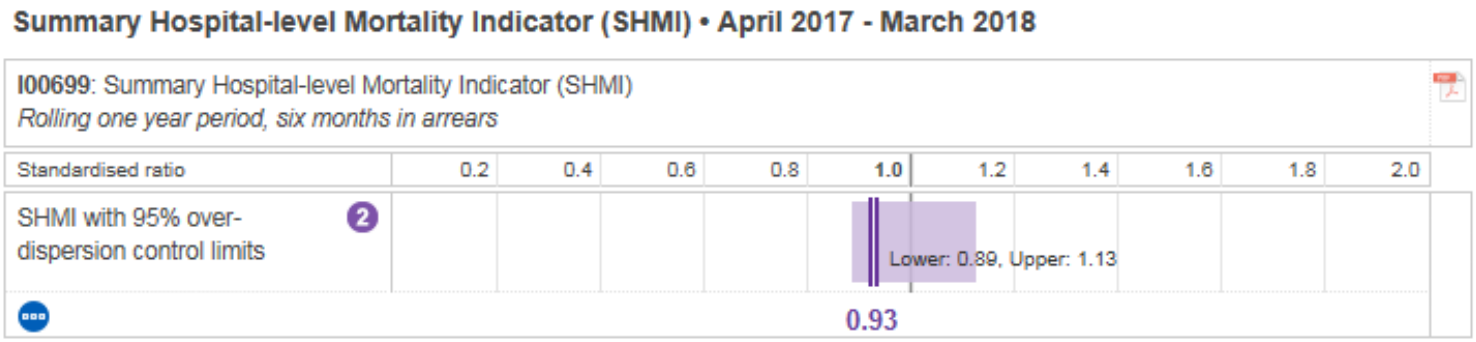
The Summary Hospital-level Mortality Indicator (SHMI), which includes out of hospital deaths occurring within 30 days of discharge, is measured by the Health and Social Care Information Centre (HSCIC). The SHMI relative risk is the ratio between the actual number of patients who die following treatment 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.

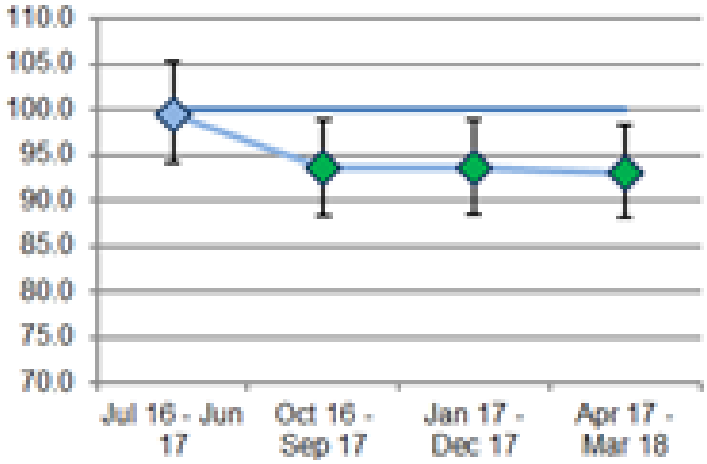
Key Highlights:

A SHMI score below 1.00 is better than average.

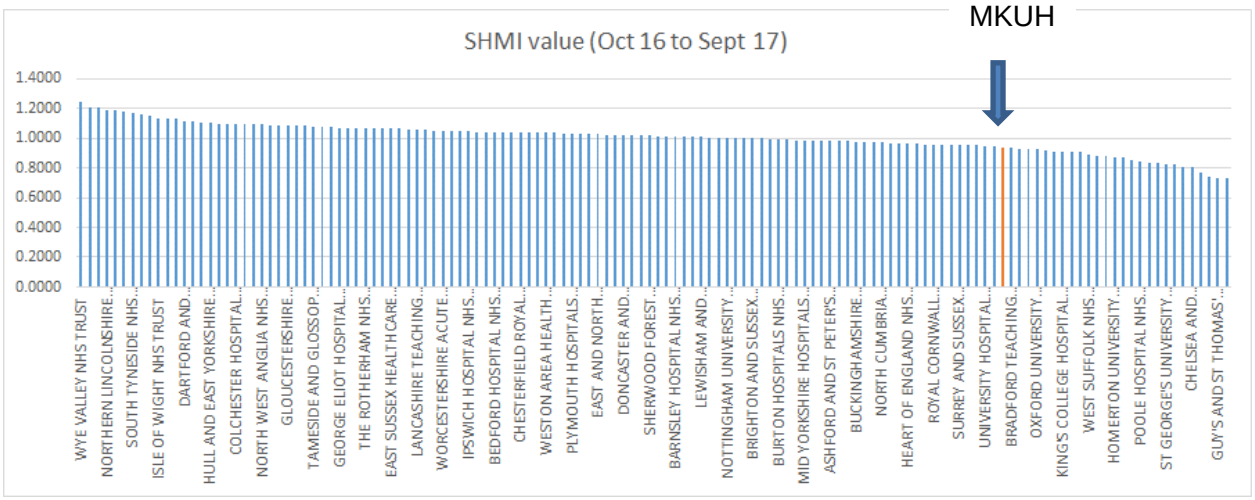
The latest SHMI published by HSCIC for the rolling 12 months to March 2018 = 0.93 '**as expected'** range.

The Trust 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.



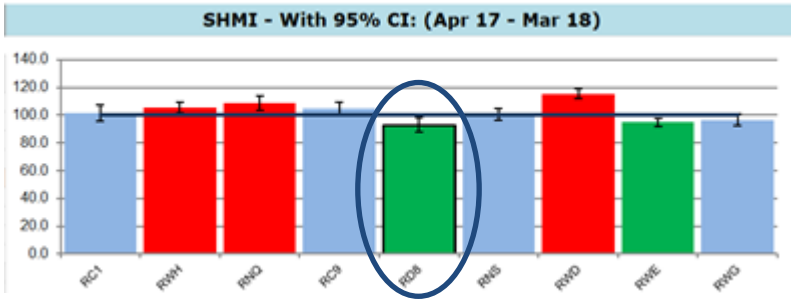


SHMI position vs. national acute peers: October 2016 – September 2017



Note – graphs are the most up to date data as supplied by Dr Foster

Comparison with peer Trusts



	Provider	Denominator
RC1	Bedford Hospital NHS Trust	36,539
RWH	East And North Hertfordshire NHS Trust	65,979
RNQ	Kettering General Hospital NHS Foundation Trust	51,001
RC9	Luton And Dunstable University Hospital NHS Foundation Trust	77,527
RD8	Milton Keynes Hospital NHS Foundation Trust	44,430
RNS	Northampton General Hospital NHS Trust	69,912
RWD	United Lincolnshire Hospitals NHS Trust	81,182
RWE	University Hospitals Of Leicester NHS Trust	157,584
RWG	West Hertfordshire Hospitals NHS Trust	61,361

This relates to MKUH SHMI data

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.

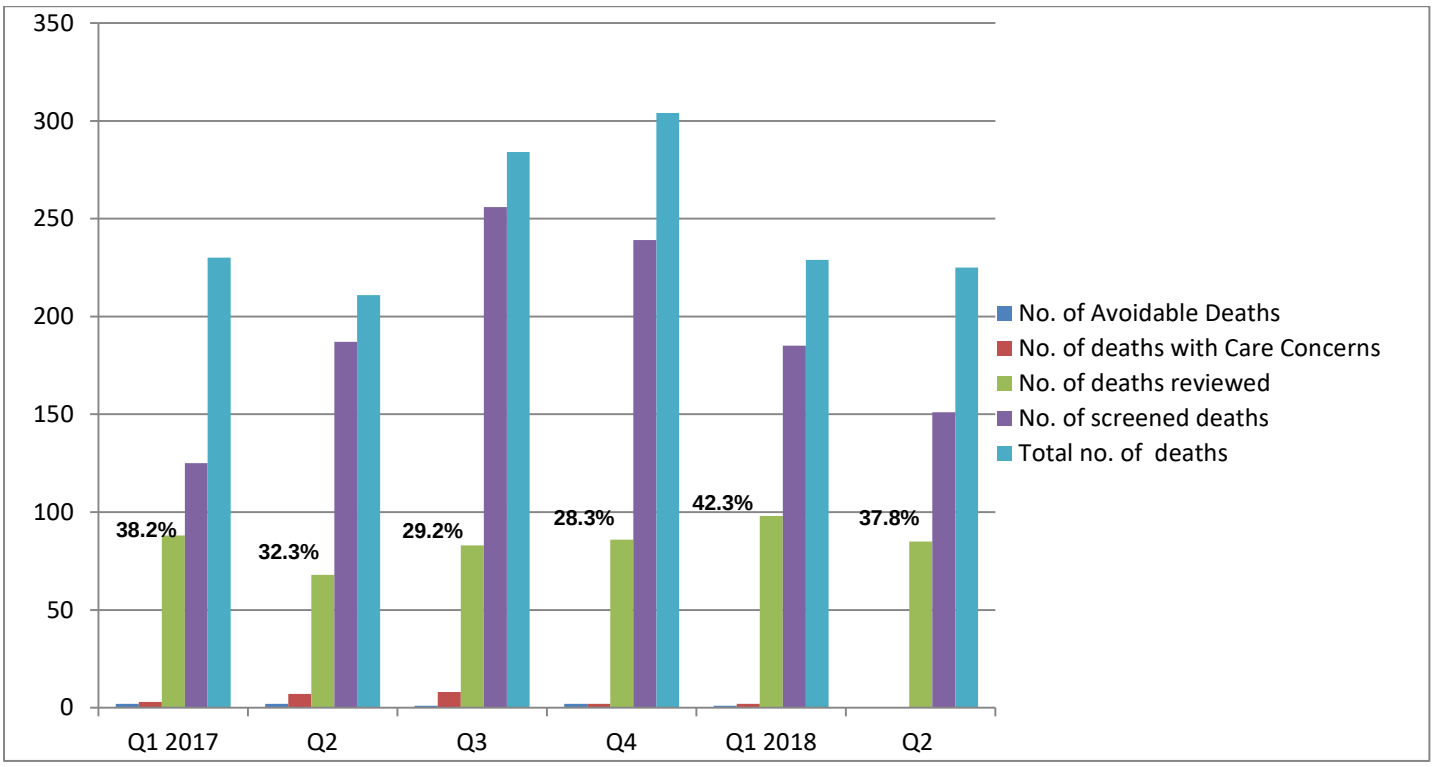
3. Judged as potentially 'avoidable' – using the current system of classification within the Trust this includes 'suboptimal care where different management MIGHT have changed outcome and 'suboptimal care where different management WOULD have changed outcome'

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'.

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

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

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



Recent changes in the description and classification of deaths during the mortality review process have taken place. These minor changes mere made following discussions at Regional Network Mortality meetings led to agreement that all Trusts within the region would use the same classification method. The method (outlined below) below also includes the opportunity to recognoise excellent care.

Good or excellent care	No problems in care	Problems in care but very unlikely to have contributed to death	Problems in care but unlikely to have contributed to death	Problems in care more likely than not to have contributed to death

Meeting title	**Trust Board**	**Date: 11 January 2019**
Report title:	**Nasogastric Tube Safety**	**Agenda item: 3.4**
Lead director **Report author** **Sponsor(s)**	**Dr Ian Reckless** **Nadean Marsh**	**Medical Director** **Head of Nursing Quality and Safeguarding**
FoI status:	**Publically 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	**This report relates to CQC:** **Regulation 12 – Safe care & treatment** **Regulation 17 – Good governance**
Identified risks and risk management actions	National Patient Safety Alert NHS/PSA/RE/2016/006 required public discussion of the issues raised and the organisation's response at a Trust Board in public. At the time, the issues were discussed only at internal Trust Committees. Following a review of nasogastric tube safety, this paper is presented at Trust Board in public for assurance.
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	Single Report
Appendices	1. NHS/PSA/RE/2016/006 2. Extract from SOP used in radiography in relation to nasogastric tubes

Executive Summary

Nastogastric tube placement is an important healthcare intervention but one which is prone to error. Such error can have a significant adverse impact upon patients, including death, and is preventable through adoption of standardised processes.

MKUH reviewed internal policy and procedure in light of a national patient safety alert (NHS/PSA/RE/2016/006). Whilst many of the required actions were undertaken shortly after publication of the alert, the requirement to discuss the issue and the Trust's position in respect of the measures outlined in the alert at a Trust Board meeting held in public was overlooked. This omission was identified during an informal review of nasogastric tube safety in 2018.

This paper meets the specific requirement of NHS/PSA/RE/2016/006. The stipulation that a Trust consider an alert in a public forum was new and has not been repeated since. Internal processes have been reviewed such that any future alerts with specific and unusual requirements such as this will be identified and actioned in a more timely manner.

1. Nasogastric tubes and associated risks

Nasogastric (ng) tubes are used relatively frequently in healthcare in order to permit the passage of food and liquid into the stomach in patients who cannot swallow safely (for example, after stroke) and/or to decompress gas from the stomach in patients with certain surgical conditions. For many patients a nasogastric tube can be an essential element of care.

Nasogastric tubes are passed through the nose, down the back of the mouth, into the oesophagus (gullet) and down into the stomach. The trachea (windpipe) runs directly in front of the oesophagus and a risk of insertion is that a tube passes down the trachea (into the lungs) rather than into the stomach. The presence of a tube in the lungs is not in itself a major issue but using a misplaced tube to pass liquid feed or fluid into the lungs can be life threatening. There have been numerous examples across the NHS of patients who have been harmed through such misplacement of ng tubes. Various measures can be used to demonstrate that an ng tube is placed in a satisfactory position in the stomach. These include the measurement of pH (acidity) in an aspirate from the tube, and the use of a chest X-ray to demonstrate an appropriate internal course of the ng tube. Historically other tests have also been in use including the injection of air into the tube, listening for resulting sounds over the stomach. This latter test has been shown to be ineffective and therefore dangerous (in that it can provide clinicians with false and baseless assurance on tube position).

2. National Safety Alerts

Patient Safety alerts are shared with NHS organisations from time to time in order to raise awareness and prompt action in respect of significant identified healthcare risks. The publication of such alerts is now the domain of NHS Improvement. Previously this duty had sat with the National Patient Safety Agency (NPSA) and other national bodies.

A number of national patient safety alerts have been issued over the last decade or more in relation to safe ng tube placement and usage. All have aimed to standardise practice in confirming correct ng tube placement prior to use. The issuing of multiple alerts is testament to the importance of this issue and continuation of adverse events, including deaths, across the NHS despite prior action.

The most recent alert (NHS/PSA/RE/2016/006) was issued in July 2016. It required specific actions by 21 April 2017. MKUH did undertake appropriate actions at the time and responded to NHS Improvement to that effect. However, NHS/PSA/RE/2016/006 included the specific and unusual requirement for the issue to be discussed at a Trust Board in public. The issue was discussed at the time at internal Boards and Committees but not at a Trust Board in public. This paper rectifies that omission.

3. Requirements of Alert NHS/PSA/RE/2016/006

The alert specified five actions to be taken by NHS Providers in relation to ng tube safety as follows:

A. Identification of named Executive Director with lead responsibility
B. Development and implementation of robust systems to support staff in tube placement checks
C. Development of an action plan – as necessary - to ensure all safety-critical requirements outlined in the alert are met
D. The sharing of the systems / plan at relevant commissioner assurance meetings
E. Discussion of key issues within a Public Board paper with a view to articulation of gaps or assurance

4. Position in respect of Alert NHS/PSA/RE/2016/006 and its requirements at MKUH

A. Identification of named Executive Director with lead responsibility

- The lead Executive Director at MKUH is the Medical Director (currently Dr Ian Reckless)

B. Development and implementation of robust systems to support staff in tube placement checks

- MKUH policy is consistent with national best practice in relation to: (1) frequency of pH checking; (2) pH thresholds and the requirement for a chest radiograph in borderline cases; and, (3) systematic use of the ‘four steps’ for the checking of ng tube placement on a chest radiograph.
- This policy has been reviewed and updated in light of NHS/PSA/RE/2016/006 (further review undertaken November / December 2018).
- Standard Operating Procedure (SOP) for preliminary clinical evaluation of ng tube position by diagnostic radiographers developed and in routine use.
- Information sheet sent with patients on return to ward from X-ray to raise profile of relevant safety issues and signpost the presence / absence of a report on ng tube position on radiology (PACS) systems.
- Diagnostic radiographers receiving training on ng tube removal (where incorrectly placed), coordinated by nutrition specialist nurse.

C. Development of an action plan – as necessary – to ensure all safety-critical requirements are met

- An action plan was formulated following NHS/PSA/RE/2016/006 but at this point in time all implementation actions are complete.
- Snapshot audits of pH checks are conducted by the nutrition specialist nurse.

- Nasogastric tube training competencies are delivered to relevant staff by practice development and are to be mandated for specific clinical areas.

D. The sharing of the systems / plan at relevant commissioner assurance meetings

- The topic of ng tube safety has previously been discussed at internal Trust meetings attended by the Clinical Chair of the Clinical Commissioning Group (CCG) but this paper will be shared formally at the January 2019 Clinical Quality Review Meeting (CQRM) between Trust and CCG.

E. Discussion of key issues within a Public Board paper with a view to articulation of gaps or assurance

- This update is being provided at the January 2019 meeting of the Trust Board, which occurs in public.

5. Conclusion

This paper provides assurance that MKUH has complied with the actions laid out in NHS/PSA/RE/2016/006. Indeed, MKUH believes that the system implemented (with diagnostic radiographers providing a standardised interpretation of chest radiographs in this context) is much more robust than a system reliant upon doctors in training (rotating through the Trust).

Appendices

1. NHS/PSA/RE/2016/006
2. Extract from SOP used in radiography in relation to confirmation of ng tube placement

NHS Improvement

Patient Safety Alert

Nasogastric tube misplacement: continuing risk of death and severe harm

22 July 2016

Alert reference number: NHS/PSA/RE/2016/006

Alert stage: Two - Resources

Use of misplaced nasogastric and orogastric tubes[1] was first recognised as a patient safety issue by the National Patient Safety Agency (NPSA) in 2005[2] and three further alerts were issued by the NPSA and NHS England between 2011 and 2013.[3-5] Introducing fluids or medication into the respiratory tract or pleura via a misplaced nasogastric or orogastric tube is a Never Event. Never Events are considered 'wholly preventable where guidance or safety recommendations that provide strong systemic protective barrier are available at a national level, and should have been implemented by all healthcare providers.'[6]

Between September 2011 and March 2016, 95 incidents were reported to the National Reporting and Learning System (NRLS) and/or the Strategic Executive Information System (StEIS) where fluids or medication were introduced into the respiratory tract or pleura via a misplaced nasogastric or orogastric tube. While this should be considered in the context of over 3 million nasogastric or orogastric tubes being used in the NHS in that period,[7] these incidents show that risks to patient safety persist. Checking tube placement before use via pH testing of aspirate and, when necessary, x-ray imaging, is essential in preventing harm.

Examination of these incident reports by NHS Improvement clinical reviewers shows that misinterpretation of x-rays by medical staff who did not appear to have received the competency-based training required by the 2011 NPSA alert is the most common error type. Other error types involve nursing staff and pH tests, unapproved tube placement checking methods, and communication failures resulting in tubes not being checked. The reports included 32 incidents where the patient subsequently died, although given many patients were critically ill before the tube was introduced, it is not always clear whether the death was directly related to the misplaced tube.

Review of local investigations into these incidents suggests problems with organisational processes for implementing previous alerts. This Patient Safety Alert is therefore directed **at trust boards** (or their equivalent in other providers of NHS funded care) and the processes that support clinical governance. It is NOT directed at frontline staff. Some of the implementation issues identified were:

- problems with systems to ensure staff who were checking tube placement had received competency-based training
- problems with ensuring bedside documentation formats include all safety-critical checks
- problems maintaining safe supplies of equipment, particularly radio-opaque tubes and CE-marked pH test strips.

The resource set that accompanies this alert provides a range of support for trust boards (or their equivalents) to assess whether previous nasogastric tube guidance has been implemented and embedded within their organisations improvement.nhs.uk/resources/resource-set-initial-placement-checks-nasogastric-and-orogastric-tubes. It includes briefings to help non-executives and governors to understand the issues, summaries of safety-critical requirements of past alerts, self-assessment/assurance checklists, and learning from reported incidents.

Actions

Who: All organisations where nasogastric or orogastric tubes are used for patients receiving NHS-funded care

When: To commence as soon as possible and to be completed by 21 April 2017

1. Identify a named executive director* who will take responsibility for the delivery of the actions required in this alert.
2. Using the resources supplied with this alert, undertake a centrally co-ordinated assessment of whether your organisation has robust systems for supporting staff to deliver safety-critical requirements for initial nasogastric and orogastric tube placement checks.
3. If the assessment identifies any concerns, use the resources supplied with this alert to develop and implement an action plan to ensure all safety-critical requirements are met.
4. Share this assessment and agree any related action plan within relevant commissioner assurance meetings.
5. Share the key findings of this assessment and the main actions that have been taken in the form of a public board paper.**

* For organisations that are not trusts/foundation trusts and do not have executive directors, a role with equivalent senior responsibility should be identified.

**For organisations without a board, an equivalent publically available alternative to a board paper should be identified eg a report on a public-facing website.

See page 2 for references

Alert reference number:	NHS/PSA/RE/2016/006
Alert stage:	Two - Resources

Resources

Patient safety incident reporting

For detail of dates and search strategy within the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (StEIS) see page x of the supporting *initial placement checks for nasogastric and orogastric tubes resource set* on the NHS Improvement website improvement.nhs.uk/resources/resource-set-initial-placement-checks-nasogastric-and-orogastric-tubes

References

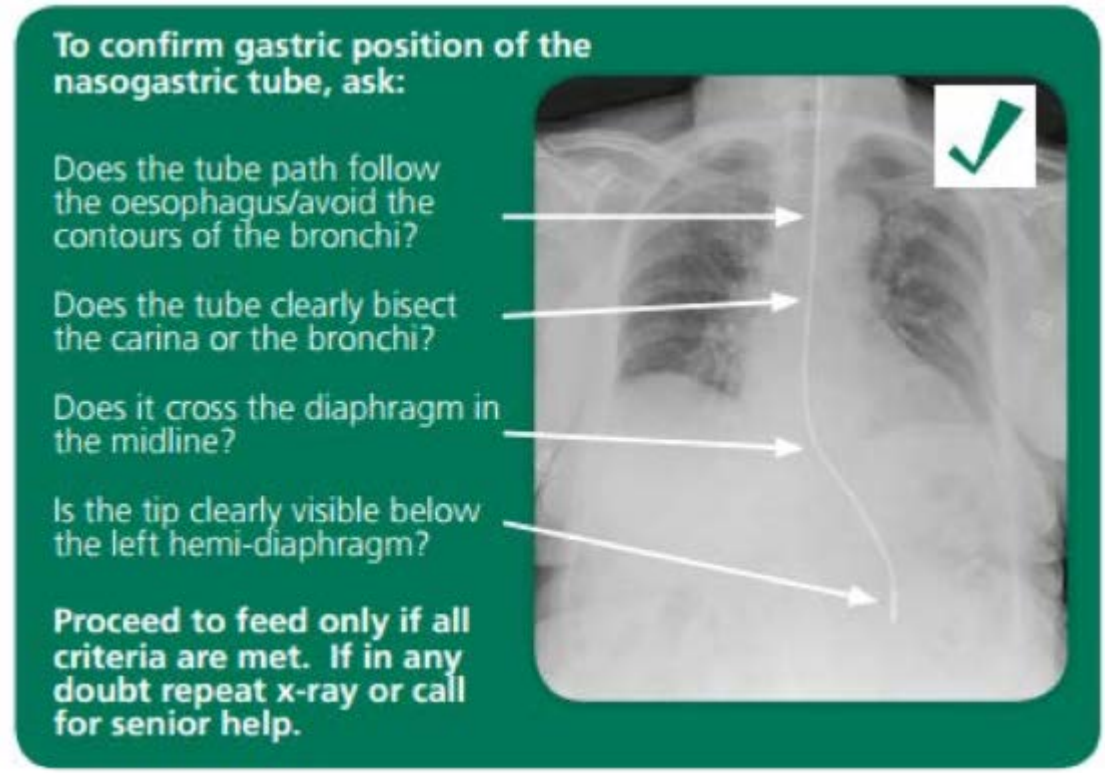
1. Hanna G, Phillips, L, Priest O & Zhifang N (201) Improving the safety of nasogastric feeding tube insertion A report for the NHS Patient Safety Research Portfolio July 2010 www.birmingham.ac.uk/Documents/college-mds/haps/projects/cfhep/psrp/finalreports/PS048ImprovingthesafetyofnasogastricfeedingtubeinsertionREVISEDHannaetal.pdf
2. National Patient Safety Agency - Reducing the harm caused by misplaced nasogastric feeding tubes 2005 www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59794&p=4
3. National Patient Safety Agency Patient Safety Alert: Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants 2011 www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=129640
4. National Patient Safety Agency Rapid Response Report: Harm from flushing of nasogastric tubes before confirmation of placement 2012 www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=133441
5. NHS England Patient Safety Alert: Stage 1 - Placement devices for nasogastric tube placement DO NOT replace initial placement checks 2013 www.england.nhs.uk/wp-content/uploads/2013/12/psa-ng-tube.pdf
6. NHS England Never Events Policy and Framework 2015 www.england.nhs.uk/patientsafety/never-events/
7. Page 9 of the supporting *initial placement checks for nasogastric and orogastric tubes resouirce set* on the NHS Improvement website improvement.nhs.uk/resources/resource-set-initial-placement-checks-nasogastric-and-orogastric-tubes

Stakeholder engagement

- Medical Specialities Patient Safety Expert Group
- Children and Young People's Patient Safety Expert Group
- Surgical Services Patient Safety Expert Group
- Patient Safety Steering Group

For details of the membership of the NHS Improvement patient safety expert groups and steering group see www.england.nhs.uk/ourwork/patientsafety/patient-safety-groups/

Evaluation of this patient's radiograph has been made using the "Four Steps" approach as depicted.



Radiographer; please circle the text which matches your evaluation:

1. If correctly sited:

   The nasogastric tube is demonstrated centrally in satisfactory position with the tip well below the gastro-oesophageal junction; no radiographic contraindication to its use is demonstrated.

2. If the NG tube is in the lung:

   The nasogastric tube is within the lung, and must be removed/ has been removed in the imaging department.

3. If the NG tube is in the oesophagus (**with the guidewire still in situ**), but not sufficiently below the diaphragm; please record the following:

   The nasogastric tube is demonstrated centrally with the tip above the diaphragm and should be advanced into the stomach.

   Please re-check the pH after the advancement, as normal.

   If no aspirate is available the recommendations would be to have a repeat x-ray.

3. If the radiographer undertaking the chest x-ray is uncertain as to the position of the NG tube (e.g. **guidewire absent**) then they may record the following:

   The position of the nasogastric tube is uncertain; review by senior medical staff, chest reporting radiographer or radiologist is advised

4. Free text response (e.g. the NG tube is coiled in the upper oesophagus).

Meeting title	Board of Directors	Date: 11 January 2019
Report title:	Performance Report indicators for 2018/19 (Month 8)	Agenda item: 4.1
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: M8 (November 2018)

1.0 Summary

This report summarises performance in November 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

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

ID	Indicator	DQ Assuran	Target 18-19	Month/YTD	Actual YTD	Actual Month	Month Perf.	Month Change
4.1	ED 4 hour target (includes UCS)		92.5%	91.4%	92.3%	91.9%	✓	▲
4.2	RTT Incomplete Pathways <18 weeks		90.1%	89.4%		88.3%	✗	▲
4.9	62 day standard (Quarterly)		82.4%	82.4%		88.6%	✓	▲

The ED performance improved in November 2018, rising from 90% in October to 91.9%. This was below the national standard of 95% but ahead of the 91.4% NHS Improvement trajectory. It was also better than the NHS England national A&E performance in November 2018, which was 87.6%.

The referral to treatment (RTT) national NHS operational standard for incomplete pathways was not achieved by the Trust in November 2018. A performance of 88.3% at the end of November 2018 was reported, which was an improvement of 0.7% on October 2018. The NHS England combined performance for the RTT standard at the end of October 2018 was 87.1%. November's national RTT performance will be published on 10/01/2019.

Cancer waiting times are reported quarterly, around six weeks after the end of a calendar quarter. This means that the most recent validated position was Q2 2018/19. The Trust performance for Cancer 62 day wait for first treatment (all cancers) surpassed the 85% national target, achieving a performance of 88.6% in that period. This was also above the NHS Improvement trajectory (82.4%). Nationally, the performance across all English providers for the same period was 78.6%.

3.0 Urgent and Emergency Care

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

ID	Indicator	DQ Assuran	Target 18-19	Month/YTD	Actual YTD	Actual Month	Month Perf.	Month Change
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.7%	0.5%	✓	▼
3.2	Ward Discharges by Midday		30%	30%	18.8%	18.5%	✗	▲
3.4	30 day readmissions		6.4%	6.4%	8.4%	8.4%	✗	▼
4.1	ED 4 hour target (includes UCS)		92.5%	91.4%	92.3%	91.9%	✓	▲

Cancelled Operations on the Day

In November 2018, the volume of operations that were cancelled on the day for non-clinical reasons remained the same as the previous month (12). This represented 0.5% of all planned operations during the month, which was within the 1% tolerance. Nationally, cancelled operations represented 0.9% of all planned elective activity in Quarter 2 of 2018/19.

Readmissions

The emergency readmission rate continued above the threshold of 6.4% with a rate of 8.4% during November 2018. At a divisional level, the readmission rate for Medicine remained high at 12.7%, whereas the rates in Surgery and Women & Children decreased to 5.4% and 4.3% respectively.

Delayed Transfers of Care (DTOC)

The number of DTOC patients (22) at midnight on the last Thursday of November 2018 remained the same as October 2018 and has been within the threshold for seven consecutive months. The cumulative number of days delayed (554) for all patients throughout the month was also consistent with October 2018 (555), indicating that the challenges around managing DTOC patients are being managed effectively.

Ambulance Handovers

In November 2018, the percentage of ambulance handovers that took longer than 30 minutes decreased slightly compared to last month to 7.2% but remained above the 5% threshold. The number of handovers reported to have taken longer than 60 minutes also decreased to 14 during November 2018, compared to 23 in October 2018.

4.0 Elective Pathways

ID	Indicator	DQ Assuran	Target 18-19	Month/YTD	Actual YTD	Actual Month	Month Perf.	Month Change
3.1	Overnight bed occupancy rate		93%	93%	92.7%	95.6%	✗	▲
3.5	Follow Up Ratio		1.50	1.50	1.56	1.59	✗	▲
4.2	RTT Incomplete Pathways <18 weeks		90.1%	89.4%		88.3%	✗	▲
4.6	Diagnostic Waits <6 weeks		99%	99%		99.1%	✓	▬
5.6	Outpatient DNA Rate		5%	5%	7.3%	7.2%	✗	▲

Overnight Bed Occupancy

The Trust bed occupancy was above the 93% internal threshold at 95.6% in November 2018. This was a decrease compared to October 2018 (96.7%). The NHS England bed occupancy statistics for Q2 2018/19 reported an average occupancy rate for all beds open overnight of 87.3%. Recent media reports have highlighted the winter strain on NHS with high bed occupancy levels (nearly 95%) reported in what was referred to as the first weekly winter situation report from NHS England.

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.

Follow up Ratio

Planning outpatient capacity to cope with new referrals is impacted by the demand for follow ups. In November 2018, the follow up ratio continued above the threshold with a ratio of 1.59 follow up attendances for every new attendance seen. This was however an improvement compared to October 2018 (1.64).

RTT Incomplete Pathways

As mentioned previously, the Trust 18 week RTT performance continued below the 92% national standard and the Trust's NHS Improvement target (89.4%). At the end of November 2018 the overall waiting list size had decreased by 1% compared to October 2018 and the number of patients waiting more than 18 weeks had also decreased by almost 7%, resulting in an improved RTT performance.

The number of 52 week waiters had been reduced to 10 at the end of November 2018. This was below the trajectory of 12.

Diagnostic Waits <6 weeks

In November 2018, the Trust continued to meet the operational standard of less than 1% of patients waiting six weeks or longer for a Diagnostic test, with a performance of 99.1%. This was the same as October 2018. Nationally, the operational standard of less than 1% of patients waiting six weeks or longer was not achieved in October 2018, which is the most recent national report available.

Outpatient DNA Rate

The outpatient DNA rate has been above 7% since May 2018. In November 2018, the Trust reported a rate of 7.2% which is much higher than the 5% target. DNAs represent clinic capacity that cannot be otherwise utilised. All services should continue to ensure that they adhere to the Trust Access Policy to minimise DNA rates.

5.0 Patient Safety

Infection Control

There were no MRSAs or CDIs reported by MKUH in November 2018. There were three cases of MSSA reported by the Trust in November - two were in Medicine (Ward 22, Ward 18), one was in Surgery (Ward 21). Four cases of E-coli were also reported – two were in Medicine (Ward 1, Ward 18), one was in Surgery (Ward 21) and the other was in Women & Children (Ward 9).

HSMR

The HSMR (93.4) moved bandings this month from 'lower than expected' to 'as expected'. The rate remains below the threshold of 100, however, is closer to the Upper Control Limit (95). MKUH is 1 of 11 Trusts (within the peer group) with an HSMR within the 'as expected' range.

For the first time in 2018/19, there were no outlying diagnosis groups attracting significantly higher than expected deaths.

ENDS

Performance Report 2018/19
November 2018 (M08)

NHS
Milton Keynes University Hospital
NHS Foundation Trust

OBJECTIVE 1 - PATIENT SAFETY										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
1.1	Mortality - (HSMR)		100	100		93.4	✓	▼		
1.2	Mortality - (SHMI) - Quarterly		1	1	0.94	0.94	✓	▬	✓	
1.3	Never Events		0	0	2	0	✓	▬	✗	
1.4	Clostridium Difficile		20	<14	11	0	✓	▲	✓	
1.5	MRSA bacteraemia (avoidable)		0	0	1	0	✓	▲	✗	
1.6	Pressure Ulcers Grade 2, 3 or 4 (per 1,000 bed days)		0.6	0.6	0.58	0.67	✗	▲	✓	
1.7	Falls with harm (per 1,000 bed days)		0.15	0.15	0.12	0.07	✓	▲	✓	
1.8	WHO Surgical Safety Checklist		100%	100%	100%	100%	✓	▬	✓	
1.9	Midwife : Birth Ratio		28	28	28	26	✓	▲	✓	
1.10	Incident Rate (per 1,000 bed days)		40	40	35.86	36.68	✗	▼	✗	
1.11	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▬	✓	
1.12	E-Coli				19	4		▼		
1.13	MSSA				13	3		▼		
1.14	VTE Assessment	Tbc	95%	95%	78.5%	74.7%	✗	▼	✗	

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%	*Not Available*					
2.2	RED Complaints Received		8	5	0	0	✓	▬	✓	
2.3	Complaints response in agreed time		90%	90%	82.5%	87.2%	✗	▲	✗	
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.7%	0.5%	✓	▼	✓	
2.5	Over 75s Ward Moves at Night		2,554	1703	1,533	199	✓	▼	✓	
2.6	Mixed Sex Breaches		0	0	0	0	✓	▬	✓	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
3.1	Overnight bed occupancy rate		93%	93%	92.7%	95.6%	✗	▲	✓	
3.2	Ward Discharges by Midday		30%	30%	18.8%	18.5%	✗	▲	✗	
3.3	Weekend Discharges		70%	70%	69.7%	67.4%	✗	▲	✗	
3.4	30 day readmissions		6.4%	6.4%	8.4%	8.4%	✗	▼	✗	
3.5	Follow Up Ratio		1.50	1.50	1.56	1.59	✗	▲	✗	
3.6.1	Number of Stranded Patients (LOS>=7 Days)		227	227		196	✓	▲		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		91	91		74	✓	▲		
3.7	Delayed Transfers of Care		25	25		22	✓	▬		
3.8	Discharges from PDU (%)		16%	16%	10.9%	10.9%	✗	▼	✗	
3.9	Ambulance Handovers >30 mins (%)		5%	5%	6.6%	7.2%	✗	▲	✗	

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%	91.4%	92.3%	91.9%	✓	▲	✓	
4.2	RTT Incomplete Pathways <18 weeks		90.1%	89.4%		88.3%	✗	▲		
4.3	RTT Patients Waiting Over 18 Weeks		1,287	1,339		1,618	✗	▲		
4.4	RTT Total Open Pathways		12,999	12,630		13,881	✗	▲		
4.5	RTT Patients waiting over 52 weeks			10		10	✓	▲		
4.6	Diagnostic Waits <6 weeks		99%	99%		99.1%	✓	▬		
4.7	All 2 week wait all cancers (Quarterly) ✎		93%	93%		97.0%	✓	▼		
4.8	31 days Diagnosis to Treatment (Quarterly) ✎		96%	96%		98.7%	✓	▼		
4.9	62 day standard (Quarterly) ✎		82.4%	82.4%		88.6%	✓	▲		

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	40,530	41,857	5,241	✗	▼	✓	
5.2	A&E Attendances		91,286	61,024	59,140	7,088	✗	▼	✗	
5.3	Elective Spells (PBR)		25,530	17,218	17,782	2,570	✓	▲	✓	
5.4	Non-Elective Spells (PBR)		35,286	23,588	22,970	3,266	✓	▲	✗	
5.5	OP Attendances / Procs (Total)		367,859	247,863	257,253	33,374	✓	▼	✓	
5.6	Outpatient DNA Rate		5%	5%	7.3%	7.2%	✗	▲	✗	
5.7	Number of babies delivered				2438	280		▼		
5.8	Number of antenatal bookings				2587	357		▼		

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		240,602	157,618	160,456	21,070	✓	▼	✓	
7.2	Pay £'000		(161,048)	(108,111)	(109,509)	(13,403)	✗	▲	✗	
7.3	Non-pay £'000		(71,891)	(48,820)	(51,941)	(6,076)	✓	▲	✗	
7.4	Non-operating costs £'000		(12,893)	(8,596)	(8,567)	(1,074)	✓	▼	✓	
7.5	I&E Total £'000		(5,230)	(7,909)	(9,560)	517	✓	▼	✗	
7.6	Cash Balance £'000		2,500	2,410		4,895	✓	▲		
7.7	Savings Delivered £'000		10,130	5,327	5,673	842	✗	▲	✓	
7.8	Capital Expenditure £'000		29,673	16,895	5,354	1,360	✓	▼	✓	

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%		11.4%	✓	▲		
8.2	Agency Expenditure %		8%	8%	5.8%	5.8%	✓	▼	✓	
8.3	Staff sickness - % of days lost		4%	4%		4.0%	✓	▲		
8.4	Appraisals		90%	90%		85.0%	✗	▬		
8.5	Statutory Mandatory training		90%	90%		89.0%	✗	▬		
8.6	Substantive Staff Turnover		12%	12%		11.7%	✓	▼		
8.7	FFT Response Rate Staff (Quarterly)		15%	15%	14.0%	14.0%	✗	▼	✗	

OBJECTIVES - OTHER										
ID	Indicator	DQ Assurance	Target 18-19	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 12 months data
O.1	Total Number of NICE Breaches		8	8		94	✗	▲		
O.2	Rebooked cancelled OPs - 28 day rule		95%	95%	73.1%	50.0%	✗	▼	✗	
O.4	Overdue Datix Incidents >1 month		0	0		168	✗	▼		
O.5	Serious Incidents		45	<30	41	6	✗	▼	✗	
O.8	Completed Job Plans (Consultants)		90%	90%		90%	✓	▲		

Key: Monthly/Quarterly Change

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

YTD Position

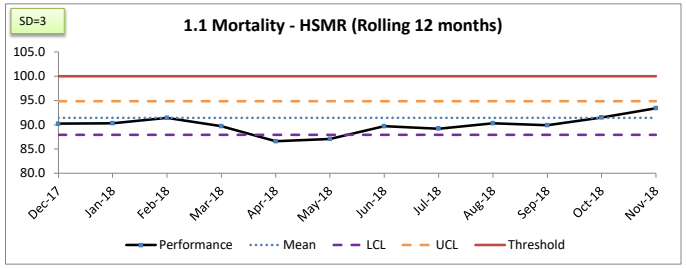
✓	Achieving YTD Target
	Within Agreed Tolerance*
✗	Not achieving YTD Target
✗	Annual Target breached

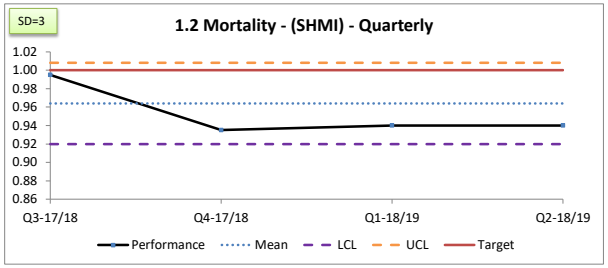
Data Quality Assurance Definitions

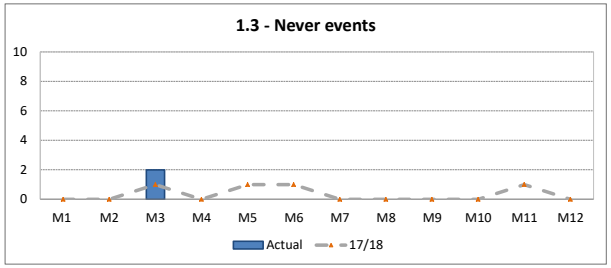
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory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

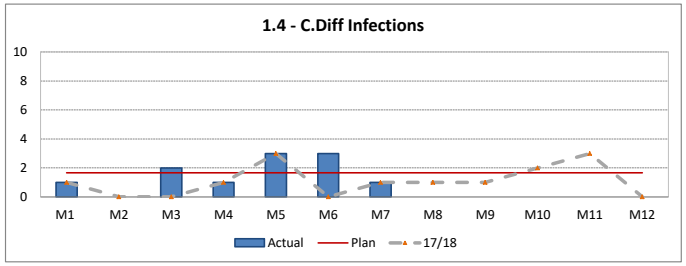
* Independently Audited – refers to an independent audit undertaken by either the Internal Auditor, External Auditors or the Data Quality Audit team.

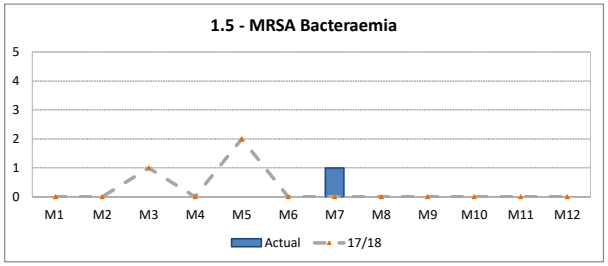
Date Produced: 14/12/2018

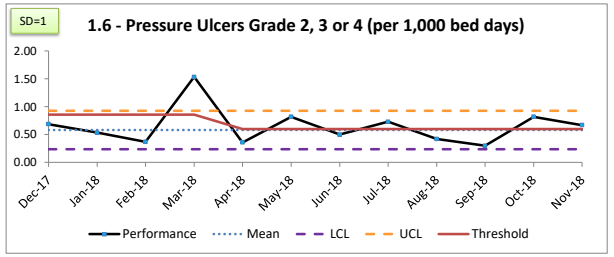


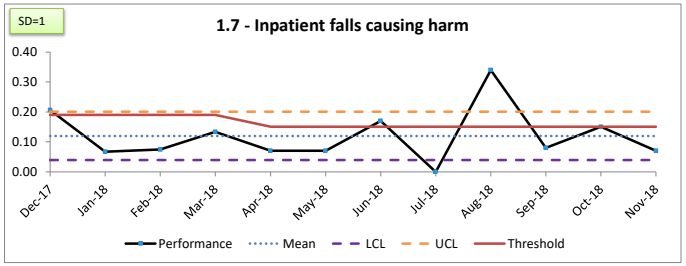


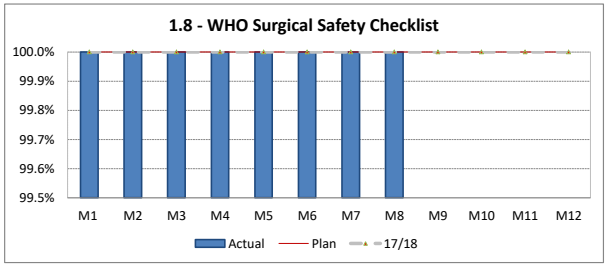


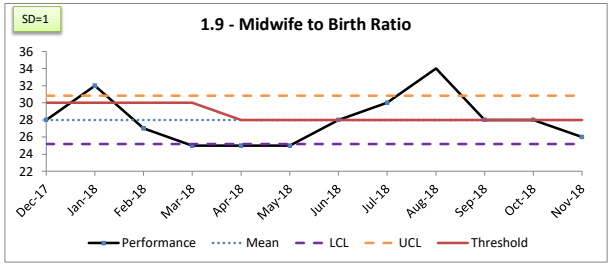


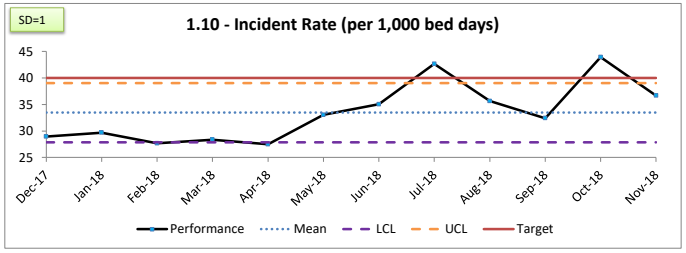


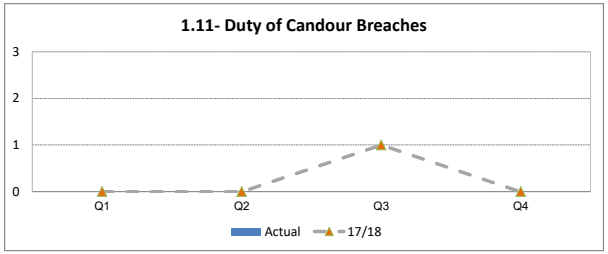


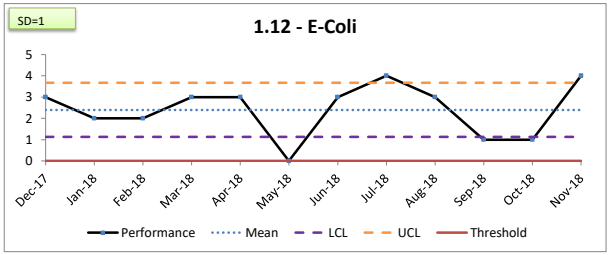












If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

- Performance activity on a rolling 12 months/quarterly
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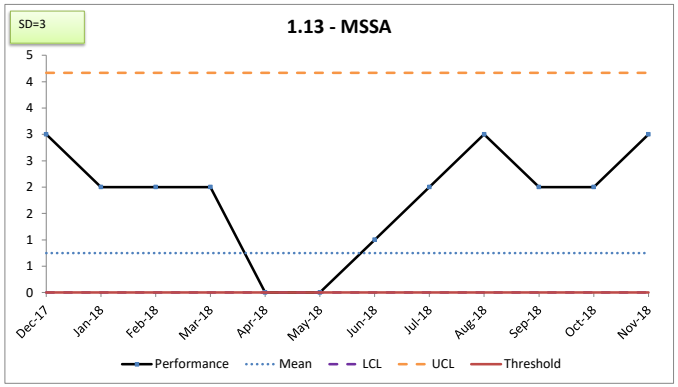

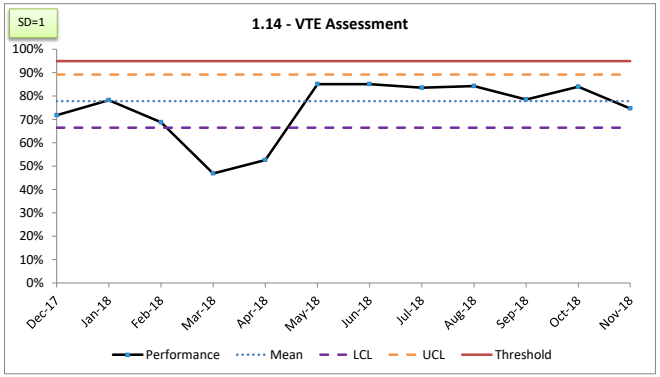

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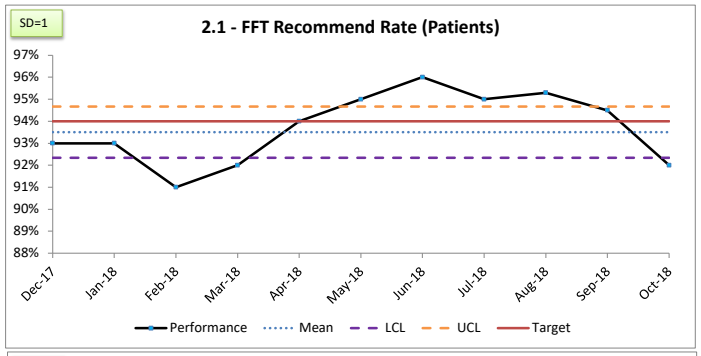
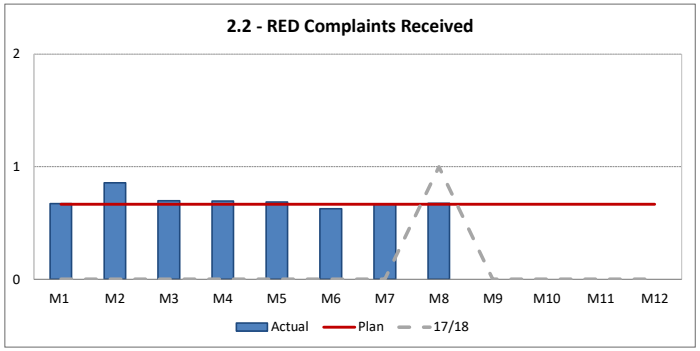
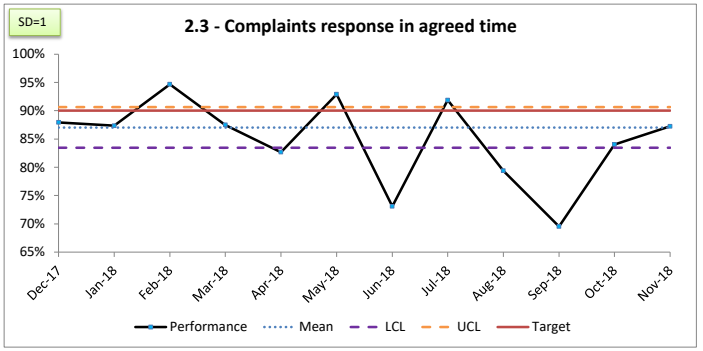
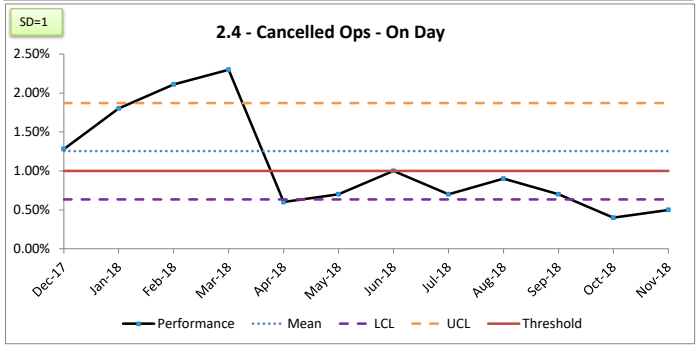
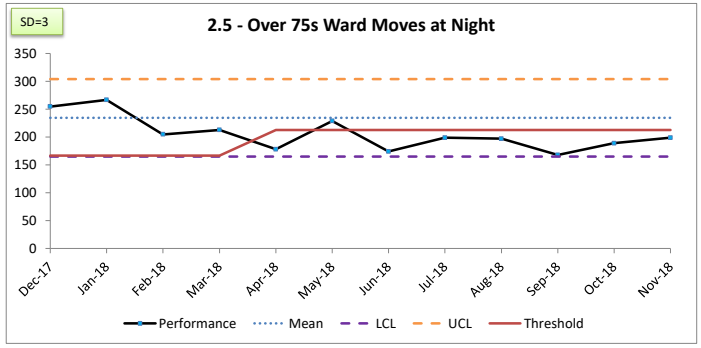
OBJECTIVE 2 - PATIENT EXPERIENCE

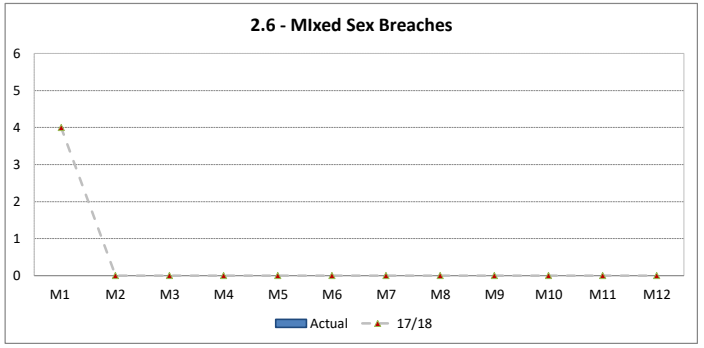












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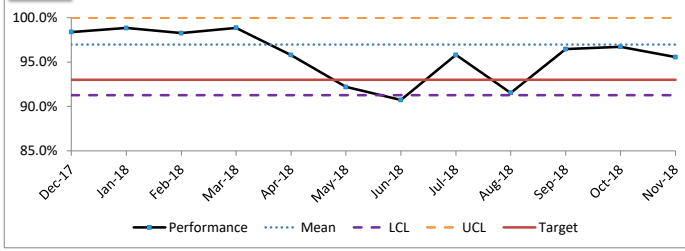
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

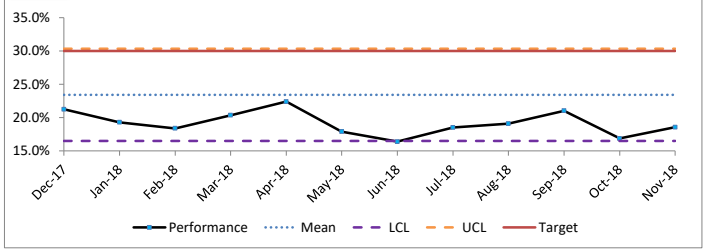
SD=3

3.1 - Overnight bed occupancy rate



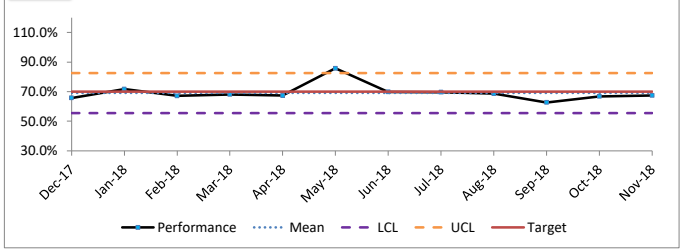
SD=3

3.2 - Ward Discharges by Midday



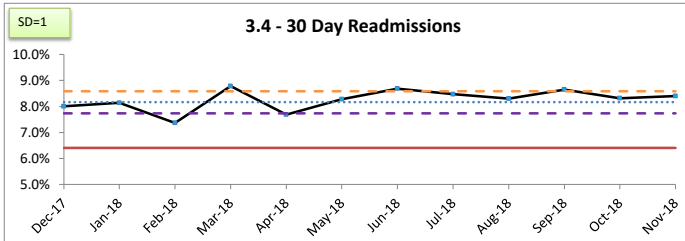
SD=3

3.3 - Weekend Discharges



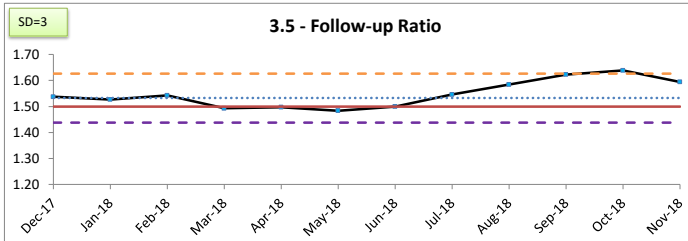
SD=1

3.4 - 30 Day Readmissions



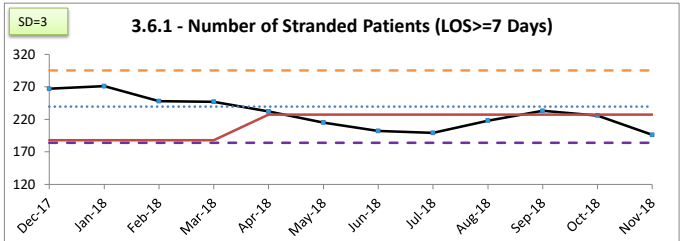
SD=3

3.5 - Follow-up Ratio



SD=3

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



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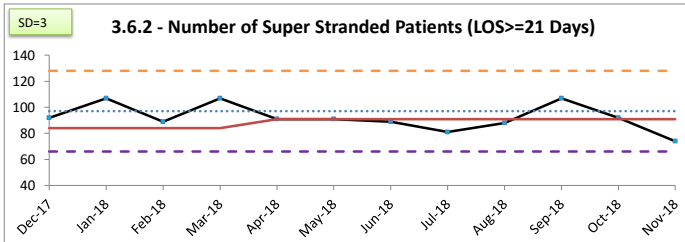
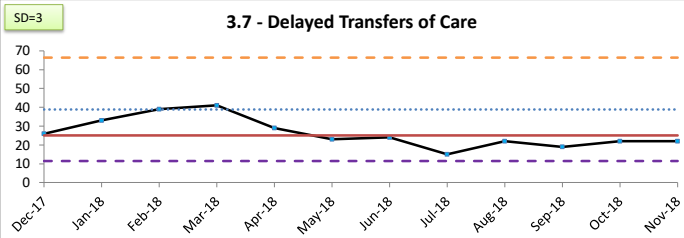
3.6.2 - Number of Super Stranded Patients (LOS>=21 Days)



SD=3

3.7 - Delayed Transfers of Care



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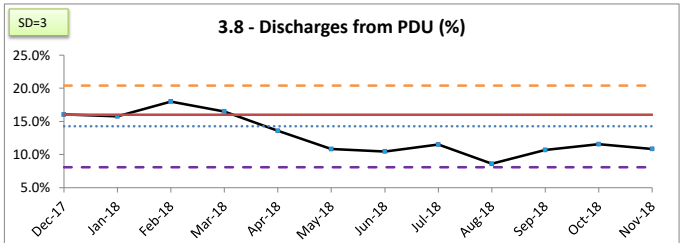
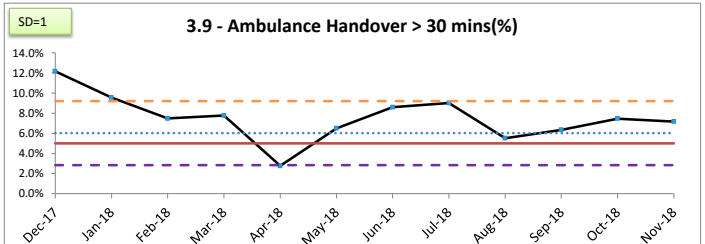
3.8 - Discharges from PDU (%)



SD=1

3.9 - Ambulance Handover > 30 mins(%)



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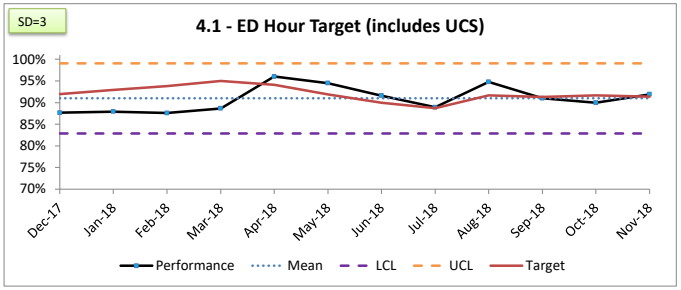
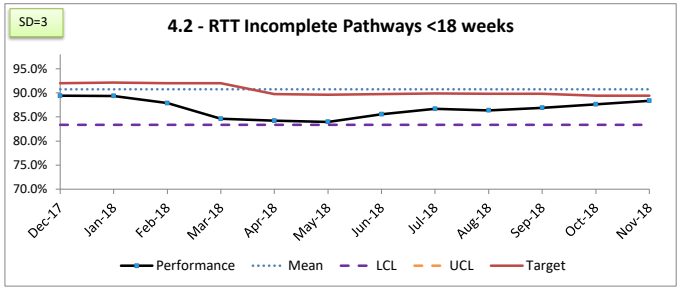
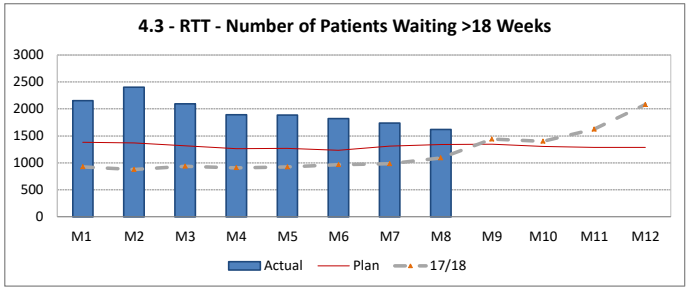
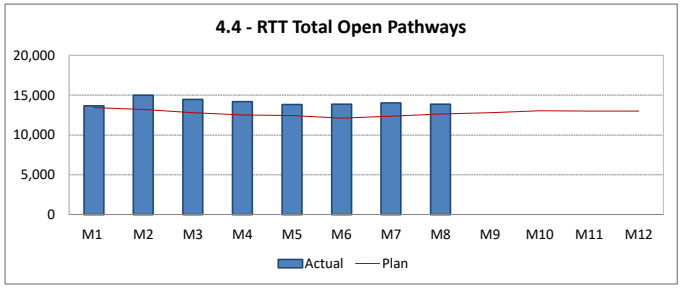
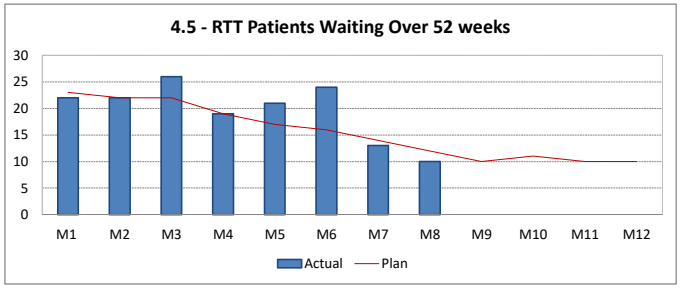
OBJECTIVE 4 - KEY TARGETS

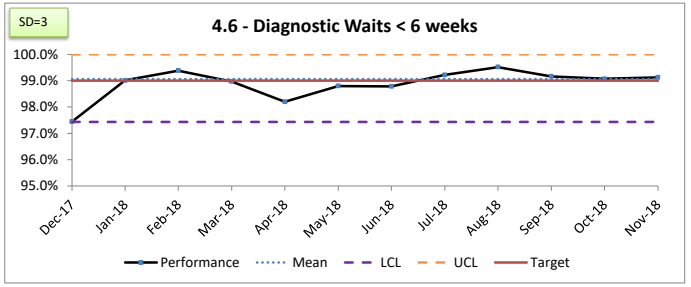


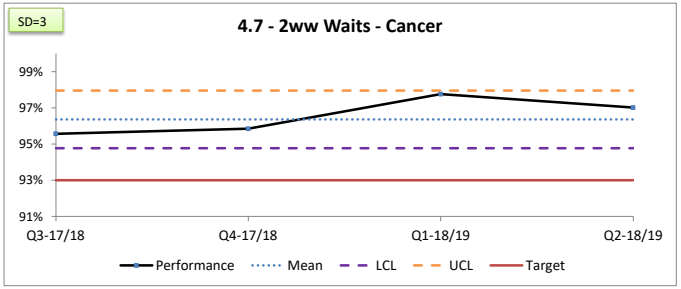


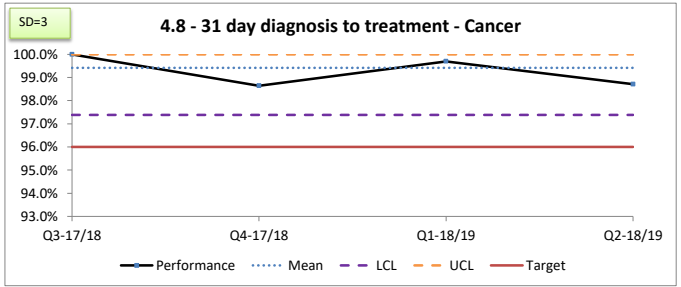


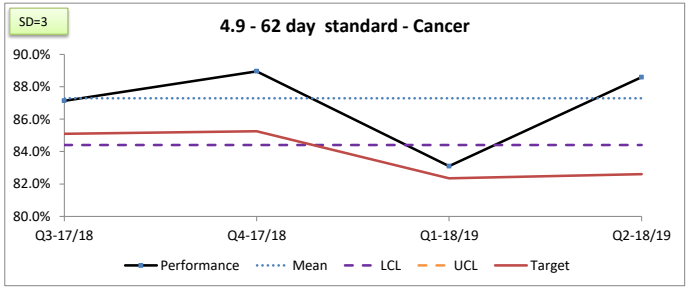












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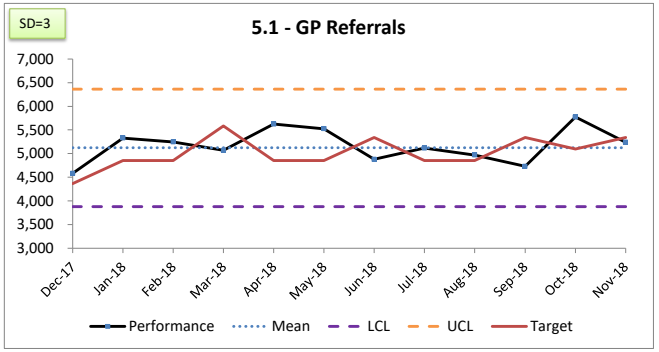
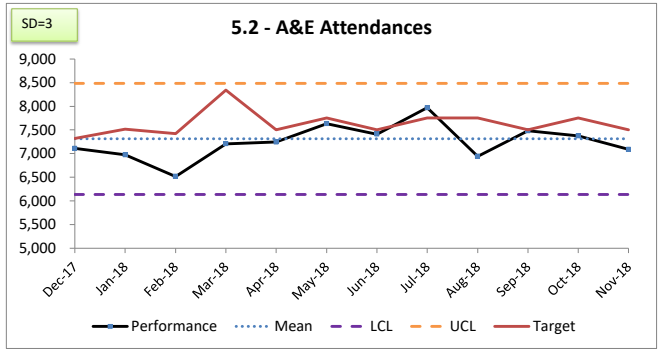
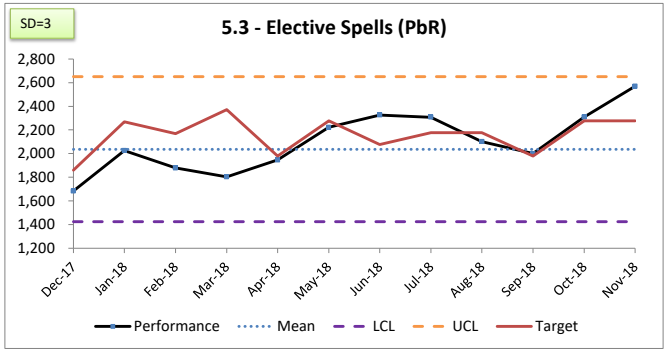
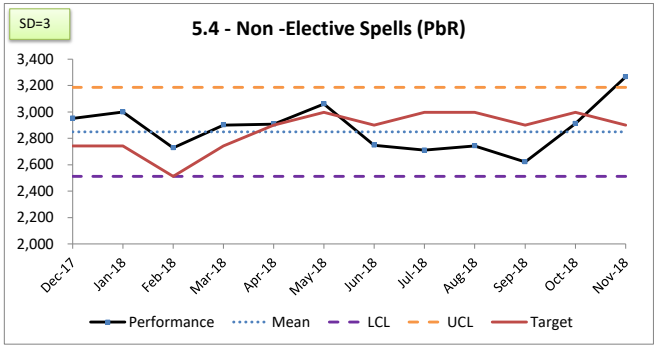
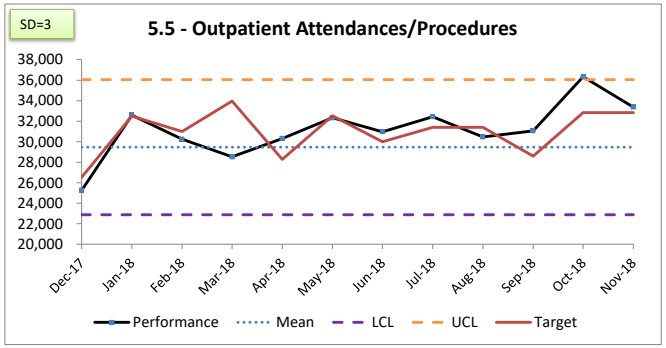
Milton Keynes University Hospital NHS Foundation Trust

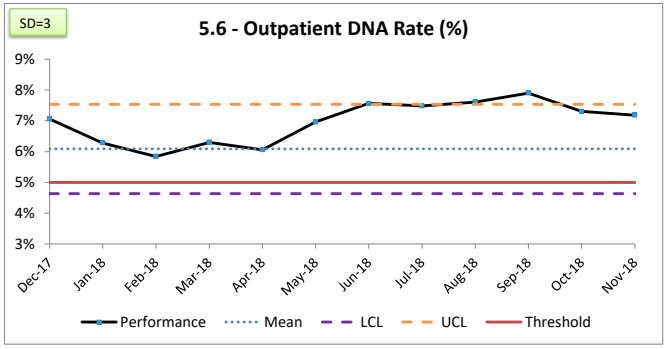


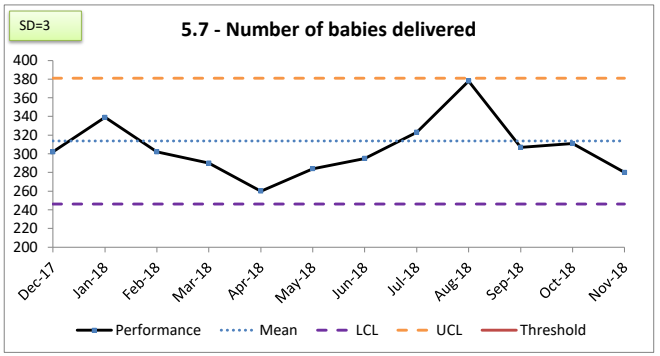


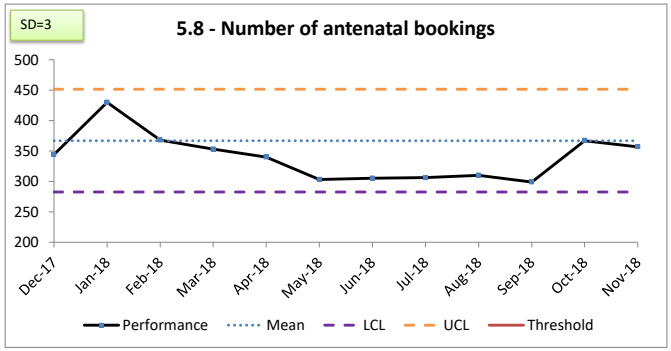












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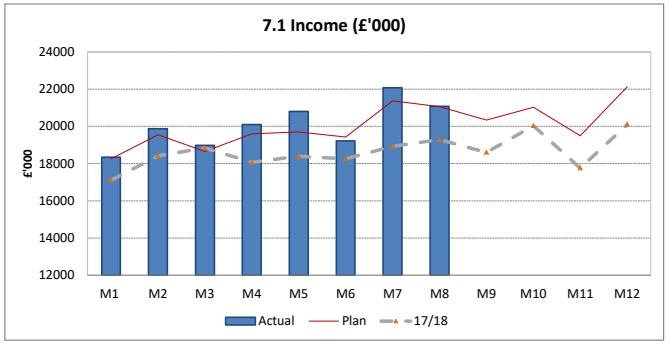
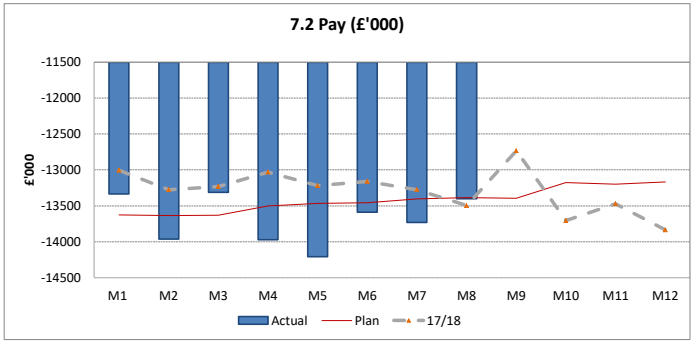
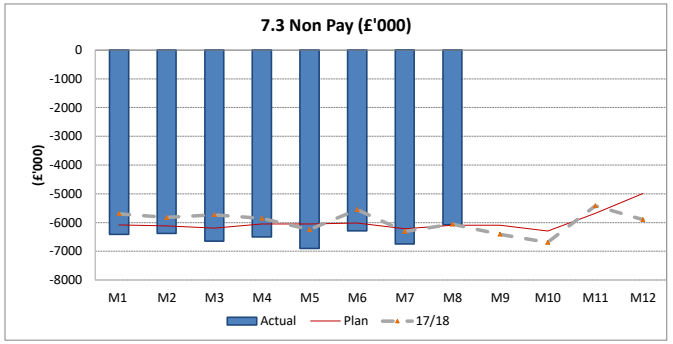
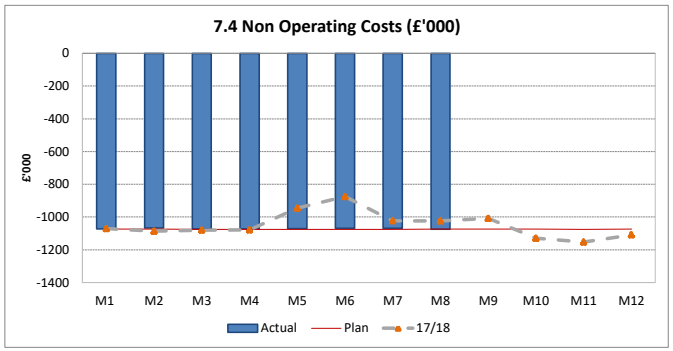
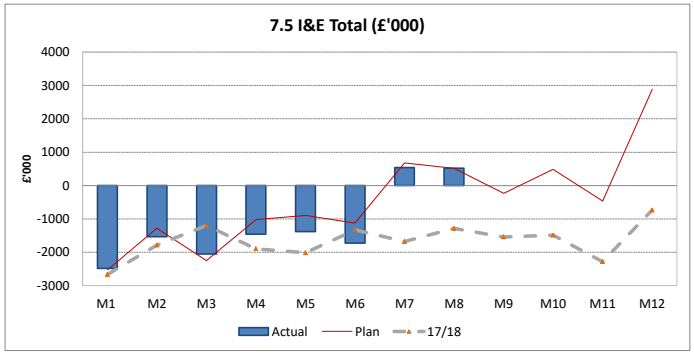
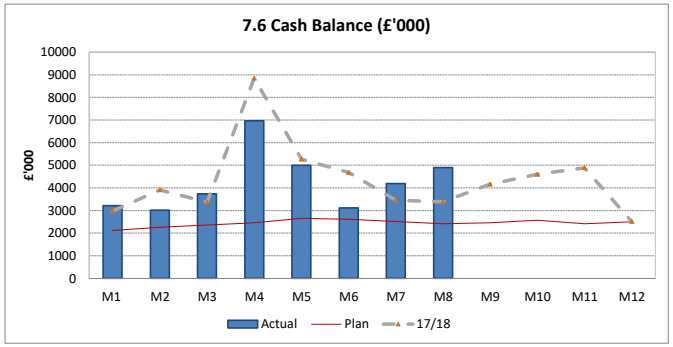

7.1 Income (£'000)
£'000
24000
22000
20000
18000
16000
14000
12000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

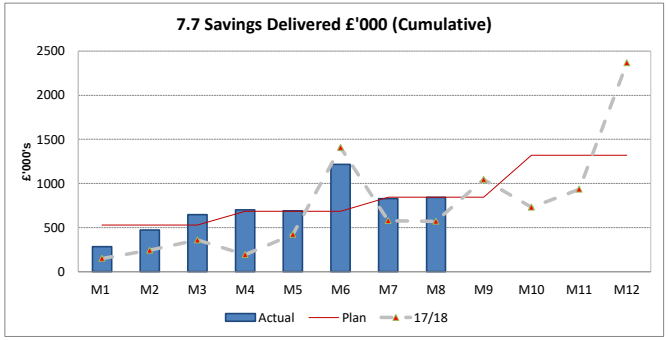

7.2 Pay (£'000)
£'000
-11500
-12000
-12500
-13000
-13500
-14000
-14500
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

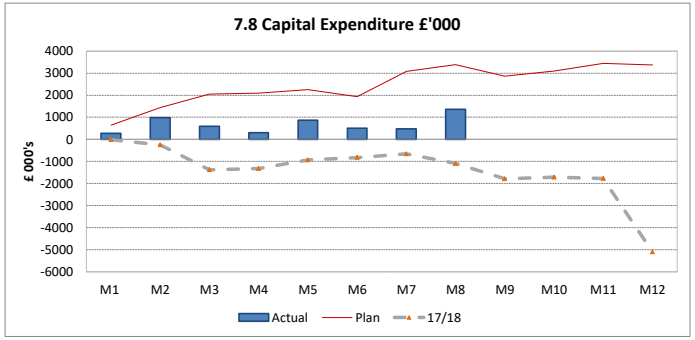

7.3 Non Pay (£'000)
(£'000)
0
-1000
-2000
-3000
-4000
-5000
-6000
-7000
-8000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18


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

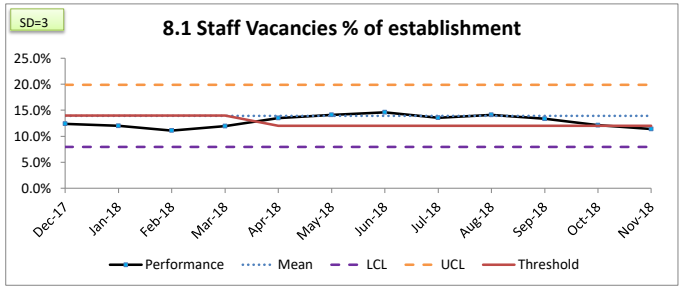

7.5 I&E Total (£'000)
£'000
4000
3000
2000
1000
0
-1000
-2000
-3000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

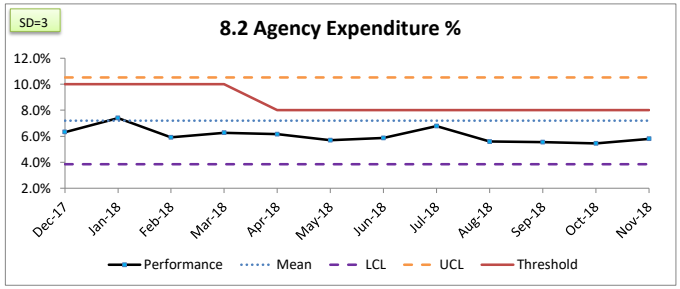

7.6 Cash Balance (£'000)
£'000
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

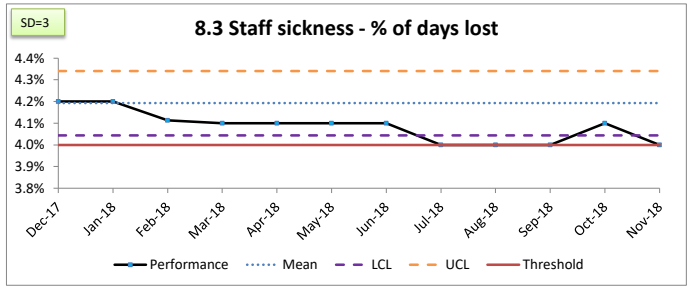

7.7 Savings Delivered £'000 (Cumulative)
£'000's
2500
2000
1500
1000
500
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

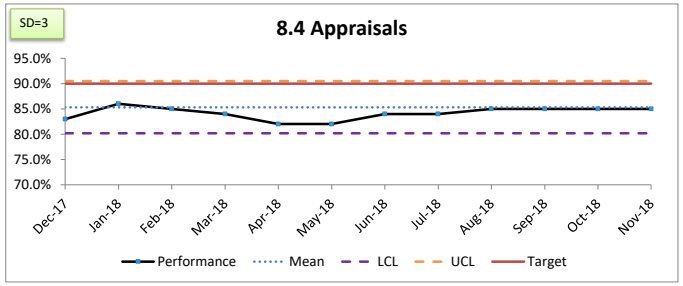

7.8 Capital Expenditure £'000
£ 000's
4000
3000
2000
1000
0
-1000
-2000
-3000
-4000
-5000
-6000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
17/18

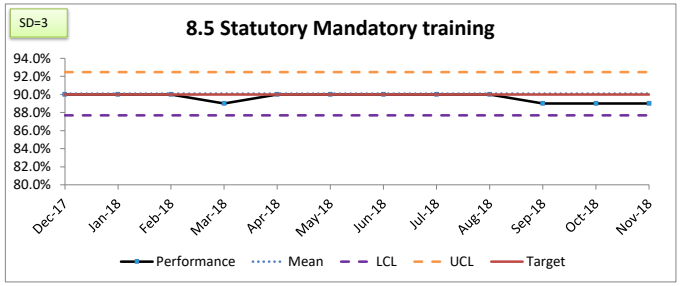
OBJECTIVE 8 - WORKFORCE PERFORMANCE

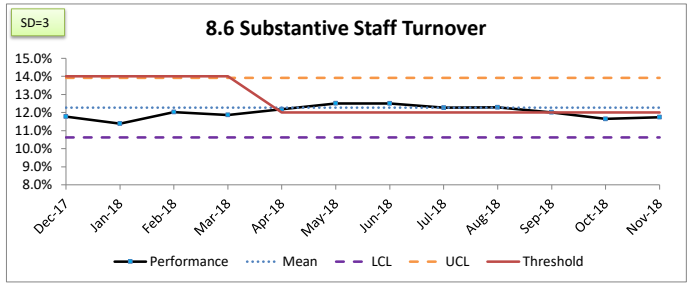


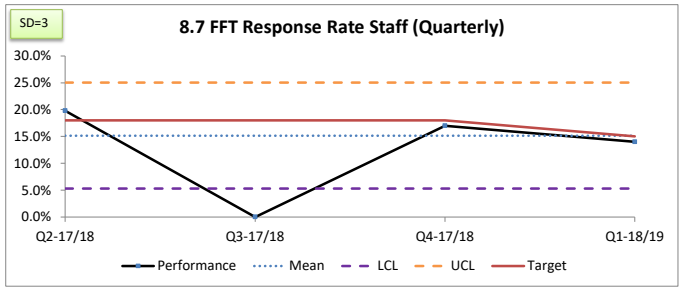












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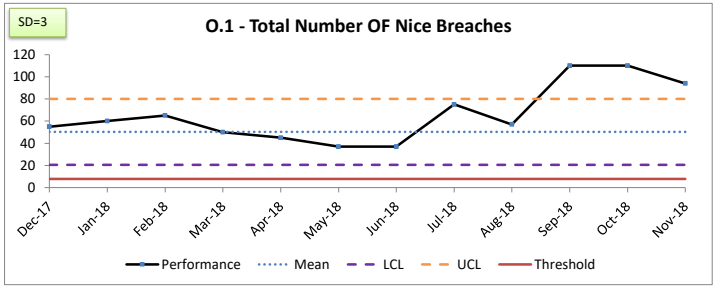

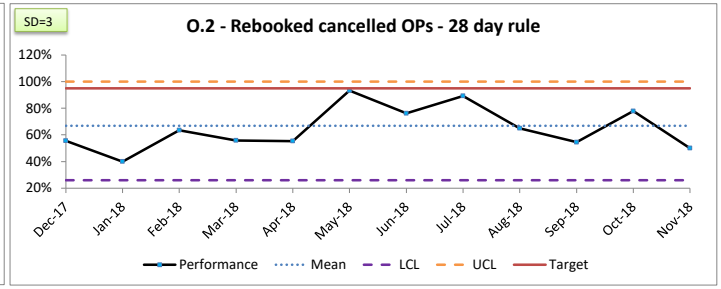

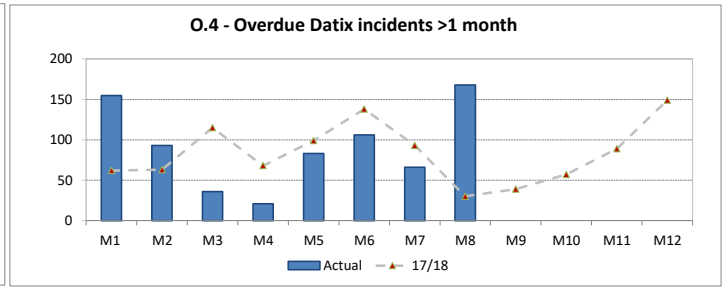

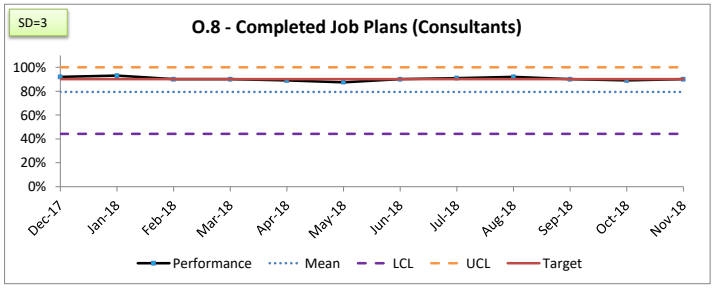

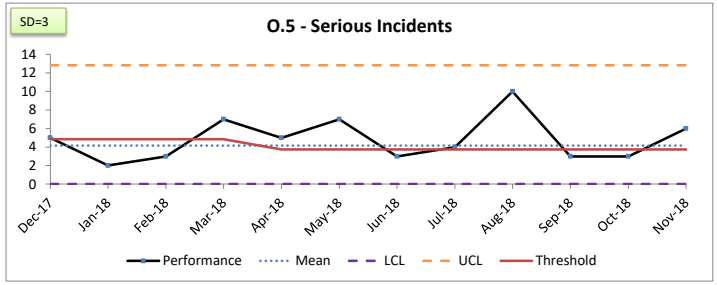

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Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Public Board	Date: 11 January 2019
Report title:	**Finance Paper Month 8 2018-19**	**Agenda item: 4.2**
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 8 (November 2018)**			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** X	**Decision** ☐
Recommendation	Finance & Investment Committee 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 Appendix 18.
Resource implications	See paper for details
Legal implications including equality and diversity assessment	This paper has been assessed to ensure it meets the general equality duty as laid down by the Equality Act 2010

Report history	None
Next steps	None
Appendices	1 to 3

FINANCE REPORT FOR THE MONTH TO 30th NOVEMBER 2018

PUBLIC BOARD MEETING

PURPOSE

1. The purpose of the paper is to:

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

EXECUTIVE SUMMARY

2. *Income and expenditure* –The Trust's surplus for November 2018 was £0.9m which is £0.4m positive to budget in the month and £1.6m negative year to date although £0.5m better than the Trust's control total (excluding PSF) on a year to date basis.

3. *Cash and capital position* – the cash balance as at the end of November 2018 was £4.9m, which was £2.4m above plan due to the timing of capital expenditure. The Trust has spent £5.4m on capital up to month 8 of which £1.4m relates to eCARE, Cancer Centre £1.4m, Multi-Storey Car Park £0.3m, North site infrastructure £0.2m, UEC and GDE £0.2m and £1.8m on patient safety and clinically urgent capital expenditure.

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

5. *Cost savings* – overall savings of £1.5m were delivered in month against an identified plan of £1.4m and the target of £0.8m. Overall for the year £9.6m of schemes have been identified, of which £8.9m have been validated and approved against the £10.1m target.

INCOME AND EXPENDITURE

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

All Figures in £'000	Month Plan	Month Actual	Month Var	YTD Plan	YTD Actual	YTD Var	Full Year Plan	Full Year Forecast	Full Year Var
Clinical Revenue	17,074	17,890	815	134,884	137,934	3,050	200,842	200,842	0
Other Revenue	1,578	1,946	368	12,808	15,451	2,643	19,107	19,107	0
Total Income	18,652	19,836	1,183	147,692	153,385	5,693	219,949	219,949	0
Pay	(13,440)	(13,807)	(367)	(108,237)	(109,913)	(1,676)	(161,241)	(161,241)	0
Non Pay	(6,039)	(6,401)	(362)	(48,693)	(52,266)	(3,573)	(72,600)	(72,600)	0
Total Operational Expend	(19,479)	(20,208)	(729)	(156,930)	(162,179)	(5,249)	(233,841)	(233,841)	0
EBITDA	(827)	(372)	455	(9,238)	(8,794)	444	(13,892)	(13,892)	0
Financing & Non-Op. Costs	(1,016)	(1,013)	3	(8,125)	(8,101)	24	(12,191)	(12,191)	0
Control Total Deficit (excl. PSF)	**(1,843)**	**(1,385)**	**458**	**(17,363)**	**(16,895)**	**468**	**(26,083)**	**(26,083)**	**0**
Adjustments excl. from control total:									
PSF- Performance	308	308	0	1,694	1,694	0	3,079	3,079	0
PSF- Financial	615	615	0	3,381	3,381	0	6,147	6,147	0
PSF- ICS Financial	104	0	(104)	571	0	(571)	1,037	1,037	0
PSF- Incentive	390	390	0	780	780	0	1,800	1,800	0
Control Total Deficit (incl. PSF)	**(426)**	**(72)**	**354**	**(10,937)**	**(11,040)**	**(103)**	**(14,019)**	**(14,019)**	**0**
Donated income	1,000	1,000	0	3,500	2,000	(1,500)	8,592	8,592	0
Donated asset depreciation	(58)	(59)	(1)	(464)	(464)	0	(697)	(697)	0
Reported deficit/surplus	**516**	**869**	**353**	**(7,901)**	**(9,504)**	**(1,603)**	**(6,124)**	**(6,124)**	**0**

Monthly and year to date review

7. The **deficit excluding Provider Sustainability Funding (PSF)** in month 8 is £1,385k which is £458k favourable to plan in month. Year to date, the deficit excluding PSF is £16,895k which is £468k better than plan year to date and therefore the Trust is on track to secure the financial element of PSF in Q3. The Trust is forecasting to meet the A&E performance requirements for Q3 however there is some risk associated with achieving this target. The STP continues to be behind plan at M8 and as a result the Trust has reported a negative variance of £104k (£571k YTD) in respect of the STP element of PSF, however this has been mitigated by the recognition of £467k of transformation fund income in month.

8. The Trust reported a surplus in month 8 is £869k which is £353k favourable against a planned surplus of £516k (£1,603k adverse against a year to date deficit of £7,901k). The adverse variance includes £104k (£571k YTD) of lost PSF linked to the STP's performance offset by £467k transformation funding and the YTD figure includes £1,500k due to timing differences in the receipt of donated income.

9. **Income (excluding PSF and donations)** is £1,183k favourable to plan in November and £5,693k favourable YTD and can be further analysed in Appendix 1.

10. **Operational costs** in November are adverse to plan by £729k and £5,249k YTD.

11. **Pay costs** are £367k adverse to budget in Month 8. The variance is a result of high substantive and bank expenditure in month partly due to the higher than budgeted national pay award which is largely offset by central funding (total of £187k).

12. **Non pay costs** were £362k adverse to plan in month and £3,573k YTD. The in-month variances relate to drugs, outsourcing and clinical supplies costs required to deliver the higher than planned activity levels.

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

COST SAVINGS

14. In Month 8, £1,513k was delivered against an identified plan of £1,438k and a target of £848k.

15. Overall for the year £9.6m of schemes have been identified, of which £8.9m have been validated and approved against the £10.1m target.

CASH AND CAPITAL

16. The cash balance at the end of November 2018 was £4.9m, which was £2.5m above plan due to the timing of capital spend.

17. The Trust required a draw down in November of £3.7m.

18. 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 £11.5m; this is mainly driven by the timing of capital projects.

    - Current assets are above plan by £4.7m, this is due to cash £2.5m, receivables £2.1m and inventories £0.1m above plan. See Appendix 12 and Appendix 13 for further debtor details.

    - Current liabilities are above plan by £1.2m. This is being driven by Trade and Other Creditors £0.9m and deferred income £0.4m above plan, offset by provisions £0.1m below plan.

    - Non-Current Liabilities are below plan by £5.2m. This is being driven by the timing of revenue loan funding from NHSI being different to planned.

19. The Trust has spent £5.4m on capital up to month 8 of which £1.4m relates to ECare, Cancer Centre £1.4m, Multi-Storey Car Park £0.3m, North site infrastructure £0.3m, UEC and GDE £0.2m and £1.8m on patient safety and clinically urgent capital expenditure.

RISK REGISTER

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

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

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

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

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

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

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

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

In order to receive the full amount of Provider Sustainability Funding (PSF, previously sustainability and transformation funding) in 2018-19, the Trust needs 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 2018/19 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 of income.

RECOMMENDATIONS TO TRUST BOARD

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

Appendix 1

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

	November 2018			8 months to November 2018			Full year
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME							
Outpatients	3,756	3,974	218	28,277	29,310	1,033	42,079
Elective admissions	2,502	2,513	10	19,208	19,687	479	28,189
Emergency admissions	5,288	6,036	748	43,006	42,710	(297)	64,335
Emergency adm's marginal rate (MRET)	(270)	(483)	(213)	(2,198)	(2,686)	(488)	(3,287)
Readmissions Penalty	(213)	(260)	(47)	(1,735)	(1,791)	(56)	(2,594)
A&E	1,093	1,007	(86)	8,892	8,285	(607)	13,302
Maternity	1,937	1,643	(294)	15,329	13,728	(1,601)	22,856
Critical Care & Neonatal	508	438	(70)	4,132	4,200	68	6,181
Excess bed days	0	0	0	0	0	0	0
Imaging	423	435	11	3,205	3,390	186	4,752
Direct access Pathology	407	386	(21)	3,081	3,110	29	4,569
Non Tariff Drugs (high cost/individual drugs)	1,367	1,420	53	11,098	12,435	1,337	16,607
Other	274	780	506	2,588	5,555	2,966	3,854
Clinical Income	**17,074**	**17,890**	**815**	**134,884**	**137,934**	**3,050**	**200,842**
Non-Patient Income	**3,995**	**4,259**	**264**	**22,734**	**23,306**	**572**	**39,763**
TOTAL INCOME	**21,069**	**22,149**	**1,079**	**157,618**	**161,240**	**3,622**	**240,605**
EXPENDITURE							
Total Pay	**(13,440)**	**(13,807)**	**(367)**	**(108,237)**	**(109,913)**	**(1,676)**	**(161,241)**
Non Pay	(4,673)	(4,981)	(308)	(37,595)	(39,831)	(2,236)	(55,993)
Non Tariff Drugs (high cost/individual drugs)	(1,367)	(1,420)	(53)	(11,098)	(12,435)	(1,337)	(16,607)
Non Pay	**(6,040)**	**(6,401)**	**(362)**	**(48,693)**	**(52,266)**	**(3,573)**	**(72,600)**
TOTAL EXPENDITURE	**(19,480)**	**(20,208)**	**(728)**	**(156,930)**	**(162,179)**	**(5,249)**	**(233,841)**
EBITDA*	**1,589**	**1,940**	**351**	**688**	**(939)**	**(1,627)**	**6,764**
Depreciation and non-operating costs	(942)	(941)	1	(7,536)	(7,511)	25	(11,309)
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**647**	**999**	**352**	**(6,848)**	**(8,451)**	**(1,602)**	**(4,544)**
Public Dividends Payable	(132)	(132)	0	(1,053)	(1,053)	0	(1,579)
OPERATING DEFICIT AFTER DIVIDENDS	**516**	**868**	**352**	**(7,901)**	**(9,504)**	**(1,602)**	**(6,124)**

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

Appendix 2

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

Statement of Cash flow For The Period Ended 30th November 2018

	Mth 8 £000	Mth 7 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	(7,016)	(8,199)	1,183
Operating surplus/(deficit) of discontinued operations			
Operating (deficit)	**(7,016)**	**(8,199)**	**1,183**
Non-cash income and expense:			
Depreciation and amortisation	6,077	5,315	762
(Increase)/Decrease in Trade and Other Receivables	624	3,677	(3,053)
(Increase)/Decrease in Inventories	(4)	(3)	(1)
Increase/(Decrease) in Trade and Other Payables	636	1,103	(467)
Increase/(Decrease) in Other Liabilities	400	224	176
Increase/(Decrease) in Provisions	(34)	(18)	(16)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	(1,000)	(1,000)	0
Other movements in operating cash flows	1	(2)	3
NET CASH GENERATED FROM OPERATIONS	**(316)**	**1,097**	**(1,413)**
Cash flows from investing activities			
Interest received	32	27	5
Purchase of intangible assets	(788)	(635)	(153)
Purchase of Property, Plant and Equipment, Intangibles	(5,111)	(4,069)	(1,042)
Net cash generated (used in) investing activities	**(5,867)**	**(4,677)**	**(1,190)**
Cash flows from financing activities			
Loans received from Department of Health	10,560	6,900	3,660
Loans repaid to Department of Health	(636)	(476)	(160)
Capital element of finance lease rental payments	(96)	(84)	(12)
Interest paid	(1,263)	(1,105)	(158)
Interest element of finance lease	(205)	(179)	(26)
PDC Dividend paid	(789)	(789)	0
Receipt of cash donations to purchase capital assets	1,000	1,000	0
Cash flows from (used in) other financing activities	0	0	0
Net cash generated from/(used in) financing activities	**8,571**	**5,267**	**3,304**
Increase/(decrease) in cash and cash equivalents	**2,388**	**1,687**	701
Opening Cash and Cash equivalents	**2,507**	**2,507**	0
Closing Cash and Cash equivalents	**4,895**	**4,194**	**701**

Appendix 3

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

	Audited Mar-18	Nov-18 YTD Plan	Nov-18 YTD Actual	In Mth Mvmt	YTD Mvmt	% Variance
Assets Non-Current						
Tangible Assets	171.9	180.2	170.7	(9.5)	(1.3)	(0.7%)
Intangible Assets	10.0	12.5	10.4	(2.1)	0.4	4.0%
Other Assets	0.4	0.4	0.5	0.1	0.1	35.3%
Total Non Current Assets	**182.3**	**193.1**	**181.6**	**(11.5)**	**(0.7)**	**(0.4%)**
Assets Current						
Inventory	3.3	3.2	3.3	0.1	(0.0)	(1.2%)
NHS Receivables	19.1	15.8	13.9	(1.9)	(5.2)	(27.2%)
Other Receivables	4.1	4.5	8.5	4.0	4.4	107.3%
Cash	2.5	2.4	4.9	2.5	2.4	95.5%
Total Current Assets	**29.0**	**25.9**	**30.6**	**4.7**	**1.6**	**5.4%**
Liabilities Current						
Interest -bearing borrowings	(32.3)	(31.6)	(31.6)	0.0	0.7	-2.2%
Deferred Income	(1.6)	(1.6)	(2.0)	(0.4)	(0.4)	25.0%
Provisions	(1.4)	(1.4)	(1.3)	0.1	0.1	-3.8%
Trade & other Creditors (incl NHS)	(28.4)	(27.6)	(28.5)	(0.9)	(0.1)	0.3%
Total Current Liabilities	**(63.7)**	**(62.2)**	**(63.4)**	**(1.2)**	**0.3**	(0.4%)
Net current assets	**(34.7)**	**(36.3)**	**(32.9)**	**3.4**	**1.8**	**(5.3%)**
Liabilities Non-Current						
Long-term Interest bearing borrowings	(83.6)	(99.4)	(94.2)	5.2	(10.6)	12.7%
Provisions for liabilities and charges	(1.1)	(1.1)	(1.1)	(0.0)	(0.0)	3.8%
Total non-current liabilities	**(84.7)**	**(100.5)**	**(95.3)**	**5.2**	**(10.6)**	12.6%
Total Assets Employed	**62.9**	**56.3**	**53.4**	**(3.0)**	**(9.5)**	**(15.1%)**
Taxpayers Equity						
Public Dividend Capital (PDC)	99.2	100.4	99.2	(1.2)	(0.0)	0.0%
Revaluation Reserve	78.7	78.7	78.7	0.0	0.0	0.0%
I&E Reserve	(115.0)	(122.8)	(124.4)	(1.6)	(9.4)	8.2%
Total Taxpayers Equity	**62.9**	**56.3**	**53.4**	**(2.8)**	**(9.4)**	**(15.0%)**

Meeting title	**Trust Board**	**Date: 11 January 2019**
Report title:	**Workforce Report**	**Agenda item: 4.3**
Lead director **Report author**	**Name: Danielle Petch** **Name: Paul Sukhu**	**Title: Director of Workforce** **Title: Deputy Director of Workforce**
FoI status:		

Report summary	This report provides a summary of workforce Key Performance Indicators for the full year ending 30 November 2018 (Month 8).			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [x]	**Decision** [ ]
Recommendation	Trust Board is asked to note the Workforce report.			

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

Report history	Full monthly Corporate Workforce Information report - Executive Management Board, Divisional Accountability, 19 December 2018
Next steps	
Appendices	

Workforce report – Month 8, 2018/19

1. Purpose of the Report

1.1. This report provides a summary of key workforce Key Performance Indicators for the full year ending 30 November 2018 (Month 8).

2. Staff in post

2.1. The Trust's staff in post by whole time equivalent (WTE) was 3065.4 as at 31 October 2018; an increase of 43.7 WTE since November 2017.

2.2. The Trust's headcount is 3547, an increase of 53 since November 2017.

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

3. Vacancy rate

3.1. A more detailed Quarterly Workforce Information Report is produced for Workforce Board, Workforce and Development Assurance Committee and JCNC, including vacancy rate by staff group.

3.2. Month 8 is the third inclusion of these data to the monthly Corporate Workforce Information Report. These data are derived from ESR and may therefore be subject to some variation from data presented from the financial ledger due to the timing and input of the post virement/changes process.

3.3. Medical and Dental (16.7% down from 18.1% in M7) and Nursing and Midwifery (17.5%) vacancy rates are the highest Trust-level vacancy rates at Month 8 – more detail is presented at Divisional level to the Executive Management Board in the Divisional Workforce reports.

4. Temporary staffing

4.1. The temporary staff usage (bank and agency) for the rolling year-to-date was 5824.7 WTE, which was 14.1% of total WTE staff employed.

4.2. Agency staff usage was 3.8% of the total WTE staff employed for the rolling year to date but was 6.2% of the total annual staff expenditure, predominantly driven by high cost Medical and Dental agency locums and volume of Nursing agency staff.

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

5. Sickness absence

5.1. The sickness absence rate (N.B. 12 months to M7, 31 October 2018) for the Trust remains slightly above the trust target of 4.0% at 4.05% (1.82% short term and 2.23% long term).

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

5.3. Steps are being taken to address under-reporting of sickness absence across the Trust, in particular in the medical and dental profession. Reported Medical and Dental absence levels remain low but are expected to rise to a more realistic level as HealthRoster interventions take effect in 2019/20.

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

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

6. Turnover

6.1. Overall, the Trust's leaver turnover rate has been lower in 2017/18 than it was in 2016/17 and in line with its trend for Q2 into Q3, has reduced from 12.6% to 11.7% since May 2018.

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

6.3. This supports further retention focused work; including; Health and Wellbeing improvement, HealthRoster utilisation improvement and implementation plan, Matron's Accountability Framework and Internal Transfer Market. Nursing and Midwifery turnover continues to decrease (10.7% from 11.1% in M6).

6.4. As agreed at Nursing and Midwifery Board in December 2018, activity in this area will pick up again in Q4.

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

7. Statutory and Mandatory training

7.1. Statutory and Mandatory training compliance as at 30 November 2018 was 89% against the Trust target of 90%.

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

7.3. It is anticipated that the 2018 Agenda for Change pay structure reform will support the Trust's improvement plans in this area. Further clarification has now been received from NHS Employers on the scope of the implementation plan for staff; the Trust is pursuing its stated strategy in this regard. To this end, policy development is ongoing to support implementation and is due for approval by February 2019 in advance of the pay system going live on 01 April 2019.

7.4. Correspondence has been sent to all employees under a pilot (including Medical and Dental colleagues) to outline their current compliance levels by individual course, means of accessing courses, how to correct anomalies and the support mechanisms available to colleagues.

Training Compliance by Division	
Core Clinical	93%
Corporate Services	92%
Medicines Unplanned Care	87%
Surgical Planned Care	86%
Women's and Children's	91%
Trust Total Compliance	**89%**

8. Appraisal compliance

8.1. Appraisal compliance as at 30 November 2018 remained at 85% against the Trust target of 90%.

8.2. Compliance has deteriorated from 86% since January 2018 but has improved since M1 (82%), reaching a plateau in recent months.

8.3. As outlined at paragraph 7.3; it is anticipated that the 2018 Agenda for Change pay structure reform will support the Trust's improvement plans in this area.

Appraisal Completion by Division	
Core Clinical	92%
Corporate Services	82%
Medicines Unplanned Care	82%
Surgical Planned Care	77%
Women's and Children's	92%
Total Trust	**85%**

9. Recommendations

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

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Meeting title	**Public Board Meeting**	**Date: 11 January 2019**
Report title:	**Freedom to Speak Up**	**Agenda item: 5.1**
Lead director **Report author** **Sponsor(s)**	**Name: Danielle Petch** **Name: Danielle Petch**	**Title: Director of Workforce** **Title: Director of Workforce**
FoI status:		

Report summary	This paper provides an updated Freedom To Speak Up policy and definition of Freedom To Speak Up responsibilities.			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** x	**Decision** ☐
Recommendation				

Strategic objectives links	To meet the top three Trust objectives of 1. patient safety, 2. patient experience 3. clinical effectiveness
Board Assurance Framework links	
CQC outcome/ regulation links	Well Led - Outcome 13 Staffing CQC outcomes - 12 and 14
Identified risks and risk management actions	
Resource implications	
Legal implications including equality and diversity assessment	

Report history	
Next steps	
Appendices	

1. Background & Introduction

Throughout 2018 new guidance documents, case studies and tools have been published by the National Guardian Office to assist Trusts in delivering the national Freedom to Speak Up (FTSU) agenda.

Throughout the guidance and documentation there is an increased focus on the propagation of FTSU principles across the entire organisation and the refocus of speaking up to be not simply taking concerns to the FTSU Guardians but embedding the FTSU ethos across the entire Trust. There is a theme of using FTSU as a mechanism for ensuring each Trust is a true learning organisation.

The most recent guidance places significant emphasis on all managers understanding their FTSU requirements as well as ensuring the Board and senior managers (not simply very senior managers, but all senior managers) are familiar with their FTSU responsibilities. To ensure this is the case a document outlining the responsibilities at all areas has been produced (Appendix A).

The staff experience has also been considered with the case studies recommending thanking anyone who speaks up as a matter of great importance. There is a requirement to keep detailed records of issues which have been spoken up about, both to the FTSU Guardians as well as generally to managers, and to report these statistics to Board and regulators as required.

At MKUH there are two FTSU Guardians, Nicky Burns-Muir and Adewale Kadiri. The Executive Lead is the Director of Workforce and the Non-Executive Lead is the Senior Independent Director (SID). The required reports are produced for Board and one of the FTSU Guardians attends to present these.

Colleagues across MKUH are familiar with the FTSU Guardians and have been speaking up when issues arise. MKUH already has an embedded learning culture, with staff raising areas for improvement as part of business as usual activities. It is worth noting however, that if asked colleagues do not necessarily recognise this as “speaking up”. This can be evidenced by the staff survey outcome in response to the question *“Last error/near miss/incident seen that could hurt staff and/or patients/service users reported”*. 97% of colleagues did so but some may not recognise this behaviour as a form of “speaking up”. This may become problematic should a regulator inspection focus on asking colleagues if they speak up as part of their regular routine/activities.

2. Self-Assessment Tool & Action Plan

The NHS Improvement and National Guardian Office have published guidance setting out the expectations for Boards in relation to FTSU in a bid to help Boards create a culture that is responsive to feedback and focused on learning and continued improvement. A self-assessment tool for Trust Boards was published alongside the case studies. The self-assessment tool is aligned with the CQC assessment, in line with good practice set out in the well-led framework.

The self-assessment tool covers 8 main areas:

1. Leaders are knowledgeable about FTSU
2. Leaders have a structured approach to FTSU
3. Leaders actively shape the speaking up culture
4. Leaders are clear about their roles and responsibilities
5. Leaders are confident that wider concerns are identified and managed
6. Leaders receive assurance in a variety of forms
7. Leaders engage with all relevant stakeholders
8. Leaders are focused on learning and continual improvement

A self-assessment was carried out using the tool and an action plan created to address the areas of improvement identified as a result. The key actions were:

- Refresh policy to ensure it reflects all the best practice guidance
- Widen FTSU process, documentation and guidance to encourage speaking up by all and at all levels, about all issues, leading to the embedded MKUH learning culture being recognised as linked to FTSU.
- Draft clear guidance for Board responsibilities
- Draft clear guidance for Senior Manager responsibilities
- Draft clear guidance for Executive & Non-Executive Lead responsibilities
- Create an audit process and timeline, ensuring recommendations as a result are followed

In addition, and taking account of the need for FTSU to be wider and about all levels of issues, not necessarily serious issues alone, the FTSU Guardians and the Executive Lead proposed the implementation of MKUH FTSU Ambassadors, additional trained people with whom colleagues can also raise concerns and issues. The FTSU Guardians led the recruitment drive for those volunteers and provide full training and oversight of FTSU Ambassador processes and procedures. Any employee can volunteer to be a FTSU Ambassador but volunteers for existing support mechanisms, such as P2P, Bullying & Harassment Advisors, etc., were encouraged to adopt this new FTSU role in addition to their existing work, as it was felt there may be significant cross over between other support mechanisms and FTSU agenda.

A FTSU Vision and Strategy document has been produced, based on the national FTSU Vision and Strategy. This can be found in Appendix B. The policy has also been refreshed to reflect the new approach. A copy can be found in Appendix C.

The refreshed policy and the new FTSU Ambassadors, as well as the campaign for the recruitment of the FTSU Ambassadors, required extensive communications and so the MKUH Communications Team have been, and will continue to be, instrumental to the success of this project.

3. Recommendations

The Board are asked to note the contents of this paper, acknowledge the Speaking Up responsibilities (Appendix A) and to assist in the communication of FTSU messages on an ongoing basis.

Danielle Petch
Director of Workforce
December 2018

Appendix A - Speaking Up Responsibilities Overview

Speaking Up: Your responsibility!

	Who	Responsibility
1	**Chief Executive and Chairman**	• Appoint the FTSU Guardian • Accountable for FTSU arrangements in the Trust • Ensure the annual report contains information about FTSU • Ensure that the Trust is engaged with both the regional Guardian Network and the National Guardian Office. • Key source for advice and support for the Trust FTSU Guardian • Meet regularly with the FTSU Guardian
2	**Non-Executive Lead**	• Keep up-to-date with latest guidance from National Guardian Office • Hold the Chief Executive, FTSU Executive Lead and the Board to account for implementing the Speaking Up strategy • Challenge the Board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement • Role-modelling high standards of conduct around FTSU • Acting as alternative source of advice and support for the FTSU Guardian • Overseeing speaking up concerns relating to Board members
3	**Trust Executive Lead**	• Keep up-to-date with latest guidance from National Guardian Office • Oversee the creation of FTSU vision and strategy • Ensure FTSU role is implemented with a robust communications strategy • Ensure FTSU Guardian has suitable ring-fenced time and resources and that there is cover available for absences • Ensure audit/ Quality Assurance of sample speaking up cases • Ensure annual review of strategy, policy and process • Provide board with assurance about effectiveness of strategy, policy and process • Ensure prompt and fair investigation of allegations • Operationalise the learning derived from speaking up issues
4	**Director of Workforce**	• Ensure that the FTSU Guardian has support of HR staff and appropriate access to information and resources to measure FTSU culture and indicators of barriers to speaking up • Ensure that the HR practice encourage and support speaking up and that learning is disseminated across the Trust • Ensure workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively

5	**Medical Director & Chief Nurse**	• Ensure that the FTSU Guardian has support and advice on patient safety and safeguarding issues • Take immediate action when potential patient safety issues are raised • Operationalising the learning derived from speaking up issues
6	**Senior Management**	• Participate in creating and launching the Trust's FTSU Strategy • Encourage and support speaking up • Disseminate learning across the Trust • Ensure workers have the right knowledge, skills and capability to speak up • Listen well and respond to issues raised effectively
7	**Line managers**	• Encourage and support speaking up • Disseminate learning across the Trust • Ensure workers have the right knowledge, skills and capability to speak up • Listen well and respond to issues raised effectively
8	**All Staff**	• Ensure they have the right knowledge, skills and capability to speak up • Aware of latest policy and process for speaking up in the Trust
9	**Staffside/ Trade Union/ Professional representatives**	• Provide appropriate support to members to enable a culture of speaking up • Work in partnership with HR to ensure that processes and policy support speaking UP
10	**FTSU Guardian(s)**	• See separate role specification
11	**FTSU Champions**	• See separate roles specification

Appendix B – FTSU Vision and Strategy

Freedom to Speak Up Vision and Strategy

Purpose:

Sir Robert Francis's 'Freedom to Speak Up' review in February 2015 highlighted the need for the creation of the National Guardian and Freedom to Speak Up Guardians at every Trust in England as a 'vital step towards developing the right culture and environment for speaking up'. This document sets out the Trust's Freedom to Speak Up vision and strategy.

This document should be read alongside the Trust's Speaking Up Policy which will be reviewed as required to continue to meet national guidance and best practice.

Our Vision

We are committed to promoting an open and transparent culture across the organisation to ensure that all members of staff feel safe and confident to speak out.

Our Board and senior leadership team will support this agenda by:

- Modelling the behaviours to promote a positive culture in the organisation;
- Providing the resources required to deliver an effective Freedom to Speak Up function; and
- Having oversight to ensure the policy and procedures are being effectively implemented.

Our FTSU Guardians have a key role in:

- Helping to raise the profile of raising concerns in our organisation
- providing confidential advice and support to staff in relation to concerns they have about patient safety, staff safety and staff wellbeing
- Providing confidential advice and support to staff in relation the way their concern has been handled.

The Trust is fully engaged with the National Guardian's Office and the local network of Freedom to Speak Up Guardians in our region to learn and share best practice.

Our Strategy

The Trust will take the following actions to deliver this vision:

- Implement separate policies which clearly differentiate between raising a grievance and speaking up

- Increase effective awareness training for all staff so they are clear about what concerns they can raise and how to raise them

- Ensure managers are clear about their roles and responsibilities when handling concerns and are supported to do so effectively

- Provide regular communications to all staff (including those permanently employed on a full time/part time basis, temporary/contracted workers and volunteers) to raise the profile and understanding of our Speaking Up arrangements

- Communicate key findings to staff about the level and type of concerns raised and any result and actions taken, as is appropriate under the scope of confidentiality

- Share good practice and learning from concerns raised, through a variety of media with the key aim of fostering openness and transparency, such as, newsletters, staff briefings, team meetings and the intranet

- Seek actively the opinion of staff to assess that they are aware of and, are confident in using local processes and use this feedback to ensure our arrangements are improved based on staff experiences and learning.

Outcomes and Measures

1. Annual staff survey results

2. Regular review of referrals with other functions involved in the process like Human Resources and Local Counter Fraud Specialist

3. Number of channels available for staff to raise concerns including champions and other internal and external routes like Staff Side Chair

4. Quarterly FTSU updates for all staff via communication team and intranet

5. Evidence that investigations are evidence based and led by someone suitably independent in the organisation, producing a report which focuses on learning lessons and improving care

6. High level findings provided to the Trust board and policy annually reviewed

Monitoring

A Freedom to Speak up Annual Report will be presented to the Board each year by the Freedom to Speak up Guardian and the Executive Lead for Raising Concerns which will include:

- An assessment of the Trust's Freedom to Speak Up Policy;

- An overview of the cases reported and the themes identified;

- Benchmarking

Appendix C – Policy

This document is uncontrolled once printed.
Please check on the Trust's Intranet site for the most up to date version.

Speaking Up Policy
Raising issues of concern

Classification :	Policy		
Authors Name:	Afusat Abdulkadir-Ayo		
Authors Job Title:	Human Resources Business Partner		
Authors Division:	Corporate		
Departments/Group this Document applies to:	Trustwide: Staff, Contractors and Service Users/Patients		
Approval Group: **Workforce Board**		**Date of Approval:**	**January 2019**
		Last Review:	July 2016
		Review Date:	**January 2022**
Unique Identifier: Governance allocate new numbers	**Status:** awaiting approval	**Version No:** 3.3	
Policy to be followed by (target staff): Staff, Contractors and Service Users/Patients			
CQC Fundamental standards: Regulation 10 – dignity and respect Regulation 13 – Safeguarding service users from abuse and improper treatment Regulation 16 – Receiving and acting on complaints Regulation 18 – Staffing Regulation 19 – Fit and proper			

Document History

Version	Date	Author	Reason
1.0	April 2006 to April 2007	Chanelle Wilkinson Director of Human Resources	Review
2.0	June 2008	Andrea Chown Deputy Director of Human Resources	Review
2.1	January 2012	Julieann Carter (with author's approval)	Minor amendment made to Page seven with the insertion of Named non-executive director.
2.1	January 2012	Wendy Bowes, Deputy Director of Human Resources	Amendment to monitoring arrangement. Document updated and review date amended.
3.0	January 2014	Afusat Abdulkadir-Ayo, HR Business Partner	Amendment to ensure compliance with recommendations in the Francis Report
3.1	July 2016	Afusat Abdulkadir-Ayo, HR Business Partner	Re-write in compliance with the 'standard integrated policy' based on recommendations by Sir Robert Francis into whistleblowing in the NHS. It is expected that this policy (produced by NHS Improvement and NHS England) will be adopted by all NHS organisations in England as a minimum standard to help to normalise the raising of concerns for the benefit of all patients.
3.2	September 2018	Afusat Abdulkadir-Ayo, HR Business Partner	Review in compliance with the NHS Improvement and National Guidance Office assessment framework
3.3	October 2018	Danielle Petch	Amended following Staffside feedback

Consultation History

You must ensure your policy has appropriate consultation or it will not be approved

Stakeholders Name	Area of Expertise	Date Sent	Date Received	Comments	Changes Made
PRG	Subgroup of JCNC	April & May 2013	April & May 2013		
PRG	Subgroup of JCNC	October 2016 March 2017			
JCNC	JCNC	October 2018			

Content

1. Introduction: Speak up – we will listen

Speaking up about any concern you have at work is really important. In fact, it's vital because it will help us to keep improving our services for all patients and the working environment for our staff.

You may feel worried about raising a concern, and we understand this. But please don't be put off. In accordance with our duty of candour, our senior leaders and entire board are committed to an open and honest culture. We will look into what you say and you will always have access to the support you need. No one who speaks up will suffer any detriment as a result of doing so. Provided you are acting honestly and reasonably, it does not matter if you are mistaken or if there is an innocent explanation for your concerns. You will be protected during and after speaking up and action will be taken against anyone discriminating against you as a result of your speaking up.

This 'standard integrated policy' was one of a number of recommendations of the review by Sir Robert Francis into whistleblowing in the NHS, aimed at improving the experience of whistleblowing in the NHS. It is expected that this policy (produced by NHS Improvement and NHS England) will be adopted by all NHS organisations in England as a minimum standard to help to normalise the raising of concerns for the benefit of all patients.

Our local process has been integrated into the policy/adheres to the principles of this policy and provides more detail about how we will look into a concern- see section 5.0.

2. Scope: Who can raise concerns?

Anyone who works (or has worked) in the NHS, or for an independent organisation that provides NHS services can raise concerns. This includes agency workers, temporary workers, students, volunteers and governors.

Someone who speaks up is a witness not a complainant. They are a person who, when faced with an acute dilemma, does not stay silent or look the other way but raises the matter with their manager/employer or takes their concerns outside the organisation.

2.1. Feel safe to raise your concern

If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully you into not raising any such concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action under policies such as the Bullying & Harassment policy and the Equality, Diversion and Inclusion policy. Provided you are acting honestly and reasonably, it does not matter if you are mistaken or if there is an innocent explanation for your concerns.

2.2. What concerns can I raise?

You can raise a concern about risk, malpractice or wrongdoing you think is harming the service we deliver. Just a few examples of this might include (but are by no means restricted to):

- unsafe patient care
- unsafe working conditions
- inadequate induction or training for staff
- lack of, or poor, response to a reported patient safety incident
- suspicions of fraud (which can also be reported to our local counter-fraud team [01223216019), or the NHS Fraud Hotline on 08000284060.
- a bullying culture (across a team or organisation rather than individual instances of bullying).

Remember that if you are a healthcare professional you may have a professional duty to report a concern. If in doubt, please raise it.
Provided you are acting honestly and reasonably, it does not matter if you are mistaken or if there is an innocent explanation for your concerns.

This policy is not for people with concerns about their employment that affect only them – that type of concern is better suited to our grievance policy which can be found on the Trust intranet.

3. Confidentiality

We hope you will feel comfortable raising your concern openly, but we also appreciate that you may want to raise it confidentially. This means that while you are willing for your identity to be known to the person you report your concern to, you do not want anyone else to know your identity. Therefore, we will keep your identity confidential, if that is what you want, unless required to disclose it by law (for example, by the police). Confidentiality cannot be guaranteed if the case is escalated, however, you will be protected in line with the principles of this policy. You can choose to raise your concern anonymously, without giving anyone your name, but that may make it more difficult for us to investigate thoroughly and give you feedback on the outcome.

4. Implementation and dissemination of document

The policy will be communicated through the "acute user" communication channel and will be on the documentation page of the Trust intranet. All staff will be expected to attend the mandatory corporate induction programme which includes information about Freedom to Speak Up. All staff will be required to undertake refresher

mandatory training every three years either in the classroom or though e-learning which will include information about Speaking Up..

5. Who should I raise my concern with?

In many circumstances the easiest way to get your concern resolved will be to raise it formally or informally with your line manager (or lead clinician or tutor). But where you don't think it is appropriate to do this, you can use any of the options set out below in the first instance.

If raising it with your line manager (or lead clinician or tutor) does not resolve matters, or you do not feel able to raise it with them, you can contact one of the following people**:**

- Our Freedom to Speak Up Guardians – Nicky Burns-Muir, Deputy Director of Nursing, and Adewale Kadiri, Trust Secretary This is an important role identified in the Freedom to Speak Up review to act as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation
- our risk management team (Tina Worth, Head of Risk & Clinical Governance – 01908 995110).

If you still remain concerned after this, you can contact:

- our executive director with responsibility for whistleblowing is the Director of Workforce.
- our non-executive director with responsibility for whistleblowing (Please contact the Chief Executive's office for details).
- Speaking Up Ambassadors/Champions – who will be departmental support to the FTSU guardians
- All these people have been trained in receiving concerns and will give you information about where you can go for more support.

If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies, such as the Office of the National Guardian.

The difference between raising your concern formally and informally is explained in section 6 below. In due course NHS England and NHS Improvement will consider how recording could be consistent nationally, with a view to a national reporting system. Appendix A, sets out an example of how a concern might be escalated.

6. Process

6.1. Informal Procedure

Staff are encouraged to raise concerns about health service issues with their immediate line manager or professional lead in the first instance. Where this happens, the manager becomes the 'designated officer' and is expected to

investigate the matter fully and feedback on the outcome of any investigation. The feedback may not include details about the precise actions that have been taken where this would infringe on a duty of confidence owed to another person. However, managers will take concerns seriously, consider them fully and sympathetically, recognise that raising a concern can be a difficult experience, and where appropriate, seek advice from other healthcare professionals.

In certain situations, for whatever reason, staff may not wish to discuss matters informally with their line manager/professional lead but, at the same time, may not wish to invoke a formal procedure (see 6.2 below). Discussion with one of the designated officers, therefore, can be held either informally or formally (see 5.0 above).

Consultant medical staff should discuss their concerns with colleagues and then, if necessary, raise their concerns with their immediate line management and professional leads. They may also wish to consider raising them with the Medical Director. In very exceptional cases, direct referral to the Chief Executive may be appropriate.

Where action is to be taken in response to a concern raised by a member of staff, this will be carried out within a reasonable timescale and the member of staff will be notified of the action taken. Where action is not considered practicable or appropriate, the member of staff will be given a prompt and thorough explanation of the reason, and will also be informed of the further action available under this procedure.

6.2. Formal Procedure

This stage of the procedure is applicable where a member of staff considers that the informal approach to the line manager proves ineffective; or where the member of staff does not wish to bring the matter to the attention of her/his line manager, for whatever reason.

The matter should then be raised formally with either their manager's manager; a member of the management team at any of the different levels within the line management structure; or any member from the 'Designated Officer' list at section 5.0. In order for such matters to be considered formally, individuals will have to put their concern in writing.

The stages contained in the Trust's Grievance Procedure should be observed as a guide to the process to be followed and a formal response to the issue(s) raised will be provided at each stage. Staff will be able to refer concerns up to the Chief Executive and ultimately, to the Chairman of the Board of Directors. In considering any matters raised, the Chairman may decide to involve non-executive board members.

7. Advice and support

The Whistleblowing Helpline for the NHS and social care can be reached on 0800 0724725. You can also get support from your professional body or trade union representative.

7.1. How should I raise my concern?

You can raise your concerns with any of the people listed above in person, by phone or in writing (including email).

Whichever route you choose, please be ready to explain as fully as you can the information and circumstances that gave rise to your concern.

7.2. What will we do?

We are committed to the principles of the Freedom to Speak Up review and its vision for raising concerns, and will respond in line with them (see Appendix B).

We are committed to listening to our staff, learning lessons and improving patient care. When a concern is raised it will be acknowledged within two working days. The central record will record the date the concern was received, whether you have requested confidentiality, a summary of the concerns and dates when we have given you updates or feedback.

7.3. Investigation

Where you have been unable to resolve the matter quickly (usually within a few days) with your line manager, we will carry out a proportionate investigation – using someone suitably independent (usually from a different part of the organisation) and properly trained – and we will reach a conclusion within a reasonable timescale (which we will notify you of).

Wherever possible we will carry out a single investigation (so, for example, where a concern is raised about a patient safety incident, we will usually undertake a single investigation that looks at your concern and the wider circumstances of the incident). The investigation will be objective and evidence-based, and will produce a report that focuses on identifying and rectifying any issues, and learning lessons to prevent problems recurring.
We may decide that your concern would be better looked at under another process; for example, our process for dealing with bullying and harassment. If so, we will discuss that with you.

If your concern suggests a Serious Incident has occurred, an investigation will be carried out in accordance with the Trust's Incident Reporting Policy. The definition of a Serious Incident can be found in the Trust's Incident Reporting Policy.

Any employment issues (that affect only you and not others) identified during the investigation will be considered separately.

7.4. Communicating with you

We will treat you with respect at all times and will thank you for raising your concerns. We will discuss your concerns with you to ensure we understand exactly what you are worried about. We will tell you how long we expect the investigation to take and keep you up to date with its progress. The timescales for these communications will be as dictated by the case and you will be made aware of these at it progresses. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others).

7.5. How will we learn from your concern?

The focus of the investigation will be on improving the service we provide for patients. Where it identifies improvements that can be made, we will track them to ensure necessary changes are made, and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

8. Board oversight

The board will be provided with high level information about all concerns raised by our staff through this policy and what we are doing to address any problems. We will include similar high level information in our annual report. The board supports staff raising concerns and wants you to feel free to speak up.

9. Raising your concern with an outside body

Alternatively, you can raise your concern outside the organisation with:

- NHS Improvement for concerns about:
    - how NHS trusts and foundation trusts are being run
    - other providers with an NHS provider licence
    - NHS procurement, choice and competition
    - the national tariff
- Care Quality Commission for quality and safety concerns
- NHS England for concerns about:
    - primary medical services (general practice)
    - primary dental services
    - primary ophthalmic services
    - local pharmaceutical services
- Health Education England for education and training in the NHS
- NHS Protect for concerns about fraud and corruption.

10. Making a ‘protected disclosure’

There are very specific criteria that need to be met for an individual to be covered by whistleblowing law when they raise a concern (to be able to claim the protection that accompanies it). There is also a defined list of ‘prescribed persons’, similar to the list of outside bodies in section 8, who you can make a protected disclosure to. To help you consider whether you might meet these criteria, please seek independent advice from the Whistleblowing Helpline for the NHS and social care (0800 0724725), Public Concern at Work (02074046609) or a legal representative.

11. National Freedom to Speak Up Guardian

The National Guardian can independently review how staff have been treated having raised concerns where NHS trusts and foundation trusts may have failed to follow good practice, working with some of the bodies listed above to take action where needed.

12. Training and Education

12.1. Training

All Trust staff and volunteers will be briefed about the importance of Speaking Up and the roles and identities of the Freedom to Speak Up Guardians.

All Trust staff acting as Freedom to Speak Up Guardians or undertaking any other recognised Speaking Up roles will receive training by attending national/regional training sessions or receive training from the MKUH Freedom to Speak Up Guardians. This will ensure all those acting in a Freedom to Speak Up capacity will have the knowledge and skills required to do so.

12.2. Supervision

Supervision and support is needed for all staff acting as Freedom to Speak Up Guardians or undertaking any other recognised Speaking Up roles to ensure that staff are able to work confidently and competently with very difficult and sensitive situations. It is important to recognise that dealing with situations can be stressful and distressing and workplace support is available to all staff from their line managers, Freedom to Speak Up Guardians and occupational health.

Staff involved with Freedom to Speak Up enquiries may wish to undertake reflective practice with access to appropriately skilled managers to provide supervision and support.

Additional support will be provided by the Freedom to Speak Up Guardians and Director of Workforce as requested.

13. Monitoring and Review

The Trust will review the effectiveness of this policy and local process at least annually, with the outcome published and changes made as appropriate. The usage of this policy is monitored by the Chief Executive Office. Due to the anonymity of speaking up issues, it may not be possible to monitor equality data. Issues of speaking up will be reported to the Trust Board and Quality Committee as appropriate.

14. Equality Impact Assessment

This document has been Equality Impact Assessed in accordance with the Equality Act 2010.

Division	Corporate	Department	Human Resources
Person completing the EqIA	Afusat Abdulkadir-Ayo	Contact No.	X86160
Others involved:	N/A	Date of assessment:	13 November 2018
Existing policy/service	YES	New policy/service	NO

Will patients, carers, the public or staff be affected by the policy/service?	YES
If staff, how many/which groups will be affected?	all staff

Protected characteristic	Any impact?	Comments
Age	NO	
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	NO	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?

Policy Review Group, JCNC, Workforce Board.

How are the changes/amendments to the policies/services communicated?

Acute User email to all staff, Intranet and Weekly CEO update

What future actions need to be taken to overcome any barriers or discrimination?

What?	Who will lead this?	Date of completion	Resources needed

Review date of EqIA	

15. Audit Criteria

Audit Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee	Responsibility for Actions
Incident Reporting – How staff can raise concerns	Datix	Clinical Governance	Annually	Health & Safety committee	Management Board
Staff are able to raise complaints and concerns about their workplace or care of patients	FTSU Tracker	FTSU guardian	Annually	Workforce Board	Management Board
Staff are supported in being able to raise concerns	FTSU Tracker	FTSU guardian	Annually	Workforce Board	Management Board

16. Overall Responsibility for the Document

The Director of Workforce has overall responsibility for the review and update of this policy.

APPENDIX A: Example process for raising and escalating a concern

Step one

If you have a concern about a risk, malpractice or wrongdoing at work, we hope you will feel able to raise it first with your line manager, lead clinician or tutor (for students). This may be done orally or in writing.

Step two

If you feel unable to raise the matter with your line manager, lead clinician or tutor, for whatever reason, please raise the matter with our local Freedom to Speak Up Guardian(s):
Nicky Burns-Muir, Deputy Director of Nursing, Nicky.Burns-Muir@mkuh.nhs.uk;
Adewale Kadiri, Trust Secretary, adewale.kadiri@mkuh.nhs.uk

This person has been given special responsibility and training in dealing with speaking up concerns. They will:

- thank you for raising your concern
- treat your concern confidentially unless otherwise agreed
- ensure you receive timely support to progress your concern
- escalate to the board any indications that you are being subjected to detriment for raising your concern
- remind the organisation of the need to give you timely feedback on how your concern is being dealt with
- ensure you have access to personal support since raising your concern may be stressful.
- If you want to raise the matter in confidence, please say so at the outset so that appropriate arrangements can be made.

Step three

If these channels have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of the above, please contact the nominated non-executive director. Their details can be found on the Trust's Freedom to Speak Up intranet page or by contacting the Trust Chairman.

Step four

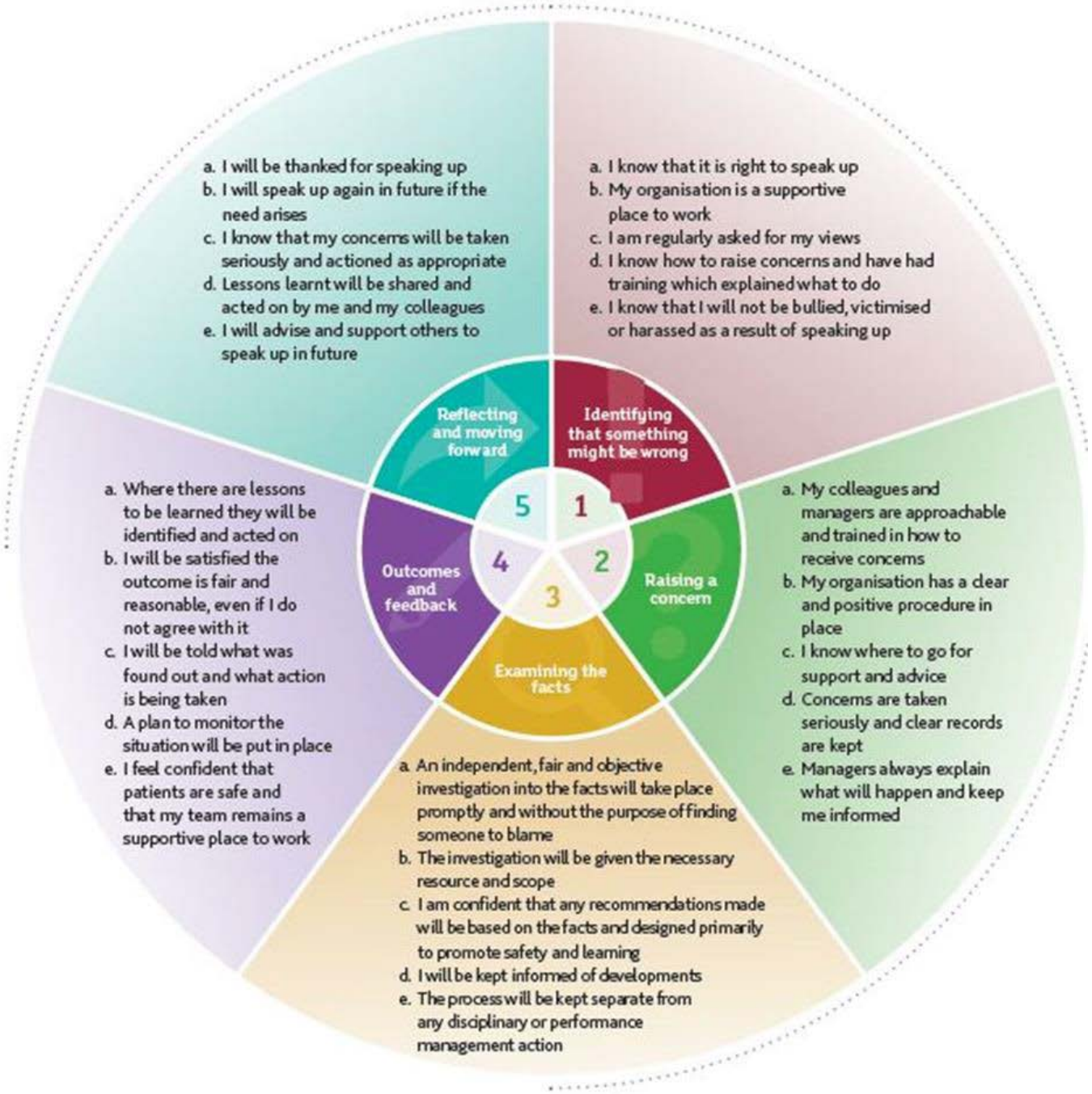
You can raise concerns formally with external bodies, such as the Office of the National Guardian**.** You can raise your concern outside the organisation with:

- NHS Improvement for concerns about:
    - how NHS trusts and foundation trusts are being run
    - other providers with an NHS provider licence
    - NHS procurement, choice and competition
    - the national tariff
- Care Quality Commission for quality and safety concerns

- NHS England for concerns about:
    - primary medical services (general practice)
    - primary dental services
    - primary ophthalmic services
    - local pharmaceutical services
- Health Education England for education and training in the NHS
- NHS Protect for concerns about fraud and corruption.

APPENDIX B : A vision for raising concerns in the NHS

Source: Sir Robert Francis QC (2015) *Freedom to Speak Up: an independent report into creating an open and honest reporting culture in the NHS.*



APPENDIX C: Speaking Up Disclosure Form

Employee to Complete Name: Contact Number/Email: Department: Line Manager:	Representative/Companion name: Contact number/email: Union name: Line Manager contact number
Date form completed:	Date Form received:
What is the concern about? (Please give details – it would help if you could supply dates/times/other witnesses) Name and Signature of person making disclosure: Date	
Plan of action to progress matter: This should be completed by the manager receiving the disclosure and should include details of agreed deadlines and key contacts. A copy should be forwarded to the Trust FTSU Guardian. Name and Signature of manager receiving disclosure: Date	

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Trust Board**	**Date: 11 January 2019**
Report title:	**Fit & Proper Person Test Policy**	**Agenda item: 5.2**
Lead director **Report author Sponsor(s)**	**Name: Danielle Petch** **Name: Danielle Petch**	**Title: Director of Workforce** **Title: Director of Workforce**
FoI status:		

Report summary	The Fit and Proper Persons Test (FPPT) Policy is a new policy which seeks to ensure that the Board of Directors are compliant with the Fit and Proper Person Regulations. That is that they have made the relevant self-declarations and have been background checked as per CQC guidance and are suitable to hold the role of Board Member at Milton Keynes University Hospital Foundation Trust (MKUH).			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** x	**Decision** ☐
Recommendation				

Strategic objectives links	In view of the scope of individuals affected, this policy aims to support all Trust objectives: 1. Deliver key performance targets 2. Develop a robust and sustainable future 3. Develop robust and innovative teaching and research 4. Become well-governed and financially viable 5. Improve workforce effectiveness 6. Make the best use of estate 7. Develop as a good corporate citizen
Board Assurance Framework links	
CQC outcome/ regulation links	~~Safe / caring / responsive / effective /~~ well led
Identified risks and risk management actions	The Trust currently has a 'Conflicts of Interest, Hospitality, Gifts, Donations & Sponsorship Policy' which helps to assess and manage the risk of any conflict of interest of its staff, including Senior Management levels and Trust Board Members. However, this does not adequately cover the Trust's obligation to meet the Fit and Proper Persons Regulations. For recent appointments Executive Search companies have undertaken this check on behalf of the Trust. However, the Trust should have its own policy and procedure to ensure the Trust's obligation to adhere to the Fit and Proper Persons Regulations is met.

Resource implications	None; manageable within current Workforce establishment.
Legal implications including equality and diversity assessment	

Document history	Drafted with Executive Directors support.
Next steps	None - policy in public domain
Appendices	None, aside from FPPT policy and appendices.

Policy **Title: Fit and Proper Persons Test Policy**	
Classification :	Policy
Authors Name:	Danielle Petch
Authors Job Title:	Director of Workforce
Authors Division:	Human Resources
Departments/ Group this Document applies to:	Board of Directors
Date of Approval:	**Review Date:**
Approval Group: Trust Documentation Committee	**Last Review:**

Unique Identifier: Governance allocate new numbers	**Status:** Draft	**Version No:** 0.1
Policy to be followed by (target staff):		
To be read in conjunction with the following documents: Appraisal Policy DBS Policy General Data Protection Regulations Policy Records Retention Policy Recruitment Policy		
CQC Fundamental standards: Regulation 5 – Fit and proper persons		

Index

Introduction

(Please note: the following section: summary of requirements for fit and proper persons is taken from the NHS Providers Briefing Fit and Proper Persons Regulations in the NHS: What Do Providers Need to Know? February 2018)

Summary of the Requirements for Fit and Proper Persons
According to the Fit and Proper Persons Regulations (FPPR) Trusts must not appoint a person to an Executive or Non-Executive Director level post unless they meet the following criteria:

- are of good character
- have the necessary qualifications, competence, skills and experience
- are able to perform the work that they are employed for after reasonable adjustments are made
- have not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity
- can supply information as set out in Schedule 3 of the Fit and Proper Persons Regulations.

When assessing whether a person is of good character, Paragraph 5 (4) of the regulation states that Trusts should make every effort to ensure that, as a minimum, they seek all information to confirm the matters listed in Part 2 of Schedule 4.

In accordance with Part 2 of Schedule 4, a person will fail the good character test if they:
- have been convicted in the United Kingdom or elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence, and
- have been erased, removed or struck off a register of professionals maintained by
- a regulator of health care or social work professionals.

Part 1 of Schedule 4 lists categories of 'unfitness' that would prevent people from holding office or necessitate their removal from their position as a Director, and for whom there is no discretion:

- the person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged
- the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland
- the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986
- the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it
- the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland
- the person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

The regulations stipulate that a Director would be considered unfit if they were included on a barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006 or on any

corresponding list. The Care Quality Commission's (CQC) guidance suggests that Trusts should undertake a DBS check for Directors on a case by case basis and only if they have a role that falls within the DBS eligibility criteria.

Some Directors who carry out regulated activities (as defined by the Safeguarding Vulnerable Groups Act 2006), such as medical and nursing Directors, will require an enhanced DBS check (with relevant barred lists).

For other Directors, a standard DBS check should be considered if the Director has direct contact and interactions with patients in the course of their normal duties. If a Director is ineligible for a DBS check, Trusts should carry out the other relevant checks (for example, qualifications and bankruptcy) to satisfy FPPR.

This issue is particularly challenging for Non-Executive Directors. CQC expects Non-Executive Directors to have a standard DBS check if they are “walking the floor” as part of their normal duties. Non-Executive Directors are only eligible for an enhanced DBS check (without barred lists) if they are involved in a children’s hospital or their role means that they work in an independent, unsupervised way with children. When considering DBS checks, Trusts should consider whether the level of the check is a proportionate measure and appropriate to the level of risk. Given that CQC assesses a Trust’s decision-making process rather than the decision itself, Trusts should be able to explain to CQC inspectors why they have or have not carried out a DBS check for Directors on a case by case basis.

Policy statement

The Fit and Proper Persons Test (FPPT) policy seeks to ensure that the Board of Directors are compliant with the Fit and Proper Persons Regulations. That is that they have made the relevant self-declarations and have been background checked as per CQC guidance and are suitable to hold the role of Board Member at Milton Keynes University Hospital Foundation Trust (MKUH).

Purpose and scope

The policy applies to Board Directors, Board Members and equivalents, who are responsible and accountable for delivering care, including Associate Directors and any other individuals who are members of the Board, irrespective of their voting rights. This policy will be implemented by the Human Resources (HR) teams. The Recruitment team will action the policy at appointment stage and then the HR teams will manage compliance annually thereafter. The Chair has ultimate responsibility for assuring the FPPT has been completed and that the FPPR are adhered to.

Abbreviations used

The following abbreviations are used in this document:

CEO	Chief Executive Officer
CQC	Care Quality Commission
DBS	Disclosure and Barring Service
EIA	Equality Impact Assessment
FPPR	Fit and Proper Persons Regulations
FPPT	Fit and Proper Persons Test
GDPR	General Data Protection Regulation
HR	Human Resources

MKUH Milton Keynes University Hospital NHS Foundation Trust

Roles and responsibilities:

Chair
The Chair has responsibility for ensuring compliance with the FPPR.

Board Member
Board members are required to comply with the FPPT and complete all requested self declarations.

Executive Director of Workforce
The Executive Director of Workforce is required to oversee the actions of the HR teams to ensure the FPPT is being conducted in an appropriate manner.

Human Resources Team
The Human Resources team are required to manage the annual FPPT process.

Recruitment Team
The Recruitment team are required to manage the onboarding FPPT process.

Implementation and dissemination of document

This policy will be placed on the Trust's intranet site and be available from the Non-Clinical documentation site.

Processes and procedures

Implementation

The evidence required to provide assurance with the FPPR is shown in Appendix A.

All Board Members are to complete a Fit and Proper Persons Test Declaration Form (Appendix B) initially upon appointment and then annually thereafter. These forms will be retained on the individual's HR file by the Director of Workforce. A flowchart providing an overview of the process can be found in Appendix C.

Process for new appointments

The Recruitment Team will process any new Director appointments. The Team adhere to the NHS Employment Standards which include:

- Proof of Identity
- Right to Work Check
- Health Clearance
- Two References – one being the most recent employer
- Qualifications/Registration applicable to the role
- DBS including safeguarding and barring lists

Upon receipt of a completed FPPT self declaration form the Recruitment team will query a number of online registers to verify the self-declaration. These include:

- Companies House – https://www.gov.uk/government/organisations/companies-house
- Insolvency Register – https://insolvencydirect.bis.gov.uk
- Charity Commission - http://apps.charitycommission.gov.uk/trusteeregister/search.aspx?RegisteredCharityNumber=&CurrentLanguage=English&SubsidiaryNumber=&=DocType&
- Financial Services Register – https://register.fca.org.uk

The Chair will be notified of any issues of non-compliance and is the responsible officer for the making an informed decision regarding the course of action to be followed. Current post holders that cannot satisfy the declaration questions will not necessarily be barred from continuation of employment/office as this will depend on the relevance of the information provided in respect of the nature of the position, and the particular circumstances. The Trust will address this in the most appropriate, relevant and proportionate way on a case by case basis.

Process for current post holders

The annual appraisal process will provide an opportunity to discuss continued "fitness" competence and how the post holder displays the Trust values and behaviour standards including the leadership behaviour expected. The Chief Executive Office (CEO) will be responsible for appraising the Executive Directors, whilst the Chair will be responsible for appraising the Non-Executive Directors. The CEO will be appraised by the Chair.

Every year there will be a requirement for post holders to complete a further Declaration Form confirming that they continue to be compliant with the FPPT (Appendix B).

Upon receipt of a completed FPPT self declaration form the HR team will query a number of online registers to verify the self-declaration. These include:

- Companies House – https://www.gov.uk/government/organisations/companies-house
- Insolvency Register – https://insolvencydirect.bis.gov.uk
- Charity Commission - http://apps.charitycommission.gov.uk/trusteeregister/search.aspx?RegisteredCharityNumber=&CurrentLanguage=English&SubsidiaryNumber=&=DocType&
- Financial Services Register – https://register.fca.org.uk

The HR Team will also review the HR file to ensure all relevant documentation is present. The checklist for this is shown in Appendix D.

Process for declaring in-year changes

Individuals will be required to make the Trust aware as soon as possible of any incident or circumstance which may mean they are no longer to be regarded as fit and proper person, and provide details of the issue, so this can be considered by the Trust.

Concerns regarding an individual's continued FPPR compliance

Where matters are raised that cause concern relating to an individual being fit and proper to carry out their role the Chair will address this in the most appropriate, relevant and proportionate way on a case by case basis.

The Trust reserves the right to suspend a Director or Non-Executive Director or restrict them from duties on full pay to allow the Trust to investigate the matters concerned. Should there be sufficient evidence to support the allegation(s), then the Trust may terminate the appointment of the Director/Non-Executive Director with immediate effect, in line with Trust's Disciplinary policy.

Where the individual is registered with a professional regulator and no longer meets the fit and proper persons requirement the Trust must inform the regulator, and also take action to ensure the position is held by a person meeting the requirements.

Statement of evidence/references

References:

NHS Providers (February 2018) *Fit and proper persons regulations in the NHS: what do providers need to know?*

West Suffolk NHS Foundation Trust (February 2018) *Fit and Proper Persons Requirements*

The Rotherham Foundation Trust (2018) *Fit and Proper Persons Guidance and Procedure*

External weblink references:

Care Quality Commission (July 2018) *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5* - https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-5-fit-proper-persons-Directors

Please note that although Milton Keynes University Hospital NHS Foundation Trust may include links to external websites, the Trust is not responsible for the accuracy or content therein.

Governance

Document review history

Version number	Review date	Reviewed by	Changes made

Consultation hhistory

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Trust Documentation Committee	Policy and procedure	October 2018			

Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
Fit and Proper Persons Test Declaration Form for each Board Director and Non-Executive Director upon appointment and annually.	MKUH Annual Report	Director of Workforce	Annual	Trust Board
Evidence that onboarding/annual checking process is followed as per sections 7.2 and 7.3	Signed checklist on each file.	Head HR Systems and Compliance	Annual	Workforce Board

Equality Impact Assessment (EIA)

As part of its development, this policy, and its impact on equality, has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified.

Equality Impact Assessment			
Division	**Corporate**	**Department**	**CEO/Chairman**
Person completing the EqIA	**Paul Sukhu, Deputy Director of Workforce**	**Contact No.**	**01908 996 253**
Others involved:	**None**	**Date of assessment:**	**24 October 2018**
Existing policy/service	N/A	**New policy/service**	**New policy**

Will patients, carers, the public or staff be affected by the policy/service?	Staff – Executive Directors, Non-Executive Directors, Associate Directors and Deputy Directors.
If staff, how many/which groups will be affected?	All staff

Protected characteristic	Any impact?	Comments
Age	NO	
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	NO	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?	**Publication of document, internal HR team meetings – process compliance purposes.**
How are the changes/amendments to the policies/services communicated?	**N/A**

Appendix A – FPPR: Assurance and evidence

Component of the regulation	Providers must have regard to the following guidance	Assurance/Evidence of Compliance	Complete at appointment	Complete annually
5(1) This regulation applies where a service provider is a body other than a partnership	This regulation applies to all providers that are not individuals or partnerships.	N/A	N/A	N/A
5(2) Unless the individual satisfies all the requirements set out in paragraph (3), a service provider must not appoint or have in place an individual — (a) as a Director of the service provider, or (b) performing the functions of, or functions equivalent or similar to the functions of a Director.	For NHS bodies it applies to executive and non-executive, permanent, interim and associate positions, irrespective of their voting rights. The requirement will also apply to equivalent Director posts in other providers, including trustees of charitable bodies and members of the governing bodies of unincorporated associations. Where a local authority is a provider, the regulations will not apply to elected members as they are accountable through a different route.	N/A	N/A	N/A
5(3)(a) the individual is of good character	When assessing whether a person is of good character, providers must follow robust processes to make sure that they gather all available information to confirm that the person is of good character, and they must have regard to the matters outlined in Schedule 4, Part 2 of the regulations. It is not possible to outline every character trait that a person should have, but we would expect to see that the	Employment checks are undertaken in accordance with NHS Employment Check Standards and include: • Two references, one of which must be most recent employer • Qualification and professional registration	☑ ☑	N/A N/A

Component of the regulation	Providers must have regard to the following guidance	Assurance/Evidence of Compliance	Complete at appointment	Complete annually
	processes followed take account of a person's honesty, trustworthiness, reliability and respectfulness.	checks • Right to work checks • Identity checks • Occupational health clearance • DBS checks including safeguarding and barring lists (as required for role) *(* DBS checks repeated at intervals as detailed in DBS policy)* In addition, we also carry out: • Self-declarations of fitness by candidates • Search of insolvency and bankruptcy register (Insolvency Register & Financial Services Register) • Search of disqualified Directors register (Companies House) • Search of Charities Commission	 ☑ ☑ ☑ ☑ ☑ ☑ ☑ ☑	 N/A N/A N/A ☑* ☑ ☑ ☑ ☑
	If a provider discovers information that suggests a person is not of good character after they have been appointed to a role, the provider must take	Disciplinary policy and procedure provides for such investigations. Contracts allow for termination in	N/A	☑

Component of the regulation	Providers must have regard to the following guidance	Assurance/Evidence of Compliance	Complete at appointment	Complete annually
	appropriate and timely action to investigate and rectify the matter.	the event of non-compliance with regulations and other requirements.		
	Where a provider considers the individual to be suitable, despite existence of information relevant to issues identified in Schedule 4, Part 2, the provider's reasons should be recorded for future reference and made available.	This would be the subject of debate at the Remuneration Committee for Executive Directors and Director-equivalents and at the Council of Governors for Non-Executive Directors. The minutes would record such decisions. The Chair would take advice from internal and external advisors as appropriate.	☑	☑
5(3)(b) the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed,	Where providers consider that a role requires specific qualifications, they must make this clear and should only appoint those candidates who meet the required specification, including any requirements to be registered with a professional regulator.	This requirement is included within the job description for relevant posts and is checked as part of the pre-employment checks.	☑	N/A
	Providers must have appropriate processes for assessing and checking that the candidate holds the required qualifications and has the competence, skills and experience required, (which may include appropriate communication and leadership skills and a caring and compassionate nature) to undertake the	Employment checks include a candidate's qualifications and employment references. The recruitment process also includes qualitative assessment, competency and values-based questions.	☑	☑

Component of the regulation	Providers must have regard to the following guidance	Assurance/Evidence of Compliance	Complete at appointment	Complete annually
	role. These must be followed in all cases and relevant records kept. CQC expect all providers to be aware of, and follow, the various guidelines that cover value-based recruitment, appraisal and development, and disciplinary action, including dismissal for Chief Executives, chairs and Directors, and to have implemented procedures in line with the best practise. This includes the seven principles of public life (Nolan principles).	Annual appraisals ensure continued ability to perform the duties of the role		
5(3)(c) the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed,	This aspect of the regulation relates to a person's ability to carry out their role. This does not mean that people who have a long-term condition, a disability or mental illness cannot be appointed. When appointing a person to a role, providers must have processes for considering their physical and mental health in line with the requirements of the role. All reasonable steps must be made to make adjustments for people to enable them to carry out their role. These must be in line with requirements to make reasonable adjustments for employees under the Equality Act 2010.	All post-holders are subject to clearance by Occupational Health as part of the pre-employment process. Reasonable adjustments are made where possible. Annual appraisals identify any additional reasonable adjustments required.	☑	☑
5(3)(d) the individual has not been responsible for, been privy to, contributed to or	Providers must have processes in place to assure themselves that a person has not been responsible for, privy to,	This is incorporated as a specific declaration as part of the pre-employment process.	☑	N/A

Component of the regulation	Providers must have regard to the following guidance	Assurance/Evidence of Compliance	Complete at appointment	Complete annually
facilitated, any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity, and	contributed to, or facilitated any serious misconduct or mismanagement in the carrying on of a regulated activity. This includes investigating any allegation of such and making independent enquiries. Providers must not appoint any person who has been responsible for, privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not) in the carrying on of a regulated activity.	It is also incorporated into a revised reference request template for all Director and Director-equivalent posts.		
	A Director may be implicated in a breach of a health and safety requirement or another statutory duty or contractual responsibility because of how the entire management team organised and managed its organisation's activities. In this case, providers must establish what role the Director played in the breach so that they can judge whether it means they are unfit. If the evidence shows that the breach is attributable to the Director's conduct, CQC would expect the provider to find that they are unfit. Although providers have information on when convictions, bankruptcies or similar matters are to be considered 'spent' there is no time limit for considering serious	Self-declaration form assesses this. Disciplinary policy and procedure provides for such investigations. Contracts allow for termination in the event of non-compliance with regulations and other requirements	☑	☑

Component of the regulation	Providers must have regard to the following guidance	Assurance/Evidence of Compliance	Complete at appointment	Complete annually
	misconduct or responsibility for failure in a previous role.			
5(3)(e) none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.	A person who will be acting in a role that falls within the definition of a "regulated activity" as defined by the Safeguarding Vulnerable Groups Act 2006 must be subject to a check by the Disclosure and Barring Service (DBS). Providers must seek all available information to assure themselves that Directors do not meet any of the elements of the unfit person test set out in Schedule 4 Part 1. Robust systems should be in place to assess Directors in relation to bankruptcy, sequestration, insolvency and arrangements with creditors. In addition, where a Director meets the eligibility criteria, providers should establish whether the person is on the children's and/or adults safeguarding barred list and whether they are prohibited from holding the office in question under other laws such as the Companies Act or Charities Act.	Employment checks are undertaken in accordance with NHS Employment Check Standards and include: • Two references, one of which must be most recent employer • Qualification and professional registration checks • Right to work checks • Identity checks • Occupational health clearance • DBS checks including safeguarding and barring lists (as required for post) *(* DBS checks repeated at intervals as detailed in DBS policy)* In addition, we also carry out: • Self-declarations of fitness by candidates • Search of insolvency and bankruptcy register	☑ ☑ ☑ ☑ ☑ ☑ ☑ ☑	N/A N/A N/A N/A N/A ☑* ☑ ☑

Component of the regulation	Providers must have regard to the following guidance	Assurance/Evidence of Compliance	Complete at appointment	Complete annually
		(Insolvency Register & Financial Services Register) • Search of disqualified Directors register (Companies House) • Search of Charities Commission	☑ ☑	☑ ☑
	If a provider discovers information that suggests an individual is unfit after they have been appointed to a role, the provider must take appropriate and timely action to investigate and rectify the matter.	Disciplinary policy and procedure provides for such investigations. Contracts allow for termination in the event of non-compliance with regulations and other requirements	N/A	☑
5(6) Where an individual who holds an office or position referred to in paragraph (2)(a) or (b) no longer meets the requirements in paragraph (3), the service provider must— **(a)** take such action as is necessary and proportionate to ensure that the office or position in question is held by an individual who meets such requirements, and **(b)** if the individual is a health care professional, social	Providers must assess and regularly review the fitness of Directors to ensure that they remain fit for the role they are in. Providers must determine how often to review fitness based on the assessed risk to business delivery and/or to the people using the service posed by the individual and/or role. Providers must have arrangements in place to respond to concerns about a person's fitness in relation to Regulation 5(3) and (4) after they have been appointed to a role, which either they or others have identified, and providers must adhere to these arrangements.	Annual assessments take place. Disciplinary policy and procedure provides for such investigations. Contracts allow for termination in the event of non-compliance with regulations and other requirements. Mechanisms for reporting individuals to the relevant regulatory body are in place.	N/A	☑

Component of the regulation	Providers must have regard to the following guidance	Assurance/Evidence of Compliance	Complete at appointment	Complete annually
worker or other professional registered with a health care or social care regulator, inform the regulator in question.	Providers must investigate, in a timely manner, any concerns about a person's fitness or ability to carry out their duties, and where concerns are substantiated, they must take proportionate, timely action. Where a person's fitness to carry out their role is being investigated, appropriate interim measures may be required to minimise any risk to people who use the service.			

Appendix B – Declaration form

Fit and Proper Persons Test Self-Declaration Form

Under the requirement of Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 the Trust is required to complete an annual Fit and Proper Persons review. Please complete the questions below:

Name	**Job Title**

Have you got the qualifications competency, skills and experience which are necessary for the position you hold/are applying for?	Yes/No
Are you able by reason of health (after reasonable adjustments are made) of properly performing the tasks which are intrinsic to the office or position you hold/are applying for?	Yes/No
Have you ever been found not to be a fit and proper person for the purposes of Regulation 5 of the Social Care Act 2008 (Regulated Activities), namely the requirements to: • Be of good character • Have the qualification, skills and experience necessary for the relevant position • Be capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010 • Not have been responsible for any misconduct or mismanagement in the course of any employment with a CQC registered provider • Not to be prohibited from holding the relevant position under any other law e.g. under the Companies Act or Charities Act. If **YES**, please provide details.	Yes/No

Are you: • an undischarged bankrupt; • a person who has had sequestration awarded in respect of your estate which is not discharged; • subject to a Bankruptcy Restrictions Order or an interim Bankruptcy Restrictions Order or an Order to the like effect make in Scotland or Northern Ireland; • a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986; or • a person who has made a composition arrangement with, or granted a trust deed for, creditors, and not been discharged in respect of it? If **YES**, please provide details.	Yes/No Yes/No Yes/No Yes/No Yes/No
Are you currently bound over, or do you have any current unspent convictions or cautions, or have you ever been convicted of any offence by a Court or Court-Martial in the United Kingdom or in any other country? If **YES**, please include details of the order binding you over and/or the nature of the offence, the penalty, sentence or order of the Court, and the date and place of the Court hearing. **Please note: you do not need to tell us about parking, or speeding offences.**	Yes/No

Have you been charged with any offence in the United Kingdom or in any other country that has not yet been disposed of? If **YES**, please include details of the nature of the offence with which you are charged, date on which you were charged, and details of any on-going proceedings by a prosecuting body.	Yes/No
You are reminded that you have a continued responsibility to inform us immediately where you are charged with any new offence, criminal conviction or fitness to practise proceedings in the United Kingdom or in any other country. **You do <u>not</u> need to tell us if you are charged with a parking or speeding offence.**	
Are you aware of any current or previous investigation being undertaken by the NHS Counter Fraud Authority (NHSCFA) or other body or organisation following allegations made against you in relation to matters of fraud or other financial mismanagement? If **YES**, please include details of the nature of the allegations made against you, and if known to you, any action to be taken against you by NHSCFA or other body or organisation.	Yes/No
Are you aware of any current or previous investigation that indicates that you, or an organisation for which you held responsibility, failed to adhere to recognised best practise, guidance or processes regarding care quality? If **YES**, please include details of the nature of the investigation made against you or the organisation, and if known to you, any action to be taken against you or the organisation by the investigatory body.	Yes/No

Have you been investigated by the Police, NHSCFA or any other investigatory body resulting in a current or past conviction or dismissal from your employment or volunteering position? If **YES**, please include details of the nature of the allegations made against you, and if known to you, any action to be taken against you by the Investigatory Body.	Yes/No
Have you ever been dismissed or disciplined by reason of serious misconduct from any employment, volunteering, office or other position previously held by you? If **YES**, please include details of the employment, office or position held, the date that you were dismissed or had disciplinary action taken against you, including the nature of the action or sanction, and provide details of the nature of allegations of misconduct made against you.	Yes/No
Have you been convicted of breaching any health and safety requirements or legislation on the basis of whether you or an organisation for which you have, or have had, responsibility for has organised or managed its activities? If **YES**, please include details of the nature of the health and safety conviction against you or the organisation, and if known to you, any action to be taken.	Yes/No

Have you ever been disqualified, erased, removed or struck off from the practise of a profession, or required to practise subject to specified limitations following fitness to practise proceedings, by a regulatory or licensing body in the United Kingdom or in any other country? If **YES**, please include details of the nature of the disqualification, erasure, removal, limitation or restriction, the date, and the name and address of the licensing or regulatory body concerned.	Yes/No
Are you currently or have you ever been the subject of any investigation or fitness to practise proceedings by any licensing or regulatory body in the United Kingdom or in any other country? If **YES**, please include details of the reason given for the investigation and/or proceedings undertaken, the date, details of any limitation or restriction to which you are currently subject, and the name and address of the licensing or regulatory body concerned.	Yes/No
Have you been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement in the carrying out of any health and social care services and/or any other services that may require registration with the CQC? If **YES**, please include details.	Yes/No

Are you subject to any other prohibition, limitation, or restriction that means we are unable to consider you for the position, for example, you are prohibited from holding the post of Director? If **YES**, please include details.	Yes/No
Have you previously been dismissed or removed in a position that involved working with children or vulnerable adults? If **YES**, please include details/reasons as to why this position ended.	Yes/No
Do you know of any other matters in your background which might cause your reliability or suitability for employment to be called into question? If **YES**, please include details.	Yes/No

IMPORTANT – DECLARATION

The *General Data Protection Regulation (GDPR)* requires us to advise you that we will be processing your personal data. Processing includes: holding, obtaining, recording, using, sharing and deleting information. Where you are applying for /hold a position which involves regulated activity, this will also include any barring decisions made by the Disclosure and Barring Service (DBS) against the Children's or Adults barred lists under the terms of the *Safeguarding Vulnerable Groups Act 2006 (as amended by the Protection of Freedom's Act 2012).*

The information that you provide in this declaration form will be processed in accordance with the *General Data Protection Regulation*. It will be used for the purpose of determining your application and ongoing suitability for this position. It will also be used for purposes of enquiries in relation to the prevention and detection of fraud.

The Trust will retain this declaration form for the length of your employment and as per the Trust's record retention policy after your employment. This declaration will be kept securely and in confidence. Access to this information will be restricted to designated persons within the organisation who are authorised to view it as a necessary part of their work.

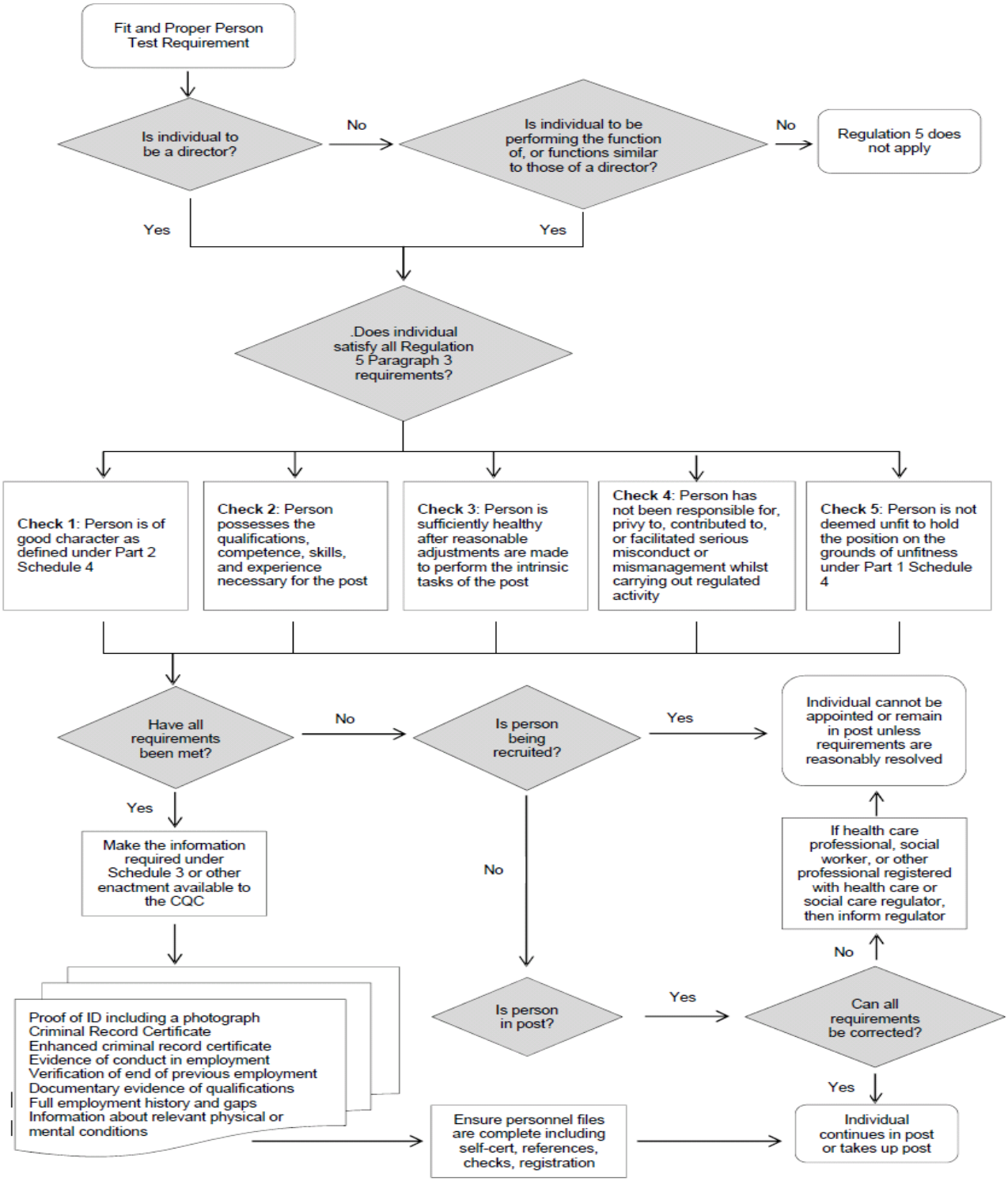
In signing the declaration on this form, you are explicitly consenting for the data you provide to be processed in the manner described above.

I confirm that the information that I have provided in this declaration form is correct and complete. I understand and accept that if I knowingly withhold information, or provide false or misleading information, disciplinary action may be taken, which may result in my dismissal.

Please sign and date this form.

Signature	
Printed Name	
Date	

Appendix C – Process flowchart



Appendix D – Annual compliance checklist

Under the requirement of Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 the Trust is required to complete an annual Fit and Proper Persons review.

Employment Checks (Check proofs present in the personal file or on ESR):

	In File	Date	Signature	Initial
Right to Work Check	Yes /No			
Proof of Identity Check	Yes /No			
Proof of Address	Yes /No			
Proof of National Insurance	Yes /No			
Proof of Qualifications	Yes /No			
Two References	Yes /No			
Health Clearance	Yes /No			
DBS – Update Service Membership	Yes /No			
Registration/HPAN Check if required for the post	Yes /No			

Annual Register Checks (Print out and attach to HR file):

	Cleared?	Date	Signature	Initial
Companies House https://www.gov.uk/government/organisations/companies-house	Yes /No			
Insolvency Register https://insolvencydirect.bis.gov.uk	Yes /No			
Insolvency Service disqualified Directors register https://www.insolvencydirect.bis.gov.uk/IESdatabase/viewDirectorsummary-new.asp	Yes /No			
Charities Commission http://apps.charitycommission.gov.uk/trusteeregister/search.aspx?RegisteredCharityNumber=&CurrentLanguage=English&SubsidiaryNumber=&=DocType&	Yes /No			
Financial Services Register https://register.fca.org.uk	Yes /No			

Checklist for policy and guidelines documentation

By submitting a document for review/approval you are confirming that the document has been checked against the checklist below to ensure it meets the Trust standards for producing Trust Documentation (for support please contact your Governance Facilitator/Patient Safety Lead.

Check	Tick
Latest template	☐
Fonts should be arial 14 for headers 12 for main body	☐
Clear Title (and saved with this title)	☐
Authors Job title:	☐
Authors Division:	☐
Department/Groups this document applies to:	☐
Approval Group/approved by:	☐
Date of approval:	☐
Review date:	☐
Approval group (according to policy requirements):	☐
Last review date:	☐
Unique Identifier: if known (new documents will be assigned at publication)	☐
Status: Approved	☐
Version numbers are the same throughout document	☐
Scope: Who will use this document?	☐
To be read in conjunction with the following documents:	☐
Latest CQC fundamental standards referenced:Trust intranet page with fundamental standards	☐
Footers completed to match main page : (on all pages)	☐
References are updated (contact the library (Jayne Plant 3077) for help if required)	☐
Consultation history includes key stakeholders required to embed document. Pharmacy are consulted if the document contains medication	☐
Audit and monitoring criteria is completed and clear (where possible reference the relevant section of the policy)	☐
Draft watermark is removed	☐
Include full & correct consultation history	☐
Dissemination should be clear	☐
Check relevant hyperlinks work	☐

Completed by name:	Position:	Division:	Date:

Meeting title	**Board of Directors**	**Date: 11 January 2019**
Report title:	**Terms of Reference Review**	**Agenda item: 5.3**
Lead director	**Name: Kate Jarman**	**Title: Director of Corporate Affairs**
Report author	**Name: Adewale Kadiri**	**Title: Trust Secretary**
FoI status:	**Disclosable**	

Report summary	Following the Board discussion at its meeting in November 2018 on updating its terms of reference and those of its Committees, the amended terms of attached for noting. The Board should also note that further changes to the terms of the Charitable Funds Committee, based on legal advice, will be put to that Committee at their next meeting in February, and will subsequently be signed off at the Board meeting in March			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** x	**Decision** ☐
Recommendation	That the Board notes the changes that have been made to the Board and Committee terms of reference			

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

Report history	The draft Terms of Reference for the Board Committees, with the exception of the Remuneration Committee, were presented and discussed at the Board meeting in November 2018, having previously been agreed at the respective committees.
Next steps	Once the changes have been approved, clean copies of the respective terms of reference will be produced and sent to Committee members.
Appendices	Terms of Reference: • Board of Directors • Audit Committee • Finance and Investment Committee • Workforce and Development Assurance Committee

Purpose of the Report

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

1. Body of the Report

When the updated Board and Committee Terms of Reference were presented at the November 2018 meeting for approval, the Board put forward the following additional changes:

- Board – paragraph 8.1 to be re-drafted to indicate that the Board will meet in public six times during the year, and once in private to sign off the annual report and accounts. Paragraph 8.2 to be deleted - DONE
- Audit Committee – Medical Director to be removed from the membership, but may be invited on occasion - DONE
- Finance and Investment Committee – the appendices to the terms of reference to be updated to reflect the current Standing Financial Instructions – DONE
- Workforce and Development Assurance Committee – the Committee's oversight of the University of Buckingham Medical School is to be restored - DONE

Track changed versions of the terms of reference reflecting these changes are attached as appendices to this paper.

Further changes to the terms of reference of the Charitable Funds Committee are to be proposed to that Committee at their next meeting in February. The aim of these changes, which are based on legal advice received, would be to bring about some more clarity as to the sorts of expenditure for which charitable funds may legitimately be used. Once these updated terms have been agreed by the Committee, they will be brought for final approval to the Board's March meeting.

2. Recommendations/ Actions

At the meeting in November, the Board agreed to approve the changes to the respective terms of reference subject to the further changes proposed being made. These updated terms are therefore attached for noting.

Board of Directors
TERMS OF REFERENCE

1. Constitution

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

2. Authority

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

3. Accountability

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

4. Duties

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

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

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

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

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

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

- review the Trust's Registration and compliance monitoring arrangements

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

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

5. Risk Management

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

6. Membership

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

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

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

The above comprise the voting membership of the Board of Directors

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

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

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

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

7. Responsibilities of Members

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

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

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

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

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

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

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

8. Frequency of Meetings

8.1 The Board will meet formally six times during the year, and once in private to sign off the annual report and accounts.~~Meetings will normally take place every two months~~. Meetings may take place more frequently at the Chair's discretion and as required;

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

9. Committee Administration

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

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

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

10. Review

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

Version Control

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

Milton Keynes University Hospital NHS Foundation Trust

AUDIT COMMITTEE
TERMS OF REFERENCE

CONSTITUTION

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

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

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

2. ~~2.~~ Delegated Authority

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2.1 The Committee has the following delegated authority:

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

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

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

3. Accountability

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

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

4. Reporting Lines

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

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

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

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

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

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

5. PURPOSE:

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

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

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

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

6. DUTIES OF THE AUDIT COMMITTEE

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

6.1 Integrated Governance, Risk Management and Internal Control

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

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

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

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

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

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

6.2 Internal Audit

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

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

6.3. External Audit

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

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

6.4 Whistleblowing

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

6. 5 Other Assurance Functions

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

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

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

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

6.6 Counter Fraud

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

7. Membership

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

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

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

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

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

8. Attendance

8.1 The following should attend Audit Committee meetings (Attendees)

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

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

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

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

~~8.5 T~~

9. Responsibilities of Members, Contributors and Attendees

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

9.2

9.2~~3~~ Officers presenting reports for consideration by the Committee should submit such papers to the Trust Secretary by the published deadline (at least 7 days before the meeting). Papers received after this deadline will normally be carried over to the following meeting except by prior approval from the Chair;

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9.3~~4~~ Members and Attendees must bring to the attention of the Committee any relevant matters that ought to be considered by the Committee within the scope of these Terms of Reference that have not been able to be formalised on the agenda under Matters Arising or Any Other Business. All efforts should be made to notify the Trust Secretary of such matters in advance of the meeting;

9.4~~5~~ Members and Attendees must send apologies to the Trust Board Secretary and also seek the approval of the Chair to send a deputy if unable to attend in person at least 3 days before the meeting;

9.5~~6~~ Members and Attendees must maintain confidentiality in relation to matters discussed by the Committee;

9.6~~7~~ Members and Attendees must declare any conflicts of interest or potential conflicts of interest at the start of each meeting in accordance with Milton Keynes University NHS Foundation Trust policy (even if such a declaration has previously been made);

10 Information Requirements

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

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

10.2 As appropriate the Committee will also be provided with:

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

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11 Frequency

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

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

12 Management

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

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

13 Financial Reporting

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

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

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

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

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

14 Committee Administration

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

15. Review

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

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

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

Finance and Investment Committee
TERMS OF REFERENCE

CONSTITUTION

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

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

ACCOUNTABILITY

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

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

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

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

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

PURPOSE:

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

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

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

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

MEMBERSHIP, ATTENDANCE AND QUORUM

Membership

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

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

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

Attendance

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

The following should attend Finance and Investment Committee meetings:

- The Deputy Director of Finance
- Trust Secretary or nominated representative

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

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

Quorum

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

MEETINGS AND CONDUCT OF BUSINESS

Frequency

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

Calling of additional meetings

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

Committee Administration

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

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

Responsibilities of Members

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

DUTIES OF THE FINANCE AND INVESTMENT COMMITTEE

Financial Management

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

Financial Reporting

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

Performance Management

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

Business and Financial Risk

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

Value for Money and Efficiency

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

Capital Investment

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

Cash

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

Technology

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

Estates

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

RELATIONSHIP WITH AUDITORS AND AUDIT COMMITTEE

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

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

Audit

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

Annual Accounts

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

SFI's and SO's

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

Fraud

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

Version control

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

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

Appendix 1

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

	Approval	Clinical Board Investment Group	Management Board
	Review stage final with recommendation to invest	Capital Control Group	Clinical Board Investment Group

In exceptional circumstances where an urgent capital investment decision is required which cannot wait until the next meeting of the relevant authorising group e.g. essential medical equipment which has failed, the approval of the Chief Executive and Director of Finance must be sought. Where approval is sanctioned, the decision will must be recorded and formally reported at the next meeting of the relevant authorising group where the decision would have been made

Approval Matrix - Business Cases For Revenue Investments			
Value		**In Annual Plan**	**Not in Annual Plan**
Greater than £500k	Document	Standard business case	
	Approval	Trust Board	Trust Board
	Review final stage - Recommendation to invest	Finance Committee	Finance Committee
	Review stage 2	Management Board	Management Board
	Review stage 1	Clinical Board Investment Group	Clinical Board Investment Group
£50k and less than £500k	Document	Standard business case	
	Approval	Management Board	Management Board
	Review stage 1	Clinical Board Investment Group	Clinical Board Investment Group
Less than £50k	Document	Dependent on type of expenditure – Discretion of Capital Programme Manager , normally a Short form business case	
	Approval	Executive Directors	Management Board

Finance Key Perofrmance Indicators

Area	Metric	Measure
Financial efficiency	National reference cost index	Comparison of activity costs against other NHS providers
Working capital	Cash variance to plan	
	Capital spend YTD against plan (cash basis)	
	Debtor days	Trade Receivables as a proportion of annualised income
	Creditor days	Trade Payables as a proportion of annualised expenditure
Use of Resources Ratings	Liquidity ratio	< -14 days (Score 4) cover - Cash plus trade debtors less trade creditors expressed as the number of days operating expenses that could be covered.
	Capital Service Ratio	<1.25x (Score 4), the degree to which the Trust's operating surplus, excluding depreciation, covers its financing obligations i.e. PDC , Loan Interest & Finance Lease costs
	I&E Variance From Plan	<-2% (Score 4), 0% (Score 1) the I&E % variance from plan
	I&E Margin metric	<-1% (Score 4), the trusts surplus or deficit as a proportion of its operating income.
	Agency metric	<50% (Score 4), 50% (Score 3), 25% (Score 2) the % variance from the trusts agency ceiling.

WORKFORCE AND DEVELOPMENT ASSURANCE COMMITTEE
TERMS OF REFERENCE

1. Constitution

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

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

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

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

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

2. Delegated Authority

2.1 The Committee has the following delegated authority:

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

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

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

3. Accountability

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

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

4. Reporting Lines

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

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

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

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

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

5. Duties

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

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

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

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

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

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

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

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

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

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

5.11.1 Ensure all workforce indicators are measured and monitored;

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

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

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

6. Membership

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

6.2 The Committee will comprise the following members:

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

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

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

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

7. Responsibilities of Members

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

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

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

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

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

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

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

8. Frequency of Meetings

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

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

9. Committee Administration

9.1 Committee administration will be provided by the Trust Secretariat;

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

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

10. Review

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

Version Control

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

Exec Lead	Risk Ref	Objective	Committee	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance				Residual risk rating	Progress since last report	Action Plans	Action completion date	Target risk score
						Consequence v Likelihood		Level 1 Operational (management)	Level 2 Oversight functions (Committees)	L3 Independent	Overall					
CH	1-1	SO1	Quality & Clinical Risk	Strategic failure to manage demand for emergency care	Lack of demand management by the local health economy Inadequate primary care provision/ capacity Inadequate community care provision/ capacity Inadequate social care provision/ capacity	4x4=16	Working with partners to manage peak demand periods (e.g expediting discharge; using full community/ social care capacity)	Strategic planning at trust-wide and service level Strategic planning within local health economy (CCG, CNWL, GP Federation)	Regular strategic planning withing the system - include Emergency Care Delivery Board Regular reporting to Management Board; Committees and Trust Board on strategic planning	System-wide Emergency Care Delivery Board Regular NHSI oversight (PRMs) External scruitny through Transformation Board, Health and Wellbeing Board and Health Overview and Scrutiny Committee Part of ICS (STP) priority programme on acute care	Good	4x3=12	Executive strategy session 23/03/17	System-wide strategic plan	Ongoing	4x2 = 8
CH	1-2	SO1	Quality & Clinical Risk	Tactical failure to manage demand for emergency care	Annual emergency and elective capacity planning inadequate or inaccurate Daily flow/ site managmement plans inadequate or ineffectual Poor clinical/ operational relationships impacting on patient flow through the organisation Poor operational/ managerial relationships impacting on escalation Ineffective engagement with stakeholders to support patient flow day-to-day	4x4=16	Introduction of ED streaming Working with UCC to manage demand Implementation of national flow improvement programmes - Red2Green; 100% Challenge; EndPJParalysis; SAFER Strong clinical and operational leadership and ownership; good team working Clear escalation and well-known and understood flow management and escalation plans Positive relationships with stakeholders through daily working and medium-term planning	Daily operational oversight Medium-term planning at service-level Daily and short/ medium-term planning with local health economy partners to support flow and right care/ right place	Regular strategic planning withing the system - include Emergency Care Delivery Board Regular reporting to Management Board; Committees and Trust Board on strategic planning	System-wide Emergency Care Delivery Board Regular NHSI oversight (PRMs) External scruitny through Transformation Board, Health and Wellbeing Board and Health Overview and Scrutiny Committee Part of ICS (STP) priority programme on acute care	Good	4x3=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	Ongoing	4x2 = 8
CH	1-3	SO1	Quality & Clinical Risk	Ability to maintain patient safety during periods of overwhelming demand	Significantly higher than usual numbers of patients through the ED Significantly higher acuity of patients through the ED Major incident/ pandemic	5x4=20	Clinically and operationally agreed escalation plan Adherence to national OPEL escalation management system Clinically risk assessed escalation areas available	Daily operational management command structure in place to manage emergency and elective activity safely Clinical site team 24/7 SMOC and EOC 24/7 Daily patient safety huddle	Daily reporting to clinical, 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	4x3=12	Daily management	Continue to clinically review escalation plans in line with demand to ensure patient safety is no compromised		4x2 = 8

Exec Lead	Risk Ref	Objective	Committee	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance				Residual risk rating	Progress since last report	Action Plans	Action completion date	Target risk score
						Consequence v Likelihood		Level 1 Operational (management)	Level 2 Oversight functions (Committees)	L3 Independent	Overall					
IR	1-4	SO1	Quality & Clinical Risk	Failure to appropriately embed learning and preventative measures following Serious Incidents	Failure to appropriately report, invesitgate and learn from incidents and complaints	5x3=15	All SIs and action plans processed through the Serious Incident Review Group Actions including learning distribution tracked through SIRG Core component of all Clinical Improvement Group Meetings Lessons communicated via Trust-wide channels Debriefing embedded in specialties and corporately Training and skills programme annually Cultural work (inc Greatix and FTSU Guardians	Incident reports and action plans Performance information on incident numbers Emerging or existing trends analysed and reported Repeat incidents analysed and reported - particularly for failure to learn	Serious Incident Review Group Oversight at Clinical Quality Board Oversight at Quality and Clinical Risk Committee	CCG satisfaction with RCA reporting Stakeholder involvement with RCA/SI investigation Internal Audit review of SI process	Satisfactory	5x2=10	QI project on incident reporting in its early stages. Plan to be in place by the end of the year			5x1 = 5
IR	1-5	SO1	Quality & Clinical Risk	Failure to recognise and respond to the deteriorating patient	Non compliance with the NEWS protocols; failure to appropriately escalate NEWS scores or failure to clinically assess patients outside protocols (i.e. 'hands on, eyes on' patients who are ill but not triggering on NEWS)	5x3=15	National NEWS protocol in place Level 1 pathway in place	Performance is reported to the Clinical Quality Board and is regularly audited Serious Incident Review Group process where issues around deteriorating patient identified eCare implementation supports early earning systems Standardised mortality review process to identify issues and learning	Serious Incident Review Group Oversight at Clinical Quality Board Oversight at Quality and Clinical Risk Committee	Coronial review of deaths	Satisfactory	5x2=10				5x1 = 5
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	eCARE has now been live for three months - recommend this risk is closed and the strategic risks in relation to eCARE are reconsidered at HIPB.			4x2 = 8

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						Consequence v Likelihood		Level 1 Operational (management)	Level 2 Oversight functions (Committees)	L3 Independent	Overall					
LK	2-1	SO2	Quality & Clinical Risk	Failure to provide an appropriate patient experience	Despite largely positve feedback that is received via social media and through the Friends and Family Test, the Trust has scored relatively poorly in most of the annual patient surveys. There are also a number of recurring themes from complaints, including poor communication, unsatisfactory food, and patients being unable to have a proper say in their care	4x4=16	Risk and incident reporting awareness campaign ongoing Risk and incident training programme in place Integrated Datix system Embedded governance and assurance teams to provide more resource, internal challenge and audit. Lesson of the week shared through the weekly CEO message, supported by divisional publications, briefings and plenary. Appointment of Picker to manage FFT responses and capture more qualitative feedback from patients Appointment of patient experience manager; clinical leads Launch of hellomynameis across the Trust Implementation of new complaints system, and raising the profile of complaint handling across the divisions Receipt of patient stories at the Trust Board Production and monitoring of action plans followjng annual patient surveys Real time feedback provided as appropriate to issues and comment on social media	Oversight at Risk and Compliance Board and Serious Incident Review Group	Oversight at Quality and Clinical Risk Committee and at the Quality and Clinical Risk Committee – reports include details of themes from complaints and evidence that learning is taking place		Poor	4x4=16	Increased executive support to co-ordinate strategy and plans to improve patient experience (July 2018) Strategy and plans to be presented to September 2018 Management Board and Board	Feedback from various patient surveys – inpatient, maternity, ED and children's.		4x2 = 8 4x2 = 8
KB/IR	3-1	SO3	Quality & Clinical Risk	Lack of assessment against and compliance with best evidence based clinical practice through clinical audit	Insufficient resource to introduce or embed process and lack of engagement by clinicians	3x4=12	Forward audit plan agreed and published annually Clinical audit leads in place with new (2018) job descriptions and agreed time within job plans Clinical governance leads and audit support in place to support audit leads in CSUs/ divisions Audit assessment process in place - supported and monitored by clinical governance leads and central audit support team New clinical governance structure (2018) in place to improve oversight and escalation of audit	Oversight and scrutiny at Clinical Effectiveness Board; Risk and Compliance Board and Clinical Quality Board Internal compliance monitoring and reporting monthly Reporting to CIGs and divisional management meetings	Oversight at the Quality and Clinical Risk Committee and the Audit Committee	External audi (KPMG) reivew in 2017/18 which identified areas for improvement. On forward audit plan for external audit review in 2018/19.	Satisfactory	3x4=12	Clinical Audit and Effectiveness Board established and first meeting held in July 2018 to improve clinical oversight and identify clinical leadership actions or support required. Improvements in compliance noted.			4x2 = 8

Exec Lead	Risk Ref	Objective	Committee	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance				Residual risk rating	Progress since last report	Action Plans	Action completion date	Target risk score
						Consequence v Likelihood		Level 1 Operational (management)	Level 2 Oversight functions (Committees)	L3 Independent	Overall					
KB/IR	3-2	SO3	Quality & Clinical Risk	Lack of assessment against and compliance with NICE guidance	The Trust has a significant backlog of NICE guidelines	3x4=12	Monthly assessments of compliance against published NICE baseline assessments Process in place to manage baseline assessments with relevant clinical lead - supported by clinical governance leads Independent review by compliance and audit lead Requires clinical engagement and ownership	Oversight and scrutiny at Clinical Effectiveness Board; Risk and Compliance Board and Clinical Quality Board Internal compliance monitoring and reporting monthly Reporting to CIGs and divisional management meetings	Oversight at the Quality and Clinical Risk Committee		Satisfactory	3x4=12	Clinical Audit and Effectiveness Board established and first meeting held in July 2018 to improve clinical oversight and identify clinical leadership actions or support required. Improvements in compliance noted.			(4x2) = 8
CH	4-1	SO4	Executive Management	Failure to meet the 4 hour emergency access standard	The Trust is unable to meet the target to see 95% of patients attending A&E within 4 hours	4x5=20	Operational plans in place to cope with prolonged surges in demand Cancelling of non urgent elective operations New elective surgical ward open to reduce liklihood of above control Opening of escalation beds Working with partners for social, community and primary care	Divisional and Trust performance reports Rates of discharge; DTOC	A&E Delivery Board	Ongoing NHSI review of key indicators Internal audit work on data quality Quality Report testing of key indicators by external auditors	Satisfactory	4x4=16	Current performance remains variable day-to-day. July has proved challenging with the heatwave and high demand.			4x2 = 8
CH	4-2	SO4	Executive Management	Failure to meet the key elective access standards - RTT 18 weeks, non-RTT and cancer 62 days	The Trust is unable to meet the 18 week RTT and 62 day cancewr targets, and unable to reduce its non-RTT backlog as required	4x3=12	Regular PTL meetings Work on improving administrative pathways Work with tertiary providers on breach allocations RTT and non-RTT action plans	Divisional and Trust performance reports Management Board scrutiny and oversight of RTT and non-RTT action plans	Finance and Investment Committee scrutiny of financial and operational performance Quality and Clinical Risk Committee oversight	NHSI regional information on performance against key access targets	Satisfactory	4x4=16	Recovery plans established. Additional resource in surgery and T&O. Alternative models to increase capacity and reduce waiting lists approved. Long waiters actively managed. Increased oversight by executive. Weekly reporting to executive directors.			4x2 = 8
JB	4-3	SO4	Audit	Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure	Data quality governance and processes are not robust	4x4=16	Robust governance around data quality processes including executive ownership Audit work by data quality team	Oversight of progress against action plans by Data Quality Compliance Board	Standing agenda item at the Audit Committee	Outcome of Internal audit assessment of data quality Outcome of External Audit Quality Report testing Outcome of NHSI review	Satisfactory	4x3=12	Testing to commence in specialties where new outcome forms have been in active use for three months or more (September 2018).			4x2= 8
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	5x3=15	Investment in better quality systems GDE investment NHS Digital audits and penetration tests	Results of penetration and phishing tests	Audit Committee review of cyber security	Performance against NHS Digital standards	Good	5x2=10				4x2 = 8
JB	5-2	SO5	Finance & Investment	Failure to adequately safeguard against major IT system failure (inability to invest in appropriate support systems/infrastructure)	Lack of suitable and timely investment leaves the Trust vulnerable to cyber attack	4x3=12	2 dedicated cyber security posts funded through GDE All Trust PCs less than 4 years old Robust public wifi network EPR investment	Robust capital prioritisation process overseen by Managment Board	Oversight of IT investment strategy and decision making by the Finance and Investment Committee	External oversight of uses of the GDE funding	Good	4x2=8				4x2 = 8

Exec Lead	Risk Ref	Objective	Committee	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance				Residual risk rating	Progress since last report	Action Plans	Action completion date	Target risk score
						Consequence v Likelihood		Level 1 Operational (management)	Level 2 Oversight functions (Committees)	L3 Independent	Overall					
CH	5-4	SO5	Executive Management	Failure to maximise the benefits of EPR	That the Trust does not derive all of the benefits in terms of efficiency and productivity from the EPR system as had been anticipated in the business cases	4x3=12	eCare operational delivery board being put into place in order to cover the spectrum of optimisation opportunities both financial and non-financial as a result of the implementation (and upcoming upgrades and changes). An initial schedule of opportunities that forecasts a lvel of savings in line with those in the original business case is being monitored against although there is likely to be some slippage against this when taking into account time for the new system to bed-in across the organisation.	Delivery of financial savings against those specified in the original business case. Delivery of non-financial savings, particualrly releasing time-to-case				4x2=8				3x2 = 6
	5-5	SO5	Executive Management	Failure to maximise the benefits of the Trust's digital strategy (patient access)	That the Trust does not adequately define its digital strategy to increase and improve patient access to online services and information supporting the management of their own healthcare	4x3=12	Integrated programme plan under development for review at Management Board/ Board in September 2018 Programme resourcing increased to support planning and delivery	Current programme managed through the Outpatients Transformation Board			Limited	4x2=8				4x1 = 4
MK	7-1	SO7	Finance & Investment	Inability to keep to affordable levels of agency and locum staffing	Inability to recruit to difficult to recruit to posts (across disciplines but particularly in medicine) Short notice sickness absence Poor planning around activity peaks Poor rostering of annual leave/ other leave requirements Increased requirement for enhanced observation levels of care National price caps mean that in a range of areas the Trust has little prospect of full compliance in short term future.	5x4=20	Weekly vacancy control panel review agency requests. Control of staffing costs identified as a key transformation work stream Bank rates and enhancements Capacity planning Robust rostering and leave planning Escalation policy in place to sign-off breach of agency rates Fort-nightly executive led agency reduction group meeting with aim of delivering reduction in both quantity and cost of agency used. Agency cap breaches are reported to Divisions and the FIC .	Transformation plans with tracked delivery. Oversight at the Vacancy Control Panel. Action plan reviews at fortnightly Executive Director Meetings Divisional deep dive sessions Monthly reports to Workfoirce Board and then to Management Board	Performance reported to the F&I Committee Oversight by the Workforce and Development Assurance Committee	Internal audit assessment on the use of medical locums NHSI performance review meetings NHSI agency weekly returns Review of processes and controls by Internal Audit	Good	4x3=12	The Agency spend up to mth 6 is £5m which is below plan. The risk to achieving the agency ceiling has reduced as the agency costs have been constantly below the planned level for 2018/19, however the situation will continue to be monitored due to the potential for rising demand to lead to increase in use of agency (particualrly over the winter period).	More robust and comprehensive capacity planning. Consistent approach to rostering and leave planning across the trust.	Current and ongoing	4x2 = 8
	7-2	SO7	Finance & Investment	Timing and release of capital and revenue funding for 2017/18		5x5=25	Ongoing dialogue with NHSI regarding status of cash commitment from the DH. Revenue funding has been approved by the DoH in the form of an uncommitted term loan. Revenue plan submitted in line with 2018/19 control total of £15.8m deficit. The Trust is in on-going dialogue regarding other strategic capital funding apporval in line with its annual plan.	Capital Expenditure is reviewed at the monthly capital control group and management board	Updates reported to the F&I Committee and Trust Board on a monthly basis	The Trust discusses the position at its monthly PRM calls with NHSI	Good	4x4=16	The Trust has received a pre-commitment for part of the funding required for the eCARE programme; however, the Trust will continue to seek apporval for funding of other capital schemes in 2018/19 in line with its annual plan. The Trust is seeking clarity over what will happen when its revenue support loan due now for repayment in March 2019 (as the Trust has no reasonable prospect of repaying the loan)	Clarification has not yet been received on repayment of the revenue support loan after March 2019, but it is expected that the loan will be rolled over to March 2020 unless a longer term is agreed.	Current and ongoing	3x3 = 9

Exec Lead	Risk Ref	Objective	Committee	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance				Residual risk rating	Progress since last report	Action Plans	Action completion date	Target risk score
						Consequence v Likelihood		Level 1 Operational (management)	Level 2 Oversight functions (Committees)	L3 Independent	Overall					
MK	7-3	SO7	Finance & Investment	Inability to achieve the required levels of financial efficiency within the Transformation Programme	Increased unplanned activity Inability to identify sufficient savings schemes, or to achieve the expected levels of savings Inability to deliver identified schemes	5x4=20	Tracker in place to identify and track savings and ensure they are delivering against plan Savings measured against trust finance ledger to ensure they are robust and consistent with overall financial reporting All savings RAG rated to ensure objectivity	Fortnightly CIP review meetings between with the Director of Service Development, DoF, divisional managers and project managers Recovery plans requested for off-track schemes Savings plan for 18/19 financial year not yet fully identified.	Monthly CEO chaired Transformation Board oversight, providing leadership and scrutiny of programme delivery		Satisfactory	4x4=16	The Trust is forecasting to achieve its control total for 2018/19 and has identified more schemes in 2018/19 than at the same time in 2017/18. Therefore the residual risk scoring has been assessed and has been reduced to 16, but the overall programme is still behind what is planned	Further saving schemes to be identified to deliver maximum savings in 2018/19 and full year effect benefits in to 2019/20.	Current and ongoing	4x3 = 12
	7-4	SO7	Finance & Investment	Disagreement with main commissioner over the level of performance that they are prepared to fund	Over performance is not payable until up to four months after the activity undertaken, putting pressure on cash flows CCG financial position is such that ability to hold their financial plan will be challenging if over-performance continues at a similar level to 2016-17.	5x4=20	Clearly defined quarterly reconciliation process of contract payments made with close monitoring of the payment for over performance invoices. Escalation of issues to NHSI for intervention where required.	Twice monthly meetings with MKCCG, attended by the DoF and the Deputy CEO to discuss contractual and actual levels of activity	Updates reported to the F&I Committee and Trust Board on a monthly basis		Satisfactory	4x4=16	Over performance for the prior year is still to be discussed with the commissioners and recovery of income remains a significant risk.	The Trust to continue to work closely with the CCG on demand management solutions.	Current and ongoing	4x3 = 12
MK	7-5	SO7	Finance & Investment	The Trust is unable to access £10.3m of Provider Sustainability Funding (PSF), split into £7.3m General Fund and £3m of additional PSF	That Trust does not meet the performance targets in relation to the A&E 4 hour standards and cancer treatment and therefore does not qualify for PSF	5x5=25	In order to receive £7.3m of PSF General Funding in FY 2018-19, the Trust needs to achieve its financial control total (ie 70% of the funding) and its A&E performance trajectory (30% of the funding). To receive the £3m of additional PSF, the Integrated Care System needs to achieve its control total. The Trust has agreed a control total of £15.8m deficit and its performance trajectory with NHSI and is forecasting to achieve its control total	Financial performance and A&E performance is reviewed at the Executive Director meetings.	F&I committee reviews the monthly financial performance against the control total and receives updates in respect of the A&E performance a monthly basis. The Trust Board reviews A&E performance as well as financial performance on a monthly basis		Satisfactory	5x4=20	The Trust achieved its Q1 and Q2 finance control total and its A&E target Q1 and Q2 YTD, however there is significant risk that the Trust will not meet the Q4 A&E target of 95% in March, soething the Trust did not achieve in 2017/18. As part of an ICS, part of the Trust's PSF is also contingent on achievement of the STP control; given underlying financial pressures in other organisations in the STP, this represents a risk to the Trust as other organisations are not meeting their control totals.	The Trust will continue to closely monitor its performance against the financial and activity targets	Current and ongoing	3x4=12
LK	7-6	SO7	Board of Directors	Failures in compliance leading to regulatory intervention (CQC)	That the Trust fails to meet the CQC's fundamental standards and receives a critical report foollowing an inspection	4x4=16	Compliance assessments embedded in divisions and CSUs (through CIGs and compliance reporting) Divisions undertaken Well Led Assessment in quarter three 2017/18 Trust commissioned GGI to prepare for corporate Well Led Assessment review process Corporate governance structure updated to further strengthen quality and compliance oversight and reporting - effective quarter one 2018/19	Oversight through CIGs Oversight at Risk and Compliance Board Oversight at Nursing and Midwifery Board Oversight at Clinical Quality Board Oversight at Management Board	Regular engagement with the local CQC relationship manager Oversight at Quality and Clinical Risk Committee Trust Board engagement in GGI review	Well Led peer review exercise to be held with kingston Hospital Commissioned GGI to undertake Well Led Assessment preparatory review	Satisfactory	4x3=12	Chief Nurse leading a review of compliance and performance against CQC KLOEs. Gap analysis and plan to be brought to Management Board/ Board in September (date tbc).			4x2 = 8

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

Exec Lead	Risk Ref	Objective	Committee	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance				Residual risk rating	Progress since last report	Action Plans	Action completion date	Target risk score
						Consequence v Likelihood		Level 1 Operational (management)	Level 2 Oversight functions (Committees)	L3 Independent	Overall					
	9-1	SO9	Finance & Investment	Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care	The current size of the Neonatal Unit does not meet the demands of the service. This risks high numbers of transfers of unwell babies and potential delayed repatriation of babies back to the hospital. There is a risk that if the Trust continues to have insufficient space in its NNU, the unit's current Level 2 status could be removed on the basis that the Trust is unable to fulfill its Network responsibilities and deliver care in line with national requirements.	4x4=16	Reconfiguration of cots to create more space Additional cots to increase capacity Parents asked to leave NNU during interventional procedures, ward rounds, etc to increase available space	Daily clinical management and operational oversight NNU feasibility study in progress and awaiting decision (DATE REQUIRED) as to whether to proceed with reconfiguration			Limited	4x3=12		Outline business case for NNU re-build still to be developed by the Estates Department and submitted to the STP for consideration		4x2 = 8
KJ	10-1	SO9	Finance & Investment	Failure to achieve the required level of investment (including appeal funds) to fund the Cancer Centre	Lack of suitable and timely engagement with key players within the city and wider area during the private phase of the appeal, and an inability to enthuse and gain the support of potential donors more broadly, means that the Charity is unable to achieve the required level of charitable contribution to the project	4x3=12	Fundraising strategy and plan in place Financial forecasts under very regular scrutiny Experienced consultancy engaged to support existing senior and experienced fundraising staff Tactical plan for private and public appeal phase developed and implemented	Regular reporting to Committee Operational oversight	Oversight at Charitable Funds Committee	Appeal Leadership Committee	Satisfactory	4x2=8	Income forecasts in place and reiewed weekly.			3x2 = 6
JH	10-2	SO10	Board of Directors	Inability to progress the Milton Keynes Accountable Care System and wider ACS/STP programme	Lack of effective collaboration among all the key local partners means that the goal of a comprehensive and integrated place based health and social care solution within MK is not realised	4x3=12	Chief Executive and Executive team engagement both at ICS and MK Place levels. MK Place leaders chairing 3 of the 5 ICS priority workstreams	Direct MKUH senior invokvement in decision making. Regular CEO progress updates to Management Board	Standing agenda item at the Trust Board		Satisfactory	4x3=12				4x2 = 8

Meeting title	**Board of Directors**	**Date: 11 January 2019**
Report title:	**Use of Trust Seal**	**Agenda item: 6.2**
Lead director **Report author** **Sponsor(s)**	**Name: Kate Jarman** **Name: Adewale Kadiri**	**Title: Director of Corporate Affairs** **Title: Company Secretary**
FoI status:	**Public**	

Report summary	To inform the Board of the use of the Trust seal.						
Purpose *(tick one box only)*	**Information**	x	**Approval**		**To note**	x	**Decision**	
Recommendation	That the Board of Directors notes the use of the trust seal for the settlement of the ADMK Limited Shareholder Agreement, and the Operated Healthcare Facility Agreement between the Trust and ADMK Limited.						

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

Report history	None
Next steps	None
Appendices	

Use of Trust Seal

1. Purpose of the Report

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

2. Context

The Trust Seal was executed on 21 December 2018 for two purposes:

- Settlement of the Shareholder Agreement for ADMK Limited, and
- Settlement of the Operated Healthcare Facility Agreement between the Trust and ADMK Limited.

Audit Committee Summary Report

1. Introduction

The Audit Committee met on 13 December 2018. A summary of the key matters discussed is provided for the Board:

2. Matters Arising

The Trust Secretary provided the Committee with an update on the submissions of declarations of interests from across the organisation. Following a recent drive, there has been an increase in the number of "decision making" staff making declarations, but there is still more to be done. A number of additional actions are to be taken, including adding declarations to relevant staff's appraisal checklists, and targeting line managers. A further progress report will be provided at the June meeting.

3. Data Quality

The Committee was notified that there has been an improvement in the quality of accident and emergency data, mainly as a result of a recent change in the systems that support the work of that department. Steps will continue to be taken to fully address concerns around data quality highlighted by the external auditor. The position regarding RTT remains difficult, with a high number of errors still being recorded. Measures to address the issue include the appointment of a new manager to specifically oversee case booking and tailored interventions to deal with the issues in different services.

4. Internal Audit

RSM, the Trust's internal audit provider, presented the final reports of its first two reviews – on key financial controls, and financial planning and budgetary control. They were rated as providing significant assurance and reasonable assurance respectively. It was noted, in relation to the financial planning audit, that it is often more difficult to achieve significant assurance in this area.

RSM confirmed that they will be following up all of the outstanding actions from reports that had been produced by the previous internal audit providers. The Committee is keen that issues around clinical audit and compliance with NICE guidance, in particular, are followed up. It was noted that the structure of the clinical governance team has been reorganised to place more emphasis on learning from clinical audit and this will receive further attention in the recruitment of a new clinical audit manager.

5. Financial Controller Report

Write-offs for the quarter amounted to £26k, £25k of which related to overseas patients, and 50% of which would be a cost to the Trust in 2018/19.

Losses in the period amounted to £94k, £92k of which related to pharmacy and stock write offs. A pharmacy technician has been appointed to help manage drug stock in order to reduce the volume of write-offs.

In terms of credit notes over £20k, the Committee was informed that an invoice for £1.2m raised to Milton Keynes Council had erroneously included VAT, as a result of which the invoice was credited in full and re-raised for the correct value. Another invoice, for £56k related to an overseas patient who had subsequently provided proof of entitlement to treatment.

6. Board Assurance Framework

A Board session is to take place in January to consider the overall risk environment, including the possible impact of the UK's exit from the EU. In addition, work is to be done to ensure that actions to address the individual risks are effective and up to date, and that scores are appropriate.

7. Minutes from Board Committees

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

- Finance and Investment Committee meeting on 5 November 2018 (approved)
- Quality and Clinical Risk Committee meeting on 28 October 2018 (draft)
- Charitable Funds Committee on 5 November 2018 (draft)
- Workforce and Development Assurance Committee meeting on 5 November 2018 (draft)

8. Recommendation

The Board is asked to:

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

MEETINGS OF THE FINANCE AND INVESTMENT COMMITTEE HELD ON 5 November and 17 December 2018

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

No matters were approved at either the November or December meetings

Matters referred to the Board for final approval:

No matters were referred to the Board for final approval.

Matters considered at the meeting:

1. Performance Dashboard:

The Committee noted that:

I. The work being done to improve length of stay for long stay patients was acknowledged.
II. The number of patients waiting for 52 weeks for treatment has reduced to 10 as at the December meeting (it stood at 13 in November). The focus is now on reducing the number of patients waiting for up to 35 weeks.
III. The rate of patients not attending outpatient appointments is rising (from 6 to 7%). MyCare is yet to have a significant impact on this.
IV. The Trust is on track to meet the A&E performance component of Provider Sustainability Funding (PSF), both on a quarterly (Q3) and year to date basis, but it was acknowledged that Q4 will be difficult.
V. So far, the winter position has not been as difficult as predicted, due in part to the relatively mild weather thus far, and the fact that there has only been a small number of flu cases.

2. Board Assurance Framework:

At the December meeting, it was agreed that:

I. 7-1 (agency and locum staffing) is to be taken off the BAF, as the percentage of Trust staffing that is agency or locum has reduced significantly.
II. 7-3 (Transformation Programme) should be changed from 16 (4x4) to 15 (5x3) on the basis that the Trust is on track to meet its control total..
III. 7-5 (PSF) to change from 20 (5x4) to 15 (5x3) on the basis that although the Trust will lose around £1m of the STP funding of PSF, it will receive some additionaltransformation funding and expects to meet the Q3 performance requirements.

3. Finance Report

I. At month 7, the Trust is on track to deliver the financial element of PSF as its performance was £14k better than plan.

II. However, it has lost £467k YTD of PSF linked to the STP's performance, leading to an overall adverse variance in month of £143k against its own control total. This lost PSF is linked to failures by other organisations within the STP to meet the system control total that all had signed up to.

III. On the costs side, pay was above budget in month, driven by higher bank usage as well as the fact that the Agenda for Change pay deal was not fully funded from the centre. Non-pay expenditure is also above plan, caused by the impact of high cost drugs, outsourcing, and the higher cost of devices related to higher levels of activity.

4. Agency update

I. There was a slight increase in usage compared to last month, but there is no cause for concern – this was mainly to do with more reliance on agency based clinical coders.

5. PLICS (patient level costing and information system) update

I. PLICS will replace reference costs next year.

II. For this year, all acute trusts were required to submit reference costs, but the Trust has also submitted PLICS data this year.

III. PLICS will enable the Trust to compare its costs to those of other provides, and this information is now ready to be shared with the divisional general managers.

IV. Currently the costs are assessed based on consultant job plans, but it will soon also include more junior staff.

V. Currently, the Trust is middle of the road compared to other organisations.

VI. The fact that the Trust has already started using PLICS means that it is ahead of the game in advance of the mandatory roll-out next year.

6. Transformation Programme

I. The position M7 is slightly improved from M6 in that the £9.6m worth of schemes have been identified, £8m of which were validated. This is £2.1m below the £10.1m target.

II. There are a number of schemes in relation to which there is now more confidence of delivery, including savings against STP budget and additional funding sources. There are other schemes for which there is further scope for development, including outpatients productivity.

III. The CIP meetings with the divisions have been re-focused with the intention of providing greater visibility of actions to Management Board.

7. Timeline for strategic capital projects

I. The Trust continues to progress its capital investment plans, with work progressing on eCARE, the cancer centre, aseptic unit and the pharmacy robot replacement.

Quality and Clinical Risk Committee Summary Report

1. Introduction

The Quality and Clinical Risk Committee met on 13 December 2018.

2. Key matters

The following items were presented to the Committee:

Quarterly highlight report

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

- The Coronial inquest into the death of the lady who jumped from the top of the multi-storey care park recorded a narrative finding centred on suicide. The case had flagged up areas in which communication between MKUH and specialist CNWL mental health teams could be improved, although it also highlighted the difficult clinical judgements that are often required in respect of patients who may not have been assessed as being at risk of committing suicide.
- Although the eCare launch had gone well, concerns are emerging that all of the required clinical information is not always being uploaded onto the system. Steps being taken to address this include daily checks of the system by senior nursing staff, and more detailed random audits of records.

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

- It was agreed that Risk 1-4 (failure to embed learning following Serious Incidents) should be broadened out to incorporate learning from complaints, inquests and audits.
- With regard to Risk 3-1(clinical audit), while it was acknowledged that the clinical governance leads are taking responsibility for audits, closing down action plans and retesting are areas requiring further attention. The recruitment of a new Compliance and Audit Manager creates an opportunity to focus more explicitly on these aspects.
- The need for the addition of a specific risk around preparedness for the impact of the exit from the EU was acknowledged.

Exception report for Quality Dashboard

- Although there had been a slight rise in the number of pressure ulcers recorded, the figures on the dashboard had erroneously included community acquired pressure ulcers. It was noted that some changes to reporting frameworks are being implemented for 2019/20. This may leads to an increase in reported pressure ulcers.
- The proportion of complaints that are responded to within the agreed timescales is improving but requires continuous focus.

Mortality update

- The Trust's banding has now moved from 'lower than expected' to 'as expected'.
- With regard to 'Other perinatal conditions', the Trust is aware of a coding issue, which is being looked into.

Quality Strategy update

The Committee received an update on the Quality Strategy. The importance of aligning the strategy to the Trust's values, quality improvement and staff engagement was stressed.

7 Day services update

Board assurance on the Trust's compliance against the 7 day standards is now required. Staffing in most areas now meets the four priority areas, and measures are being taken to achieve further progress throughout 2019.

Update on qualitative analysis of safety culture in the surgical patient pathway
A survey of theatre staff, up to and including at consultant level, has been carried out, and will be repeated next year. The Trust has buddied up with its counterparts at the Royal Berkshire Hospital in Reading, who will undertake a similar process. In advance of the next survey, clinical staff from both organisations may take on shifts at each other's hospitals with a view to providing a constructive assessment of their respective behaviours and cultures.

Pressure area care at MKUH
- There are multiple reasons for pressure ulcers – while some are avoidably caused by neglect of care, in other cases, the care would have been good, but the development of pressure ulcers is unavoidable, for example, in the cases of patients with circulation issues.
- The metric of 0.6 pressure ulcers per 1000 days is the national average and has been adopted at MKUH – the Trust's current rate is 0.56, but there is acknowledgement that it could do better.
- Risk summits are held in respect of every pressure ulcer – there are none currently outstanding.
- The reasons behind the recent increases have been identified and dealt with, and there has been a significant improvement this month.
- Non-executive members were encouraged to raise this issue with staff on wards during their visits.

Divisional discussion – Women's and Children's Health
Representatives from Women's and Children's attended the meeting to discuss the key successes and challenges within their division. Issues raised included:

- The proposal to create a midwifery led unit is to be considered by Management Board early next year.
- The number of home births recorded has reached 4.6% of all births, the highest for some time.
- The changes made in October, which saw ward 9 revert to an antenatal ward and ward 10 become the postnatal ward were well received by staff, students and patients.
- Poor connectivity with eCare for community midwives is a significant issue. A task and finish group has been set up to address the issue.
- In terms of culture, paediatrics was described as a highly resilient team with good working relationships between doctors and nurses. This is similarly the case in obstetrics.
- There has been a steady decline in the number of births, which has allowed for the development of some flexibility in the system. The department is appropriately staffed for the current number and complexity of births, but there are capacity concerns with regard to paediatrics due to the growth in the number of young families moving into the area. There have been 300 more paediatric cases this year than there were in 2015/16.

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

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

Workforce and Development Committee Summary Report

1. Introduction

The Workforce and Development Committee met on 5 November 2018. A summary of key issues discussed is provided below.

2. Workforce

Staff Story

A married couple, both nurses working in different departments in the Trust, attended to provide their story. They have both worked at the trust for over 10 years. They were both broadly positive about their time here, including the opportunities that they have had for training, upskilling and progression. However, the female nurse, who had recently taken on her first management role, expressed the need for more training specifically around the acquisition of management skills. She also raised concerns about what she saw as a lack of inclusiveness among some of her colleagues, although she conceded that this may be linked to her management role.

The Committee thanked the pair for attending to share their experiences.

Workforce Strategy 2018-2022

A detailed delivery plan for the next 3 years of the strategy has been devised focusing on the themes of attraction to the Trust, effective employee engagement and wellbeing, and maximising productivity through innovative and efficient workforce and infrastructure. The Committee will review progress against the plan as a standard item at each of its meetings, and it was noted that the level of ambition within the plan will require significant Board support. It was acknowledged that the extent to which electronic tools such as webex and e-rostering have been incorporated into ways of working is mixed. Measurable impacts of the strategy would include reductions in the time it takes to hire new staff, reductions in agency expenditure and the improvement in staff survey results.

Workforce Information Quarterly Report

Highlights from the report include:

- Temporary staffing costs have reduced by 2.5%, while bank usage is at an all-time high at £1.3m. Agency spend is well within the ceiling that had been agreed with NHS improvement
- The leaver turnover rate has been steadily falling over the recent months. However, vacancy rates among medical and dental and nursing and midwifery staffing groups remain the highest at around 20%.
- Appraisal and statutory and mandatory training rates have remained around the 90% mark. Changes being introduced under Agenda for Change are expected to have a further positive impact on these measures.

Findings from exit questionnaires

600 members of staff left the Trust in the last year and 16.3% of them had completed a leaver's questionnaire. The Committee made a number of suggestions to improve the questionnaire, such as the inclusion of a question as to whether people felt included.

Staff health and wellbeing report
This more detailed staff health and wellbeing report included the following information:

- The 3 key reasons for contact with the staff health and wellbeing team in Quarter 2 were psychological wellbeing, musculoskeletal and mental health. A backlog of referrals has grown as a result of a reduction in service provision by the occupational health consultant. The service is to be reviewed.
- Progress towards accreditation of the department is continuing.
- After 3 weeks of the flu campaign the Trust had achieved 58% coverage (the target is 75%). Achievement of this target would help the Trust to deliver the health and wellbeing CQUIN which is worth £130k.
- Usage of the Care First service has fallen to 8.5% but remains above the national average of 6%. The facility to receive feedback as to whether the service is deemed valuable by users is to be added.
- The Trust now has a manual handling adviser in post. A 3 year plan has been submitted the main focus of which is on musculoskeletal health.

We Care update
- This work is based around the outcomes of the 2017 staff survey and focused on the 7 areas that showed the most room for improvement. The main themes are around a lack of respect and value for people and their roles, as well as work related stress.
- Many of the staff in the areas that had been identified as having the most scope for improvement felt that they had made improvements themselves since the survey was completed, and it is anticipated that the results of such work would be demonstrated in the results of the 2019 survey.
- The suggestion was made for the introduction of a management charter setting out the Trust's expectations for managers.

3. Education

Library and eLearning services update
The library is being reconfigured to provide more space, and the Library Manager is working with colleagues to assist with the provision of evidence based information. The learning intranet site has not been as well used as had been expected – some pages need to be updated and the whole site is to be linked to the new Trust intranet site.

Medical Education update
The training programme for new consultants, which began 3 years ago, is now being recommended by consultants to their colleagues. It was suggested that we review if this should be rolled out to non-medical managers.

Education Update

- Going forward, pay progression is to be linked to the completion of statutory and mandatory training.
- The compliance rate for appraisals was 85% as at September.
- There has been a rise in the number of apprentices, linked to the nursing associate initiative. However national standards relating to a number of apprenticeships are still awaited. The requirement for the provision of 20% off the job training is proving difficult for a number of departments and this is contributing to the relatively low take up of apprenticeships.
- Contact has been made with The Samaritans with a view to assessing whether they can assist with the provision of suicide awareness training, and providing support for those involved.
- 3 students will receive £300 each from the MKGU Rotary Club Bursary to support them with their studies.

Equality and Diversity Annual Report

- The Committee highlighted one of the themes from the report which is the greater likelihood that White people, rather than those from an Asian background, are appointed to roles. Work is being done to review this position, with measures being considered including the adoption of a management toolkit approach alongside a recruitment training session, attendance of which would be a requirement before joining a recruitment panel.
- Applications from the more disadvantaged groups are reviewed, and targeted work is being done with such applicants with a view to improving the quality of their applications.
- We will benchmark the data to assess whether it is indicative of the region and other NHS bodies.

Other business

It was noted that the staff survey response rate currently stands at 28.6%, which is 1.5% above the average.

The Board is asked to note the summary report.

Charitable Funds Committee Summary Report

1. Introduction

The Charitable Funds Committee met on 5 November 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.

Update on the Cancer Centre appeal

- A Patron has been appointed for the Cancer Centre appeal. Their identity will be released in due course. In this capacity it is expected that they will make a significant personal donation, and help facilitate the provision of further substantial gifts from others.
- The Committee received an update of progress being made on the appeal, and noted that a number of significant donations have either been made or promised. The charity is on track to achieve the £2.5m target.
- A new corporate fundraiser has been appointed. This appointment will allow the Head of Fundraising to focus more on sustainability, promoting regular giving and legacies

Charitable Funds Finance updates

- The charity's Annual Accounts were signed off at the meeting.
- It was suggested and agreed that going forward, the preparation of the annual account is to be taken over by the fundraising team in order that it better reflects the charity's aims and highlights the work that it does. It was agreed that this more comprehensive report would provide the opportunity for a comparative analysis of the charity's costs to spend ratio.
- To date, both income and expenditure are slightly under plan.
- Charitable spending on the Cancer Centre, which will mainly be on equipment and furnishings, is not expected to take place until the building is at or near completion.
- In terms of the charity's 'business as usual' funding, it was agreed that steps should be taken to avoid an unduly large amount of uncommitted spend at the end of the financial year.

Future strategic direction of the MK Hospital Charity

- The Committee noted the contents of a presentation from a firm of charity lawyers, providing guidance on how and where NHS charitable funds may be spent.
- A scoping exercise is to be carried out drawing on comparisons with other similar sized hospitals, and this Committee's terms of reference are to be amended in light of this guidance.

Registration with the Fundraising Regulator

- The Head of Fundraising made the point that it is advisable for any charity raising more than £100k a year to register with the Fundraising Regulator.
- It is considered best practice to register and provides assurance to the public. The cost of registration is relatively low.
- The Committee agreed to consider the Code in detail and make a decision offline.

Other business

- It was confirmed that the charity is up to date on Gift Aid claims.

3. Risks highlighted during the meeting for consideration on BAF/SRR

None