Board of Directors

Public Board to be held at 10:00 on Thursday 02 July 2020
via video-conference in line with social distancing requirements

Item No.	Title	Purpose	Type and Page No.	Lead
1. Introduction and Administration				
1.1	Apologies	Receive	Verbal	Chair
1.2	Declarations of Interest i) Any new interests to declare ii) Any interests to declare in relation to open items on the agenda	Receive	Verbal	Chair
1.3	Minutes of the public meeting held on 7 May 2020	Approve	Pg 3	Chair
1.4	Matters Arising/ Action Log	Approve	No open actions	Chair
2. Chairman and Chief Executive Reports				
2.1	Chair's Report	Discuss	Verbal	Chair
2.2	Chief Executive's Report • Covid-19 update • Elective activity • Partnership working • Workforce wellbeing	Discuss	Verbal	Chief Executive
3. Quality				
3.1	Patient Story	Receive / discuss	Presentation	Director of Patient Care & Chief Nurse
3.2	Nursing staffing update	Discuss	Pg 10	Director of Patient Care and Chief Nurse
3.3	Mortality report	Discuss	Pg 17	Medical Director
3.4.	Serious Incident Report	Discuss	Pg 27	Medical Director
4. Strategy				
4.1	Use of Day Surgery Unit for ICU	Note	Verbal	Director of Clinical Services
4.2	Objectives	Note	Verbal	CEO
4.3	HIP 2 development		Presentation	Deputy CEO
5. Performance				
5.1 5.2 5.3	Performance Report Month 2 Finance Month 2 Workforce Report Month 2 • BAME risk assessment update	Receive / Discuss	Pg 38 Pg 50 Pg 59 Verbal	Deputy CEO/ Director of Operations Director of Finance Director of Workforce

Item No.	Title	Purpose	Type and Page No.	Lead
6. Assurance and Statutory Items				
6.1	Infection Prevention Control (IPC) Board Assurance Framework	Discuss/ Approve	Pg 63	Chief Nurse
7. Governance				
7.1	Use of Trust seal	Note	Pg 86	Director of Corporate Affairs
7.2	Summary reports Finance & Investment Committee – 1 June 2020 Quality & Clinical Risk Committee – 22 June 2020 Audit Committee – 22 June 2020 Charitable Funds Committee – 10 June 2020	Note	 Pg 88 Pg 90 Pg 93 Pg 95	Committee Chairs
8. Closing Administration				
8.1	Any Other Business	Discuss/ Note/ Approve	Verbal	Chair
8.2	Questions from Members of the Public While under normal circumstances the public can attend part of provider board meetings, current Government social isolation requirements constitute 'special reasons' precluding face to face gatherings as permitted by legislation	Note	Verbal	Chair
8.3	Motion to Close the Meeting	Receive	Verbal	Chair
8.4	Resolution to Exclude the Press and Public The Chair to request the Board pass the following resolution to exclude the press and public and move into private session to consider private business: "That representatives of the press and members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted"	Approve		Chair

BOARD OF DIRECTORS MEETING

Draft Minutes of the Board of Directors meeting held in PUBLIC on May 7, 2020 remotely via Teams due to pandemic

Present:	
Simon Lloyd	Chairman
Joe Harrison	Chief Executive
Ian Reckless	Medical Director
Danielle Petch	Director of Workforce
Mike Keech	Director of Finance
Ian Reckless	Medical Director
Sam Donohue	Depute Chief Nurse
Heidi Travis	Non-Executive Director (Chair of the Finance & Investment Committee
Helen Smart	Non-Executive Director (Chair of the Quality and Clinical Risk Committee)
Andrew Blakeman	Non-Executive Director (Chair of the Audit Committee)
Nicky McLeod	Non-Executive Director (Chair of the Workforce Development & Assurance Committee)
John Clapham	Non-Executive Director (and representative of University of Buckingham)
Haider Husain	Non-Executive Director
John Lisle	Non-Executive Director
Luke James	Associate Non-Executive Director
In attendance:	
Alison Marlow	Trust Secretary

1	**Welcome**
	The Chairman welcomed all present to the meeting and made a special point of welcoming Dr Luke James, who joined the Trust as Associate Non-Executive Director on May 1, 2020.
1.1	**Apologies**
	Apologies were received from John Blakesley and Nicky Burns-Muir (Sam Donohue present on her behalf)
1.2	**Declarations of interest**
	No new interests had been declared and no interests were declared in relation to the open items on the agenda.
1.3	**Minutes of the meeting held on March 6, 2020**
	The minutes of the public Board meeting held on March 6, 2020 were accepted as an accurate record.
1.4	**Matters Arising/ Action Log**
	There were no matters arising.
2	**Chairman and Chief Executive's Reports**
2.1	**Chairman's Report**

2.2	• Simon Lloyd reported that he was still involved as much as possible with the hospital, and in regular contact via telephone and teams/teleconferencing meetings. He attended (virtually) a meeting of Eastern region chairs earlier in the week and the consensus was that the region has coped well with the effects of the pandemic **Resolved**: The Board **noted** the Chairman's' Report **Chief Executive's Report** Joe Harrison gave an update on the current situation within the organisation. Numbers of Covid positive patients have been coming down with the peak two weeks ago when the Trust had 70 positive patients on site and 40 awaiting testing. This led to pressures in critical care but staff as a team have coped remarkably well ensuring that patients and families stay safe. Today our Intensive Care Unit (ICU) activity is down to normal levels. Emergency patients are routinely tested so they can be streamed to appropriate areas. PPE – the Trust has been able to follow and adhere to all national guidelines. There has been comprehensive training and good signage to ensure staff know which PPE should be worn and when. Ian Reckless added that there were still some supply issues with medicines and that the anaesthetic staff group and theatre practitioners were still under some pressure, but that it was calmer than two weeks ago. He said that collaborative work with Estates meant that there were no significant pressures on the supply of oxygen. JH said that news in the media was the disproportionate numbers of BAME (black and minority ethnic) people affected. The Trust had done the following to address concerns: organised a virtual meeting so concerns could be voiced (attended by 100 people) and further engagement with staff and consultants regarding their thoughts. Danielle Petch said she was in touch with others regionally/nationally to see what other Trusts were doing – the aim was to see what further steps could be taken to address concerns. JH expressed his thanks to Mike Keech and the finance team for completing the Annual Accounts on time in difficult circumstances. JH also recorded his thanks to the people of Milton Keynes for their kind charitable donations, both financial and in the form of goodies and treats for staff. The Charitable Funds Committee will ensure that any donations are appropriately spent to make sure staff feel supported. The new Staff Hub has been well received as a calm space to have some down time, with snacks and drinks available. JH encouraged the Non-Executive Directors to visit when they return to the site. Next steps: JH said the next stage was to look at how the Trust start/reset the organisation and open up appropriate services. There has been a huge drop off in routine patients and when services start to return there are

	many things to consider – ensuring that we separate Covid and non Covid patients, that PPE is appropriate etc. He thanked the Board, every member of staff and the wider health and social care organisations in Milton Keynes for their efficient, dedicated and collaborative approach. Resolved: The Board **noted** the Chief Executive's Report
3	**Quality**
3.1	**Patient Experience** Sam Donohue presented the many new patient experience initiatives that have been introduced since the pandemic, many of which will continue. With very limited visitors and no volunteers on wards, many patients had limited stimulation, so relatives were invited to send in letters, which were then printed, laminated and given or read out to patients. A relatives' information line was also set up in the PALS office (one of the PALS team and a nurse), so that next of kin could receive updates easily. This has been very successful and going forward they would like a resident nurse in the PALS office to assist with the clinical side of this work. 50 phones had been obtained through charitable funds and linked to a Nye app so that staff could help patients have daily video calls with their loved ones. This had proved excellent for wellbeing with one lady who hadn't eaten much for days, reviving her appetite after seeing her pet on the video call. Bag drop off – relatives were able to leave bags of clothes/treats at reception which would then be delivered to the wards. Belongings – bereaved relatives were able to collect a loved one's belongings from the PALS office. Simon Lloyd commented that these initiatives were making a tremendous difference to patients at their families at this time. **Resolved:** The Board thanked SD for her comprehensive presentation.
3.2	**Summary Reports**
	-Finance and Investment Committee. **Resolved:** the Board received and **noted** the report.
3.3	**Nursing Staffing Update**
	SD reported that many nursing and midwifery staff had been deployed to many different areas and had adapted brilliantly. The Trust also welcomed 55 third year student nurses/midwives for an extended six-month placement. Therapy staff had adapted well to working in different areas too and had been running some very successful outpatient clinics. Senior nursing leadership had been introduced 24/7 and that model would continue. All staff had adjusted to the changes with flexibility and a can-do attitude.

	Helen Smart congratulated the Chief Nurse and her team and commented that the innovative work regarding leadership presence would drive quality. SD said this would be discussed at the Nursing, Midwifery and Therapies board next week. HS asked about therapy workload of patients leaving ICU for rehab. SD said there had been a reduction in length of stay for some patients due to more input. HS congratulated the team on their great work.
3.4	**Obstetrics and Gynaecology Training Concerns**
	Ian Reckless said these had been discussed in depth at both QCRC and Workforce Committees. It related to concerns among trainees in O&G over trainees' dissatisfaction over training experience (not patient safety). Many steps had been taken including a formative review with resulting action plan, a team off-site away day with a leading patient safety expert. Two additional middle grade doctors were to be appointed from August and there was a slow but definite improvement and so far, the Deanery (next visit November) were satisfied with progress. JH added that the specialty's management team were well supported by IR and there was real evidence of measures having effect. HS asked how the Trust could change students' perception. IR said when there were concerns around a training environment, perceptions didn't change overnight. He said they had to do everything possible to improve multi-disciplinary professional working and ensure that different groups valued each other. He said using initiatives such as appreciative enquiry were being implemented, along with celebrating success through Greatix.
3.5	**Mortality Report**
	IR discussed the Mortality Report and for the benefit of new members explained the two different quantitive methods used. He explained some of the apparent discrepancies were due to different time frames and added that since the introduction of eCare, the Trust's ability to accurately code has fallen somewhat. He said that every death was reviewed by an independent medical examiner. He explained that the review of deaths has changed over time and that the practice of using multi-professional teams to review deaths using the death as a prism for discussion had been superseded by the medical examiner arms' length review model. Andrew Blakeman asked if there were comparisons to be made from other Trusts, but IR said that good benchmarking data was not available from other hospitals.
3.6	**Seven Day Services**
	IR explained that NHS England introduced 10 key standards to encourage the NHS to deliver seven-day services, with four being defined as priority, with the expectation of meeting standards by March 2020. With Covid, that had been paused but he said the Trust had still been collecting data and that recent results had been positive (though not there was no suggestion that they were representative bearing in mind the smaller number of patients in hospital in recent weeks). Essentially, he said that the Trust was

	meeting 2.5 of the 4 priority standards, with the requirement that patients should be seen by a consultant once a day having increased from 64-84%. JH asked how the Trust compared to other Trusts. IR said this was difficult to answer but that MKUH probably fell into the middle third.
4	**Strategy**
4.1	**Use of Ward 12** JH explained that Ward 12 had been used earlier in the winter as a clean ward for orthopaedic cases but had been since used as part of the new respiratory unit. He explained that when routine work restarted there would still be a requirement for a clean space.
4.2	**Objectives** JH said that as the site had been very much focused on Covid work it hadn't been business as usual in a number of areas. He said the executive team would therefore review the objectives and bring them back to the next Public Board in July
4.3	**Health infrastructure Programme (HIP20 update)** JH said there was clear recognition that the work of HIP2 was well advanced and that the Trust was seen in a positive light. A governance structure had been put in place, via Finance & Investment Committee and reporting into Board. A formal paper would be presented at the next Board.
5	**Performance**
5.1	**Covid-19 update** Emma Livesley recorded her thanks to the organisation, saying that the staff response had been phenomenal. To date the Trust had seen 415 Covid positive patients and 100 deaths, though that figure had been static for the past two days. In addition, there had been 129 positive staff cases, some of which required hospital admissions. Staff testing (so far 1000 tests) suggested that there was a 2.7% prevalence of Covid among asymptomatic staff. The Trust has been asked to submit the first part of the recovery plan to the East of England, with the expected proviso that cancer and emergency cases would be prioritised. EL said they were looking at new ways of working, which would include considering PPE, staffing levels (1000 staff had now returned to work), the constraint of some medication supply and the public appetite regarding coming onto the site. Andrew Blakeman wanted to note what a professional job the teams had done, and this was echoed by Helen Smart.
5.2	**Performance Report M12** EL said that due to Covid, during March activity was considerably reduced, with many empty beds in parts of the organisation but high demand in ICU which was three times the normal run rate. A&E attendances were around 100 per day compared with the usual 260 attendances and multiple pathways were established to ensure safety of patients. A separate Respiratory Assessment Unit (RAU) was established. EL paid tribute to the tremendous work of every service – including clinical, IT, HR and estates teams. Their versatility and flexibility was noted. She said that the Trust had been using independent and private healthcare providers for elective operations and that would continue to ensure patients were supported. **The performance report was received and noted.**
5.3	**Finance Report M12**

	Mike Keech presented the M12 report. The Trust's deficient for March was £3.6m, £5m adverse to budget in the month and £11.8m adverse year to date. The adverse full year position was mainly due to timing differences on donations and an impairment following a revaluation of the Trust's estate. The cash balance at the end of March was £16.8m which was £14.3m above plan due to the timing of capital expenditure and an increase in liabilities at year end. Cost savings – overall savings of £0.9m were delivered in month against an identified plan of £1m and the target of £1m. For the year £6.1m has been delivered against a target of £8.4m. The annual accounts were submitted to the external auditors on April 27 – MK recorded huge thanks to his team who worked in difficult circumstances to submit on time despite options to extend if needed. **The month 12 finance report was received, discussed and noted**
5.4	**Workforce** Danielle Petch gave an overview of the M12 report. Vacancies had reduced from 12.9% in April 2019 to 8.1% in March 2020. Staff turnover has decreased to 8.7% and sickness absence is under the 4% target. Statutory/Mandatory training/appraisals – the team worked hard to improve the compliance rate on this. Since Covid, training and appraisals have only been carried out if necessary, but DP said she was confident that the target position could be achieved. She said the HR teams had worked hard to support staff during Covid – including regular welfare calls to staff off sick or self-isolating, the development of a staff hub, extra support from the employee assistance programme, including face to face counselling. There was also a Covid helpline and staff food parcels. Staff swabbing for both symptomatic and asymptomatic staff – there was no waiting list for this, and capacity was sufficient for any member of staff to be swabbed HR had carried out over 700 risk assessments for staff and either moved them into low risk areas/working from home/ or given specific advice. This included pregnant colleagues. There have been Q&A sessions for BAME staff, and more work is going on in this area. 300 volunteers had also been fast-tracked and an additional 100 staff had joined the Bank. Nicky Mcleod gave her thanks and congratulations to the HR team for continually improved metrics and a positive and proactive approach to staff health and wellbeing. This was echoed by Andrew Blakeman and Haider Husain. Andrew Blakeman asked why some staff were reluctant to have appraisals. DP said it was for several reasons – some don't see the value, some may have theirs postponed due to service pressures, and some don't realise that it's due. MK pointed out that from April 2020, pay progression is linked to appraisal compliance.

	Simon Lloyd commented on what great ambassadors the staff on the Ross Kemp documentaries had been for the Trust and said the programme carried many sensitive and significant messages. Kate Jarman said that there had been a huge amount of internal communications to ensure that staff felt supported and informed and this had been very well received. AB asked if the Trust expected to see a drop in applications to the NHS due to fear. DP said there had been a 14% rise in the number of people wanting to work in the NHS and SD said there had also been a surge in applications for nursing courses starting in September. **The Workforce report was received, discussed and noted.**
6	**Assurance and Statutory Items**
6.1	**Board Assurance Framework and Risk** • KJ said that risks regarding Covid had been added to the BAF. • She said the BAF was due for significant review, which would be reported to the Audit Committee. There was due to be a risk seminar, and this would be on the afternoon of July 2, following the Board meeting. • Andrew Blakeman acknowledged this is emphasised that how the Trust did the recovery phase was critical.
7	**Governance**
7.1	**Use of the Trust Seal** This was noted by the Board.
8	**Closing Administration** There was no further business and the meeting was closed at 11.50am.

Meeting title	Board of Directors			**Date:** 2nd July 2020	
Report title:	Nursing Staffing Report			**Agenda item: 3.2**	
Lead director **Report author Sponsor(s)**	**Name:** Nicky Burns-Muir **Name:** Matthew Sandham			**Title:** Director of Patient Care/Chief Nurse **Title:** Associate Chief Nurse	
FoI status:					
Report summary					
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [x]	**Decision** [ ]	
Recommendation	That the Board receive the Nursing Staffing Report.				

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

Report history	To every Public Board
Next steps	
Appendices	Appendix

Board of Directors Report on Nursing and Midwifery staffing levels
Amalgamated report for April and May 2020

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.

Are we safe ?

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

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

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

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

CHPPD	Total Patient Numbers	Registered Midwives/Nurses	Care Staff	Overall
April	N/A	N/A	N/A	N/A
May	8422	7.1	4.4	11.5

Month	**RN/RM Day % Fill Rate**	**HCA/MCA Day % Fill Rate**	**RN/RM Night % Fill Rate**	**HCA/MCA Night % Fill Rate**
April	N/A	N/A	N/A	N/A
May	75.2%	82.2%	88.5%	94.0%

- *May 2020 data is included in Appendix 1.*

The CHPPD hours in April were not recorded due to the reconfiguration of clinical areas and wards in response to the COVID-19 situation. Nursing staff were redeployed, and clinical ward areas closed, and a different model of nursing was implemented to support isolation of patients and increased acuity. Therefore, we are unable to have an accurate report due to staff sickness (including self-isolating and shielding), redeployment of staff and changes in bed occupancy. This will be reviewed monthly during the pandemic.

Areas with notable fill rates

All areas had an increased CHPPD due to the low number of patients during May. The CHPPD was particularly high on Ward 24 and Ward 5 as both had very few admissions.

The staff were reallocated as follows:

- Staff on Ward 24 were reallocated daily to all adult wards.
- Staff Nurse moved from Ward 5 to Ward 16 for 3 months
- Band 6 SR redeployed to Paediatric Diabetes Service to cover long term sickness and unprecedented increase in newly diagnosed diabetics
- Nursery Nurse redeployed to cover Newborn Hearing Screening vacancies and allow for extended service hours reducing the need for parents to return for hearing screening clinics
- Health Care Assistant redeployed to all wards including Neonatal Unit for 3/12.
- Staff from Paediatrics covered Children's Emergency Department reducing their bank /agency costs.
- Mandatory Training, datix's and Appraisals completed.

Vacancies and Recruitment

Maternity

Following robust recruitment there continues to be minimal vacancies within the maternity department.

In May we recruited 1.67 WTE Band 6 midwives who are now in pre-employment checks.

Midwifery Vacancies June 2020								
Band	B7	B6	B5	B4	B3	B2	Ward Clerks	Housekeeper
Total	2.6 WTE	4.86 WTE	0 WTE	0.2 WTE	1.86 WTE	4.47 WTE	1.58 WTE	0 WTE

Recruitment is currently taking place for preceptorship midwives who will take up post in October 2020 once they have completed their midwifery training. Interviews are scheduled for 14th July.

Recruitment currently taking place for Band 7 Labour ward coordinators. Interviews are scheduled in July

Surgery

Surgery has continued to recruit during this period using Information Technology to support the interview process.

Intensive Care Unit has had two successful recruitment days and have offered 6 WTE Band 5 jobs.

Surgery Vacancies June 2020								
Band	B7	B6	B5	B4	B3	B2	Ward Clerks	Housekeeper
Total	0 WTE	2.8 WTE	26.6 WTE	1.2 WTE	1.4 WTE	9.6 WTE	0 WTE	0 WTE

Medicine

Medicine carried out interviews in May and offered 10wte posts. They still have significant challenges on wards 8,15 and 16.

Medicine Vacancies June 2020								
Band	B7	B6	B5	B4	B3	B2	Ward Clerks	Housekeeper
Total	0 WTE	1.3 WTE	72 WTE	0 WTE	0 WTE	17.5 WTE	0 WTE	0 WTE

Are we efficient?

Maternity Update

Maternity services have remained at pre COVID levels. COVID pathways are in line where possible and practical with RCOG, Royal College of Midwives and Local Maternity System (LMS) guidance was put in place to minimise risk of staff and patient transmission.

The Trust limited visits of 90 minutes post birth for mother and birth partnering to maternal requests for LSCS (similar stance to local Trusts). There are many examples during this period of scrutinising of pathway design and reacting to changing situations to maximise patient experience and patient care e.g. rapid reinstatement with overview by Gold Command of Day 3 midwife face to face visit with suitable social distancing and PPE after admission of dehydrated and jaundiced babies who had not been able to be seen until day 5 following changes to postnatal pathway in line with RCOG guidance. Maternity visiting and reinstating the day 1 postnatal face to face visit by the midwife are currently under review by GOLD.

The Early Pregnancy Assessment Unit (EPAU) was moved from Ward 21 to Ward10. Emergency gynaecology inpatient services were also moved to Ward 10 and staffing was provided by dual trained midwives and specialist outpatient gynaecology nurses rather than nurses from Ward 21. These members of staff were supported in this redeployment by additional training, Ward 9 staff, Trust nurses and practice development teams. Hysteroscopy,

colposcopy and urogynaecology services have now been reinstated and the specialist nurses have been released from working in the inpatient clinical areas.

A number of clinical staff have had periods of working from home for shielding, and COVID isolation, this has proved positive for the Division and has addressed overdue guidelines, outstanding Datix, standard operating procedures, audits and is now maintaining acceptable levels of review in these areas. This has also provided an opportunity for development of staff who would not normally be involved in these areas and has given staff a greater understanding of the governance agenda.

Throughout COVID 19 escalation period the Trust has continued to provide support for home births, waterbirths and the Continuity of Care case loading midwifery teams that provide women with a personalised midwifery experience throughout pregnancy, labour and the postnatal period. Currently these teams are providing 31% of women in Milton Keynes with continuity of care. These services in many Trusts nationally have been suspended.

Extremely positive feedback received from year 2 student midwives who have been redeployed to undertake clinical placements from other universities during the COVID 19 Pandemic. These students live in Milton Keynes and are now requesting transfer to Milton Keynes to complete their clinical practice.

Maternity Staffing

Our midwifery staffing is planned in line with the national recommendation for safe staffing, which is one midwife to every 28 births. The service is currently funded to provide this level of staff and we use them effectively to follow women throughout their pregnancy to birth and the postnatal period.

We prioritise women who are giving birth by providing one to one care in labour and to those who have additional clinical needs within the hospital.

Midwife to Birth ratio

Midwives are present at all births and are the main providers of antenatal and postnatal care. Staffing needs in both hospital and community settings depend on service design, buildings and facilities, local geography, and demographic factors, as well as models of care and the capacity and skills of individual midwives. Other significant variables with an impact on staffing levels include women’s choice and risk status.

To provide a safe maternity service, the Royal College of Midwives (RCM) says there should be an average midwife to birth ratio of one midwife for every 28 births. The ratio recommended by *Safer Childbirth (The Kings Fund)*, is also 28 births to one WTE midwife for hospital births and 1:35 for home births.

At Milton Keynes, the Midwife to Birth Ratio is stated on the obstetric dashboard on a monthly basis and reported at Management Board, Women’s CSU meetings and Clinical Quality Board bi-monthly

In May 2020, the Midwife to Birth Ratio was 1:27.

Student Nurses/Midwives Update

A further cohort of third year student nurses were offered the opportunity to complete their final clinical placement in practice and become part of the workforce on a Band 4 which is supported by HEE (Health Education England).

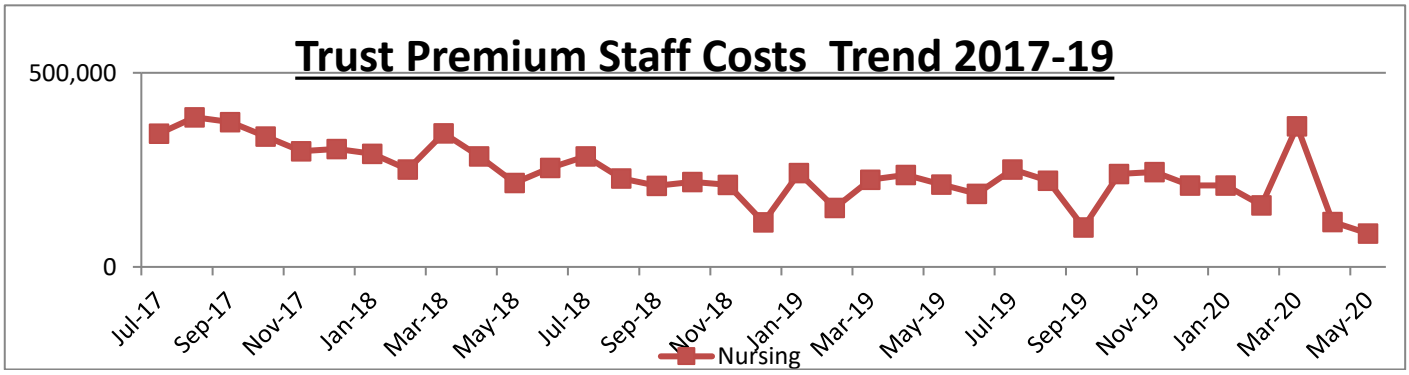
We have welcomed a cohort of 65 Nursing students, 14 Midwifery Students and 4 Allied Health Professionals to MKUH and all have undertaken an extensive induction and orientation programme.

The student nurses will be supervised using a coaching model, where each group of students (under direction and supervision of a registered nurse) provides total care for a group of patients. Students are not currently counted within the establishment nursing numbers.

Across nursing and midwifery, the students have positively received the introduction of protected learning time/ study days. We have been able to identify students who live in the local area that wish to continue placements at MKUH that we would not have been able to offer placements to in 'normal' times. We have several students from Hertfordshire, Oxford Brookes, and Kings College London that we would not have had before and more students from University of Bedfordshire than we were allocated in 'normal' times.

Are we effective?

Agency graph



During the period of April and May the premium staff cost reduced. This was due to the redeployment of staff and staff returning from isolation. The Agency spend has returned to its lowest in three years.

Fill rates for Nursing, Midwifery and Care Staff May2020 (Appendix 1)

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
AMU	82.2%	95.9%	101.3%	106.2%	427	9.6	3.8	13.3
MAU 2	74.3%	90.1%	103.4%	122.6%	334	8.7	6.2	14.9
Phoenix Unit	-	-	-	-	0	-	-	-
Ward 15	85.6%	93.6%	104.1%	104.8%	301	10.4	6.7	17.1
Ward 16	80.6%	88.9%	96.8%	101.6%	314	9.4	6.0	15.4
Ward 17	78.1%	90.0%	98.8%	112.8%	541	6.0	3.0	8.9
Ward 18	79.3%	102.0%	105.4%	112.9%	687	4.0	4.3	8.3
Ward 19	74.4%	91.0%	100.1%	113.0%	613	4.1	4.6	8.8
Ward 20	90.4%	98.1%	102.6%	118.1%	632	5.1	3.4	8.5
Ward 21	70.1%	105.1%	84.2%	121.0%	234	9.5	7.7	17.2
Ward 22	100.8%	64.8%	93.2%	63.6%	414	8.6	5.4	14.0
Ward 23	85.4%	99.1%	101.6%	104.5%	913	4.8	4.5	9.3
Ward 24	55.9%	30.8%	53.8%	61.1%	30	50.9	11.6	62.5
Ward 3	59.8%	63.6%	69.6%	72.1%	230	8.2	8.3	16.6
Ward 5	71.2%	50.8%	95.8%	41.4%	215	16.2	1.7	17.9
Ward 7	77.9%	86.4%	102.2%	109.7%	435	6.0	6.2	12.3
Ward 8	74.6%	107.0%	102.0%	141.9%	609	4.1	4.0	8.2
DOCC	53.6%	30.1%	53.2%	10.5%	128	42.1	6.2	48.3
Labour Ward								
Ward 9	85.2%	92.6%	95.2%	88.7%	1051	3.4	2.1	5.4
Ward 10								
NNU	72.6%	80.1%	89.7%	103.2%	314	13.0	2.3	15.4

Meeting title	**Trust Board**	**Date: 02 July 2020**
Report title:	**Mortality Report**	**Agenda item: 3.3**
Lead director **Report author** **Sponsor(s)**	**Dr Ian Reckless** **Dr Bina Parmar**	**Medical Director** **Associate Medical Director**
FoI status:	**Publically disclosable**	

Report summary				
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** [x]	**Decision** ☐
Recommendation	To note content and provide feedback / challenge.			

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 concern to the public and regulatory bodies.
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 to Board. Also covered in deatil at QCRC.

Executive Summary

This paper summarises the Trust's current position in relation to mortality indices, based on the latest available Dr Foster data, and as discussed through the Trust's mortality and morbidity (M&M) meeting framework.

The Trust's current HSMR is numberically better than the national average and statistically within the 'as expected' range. There has been a downward (improving) trend in HSMR over recent months. Conversely, the SHMI has increased over recent months and has now statistically flagged as 'higher than expected'. There are a number of important contextual factors which should be taken into consideration (in considering the SHMI) as detailed on pages 6 to 8 of this report. It is believed that the increase does not represent care quality concerns but that it is a function of unintended consequences of eCare (reduced coding depth and an increase in uncoded epsiodes due to selected outpatient encounters being considered as admissions). Assurance is gained from the qualitative review of deaths by medical examiners, described below.

The Medical Examiner System underwent a review of pathways to accommodate the COVID-19 crisis. This involved compliance with the changes in Law as laid out in the Coronavirus Act. Initially, it was difficult to ascertain if a Medical Examiner System would run during the panemic due to a significant number of the ME team being redeployed. There has been much engagement from various team members and a virtual ME pathway process was also developed. The teams worked over weekends and bank holidays to ensure that there has been a quick turnover of paperwork. To date, we have reviewed all deaths through Medical Examiner scrutiny.Thankfully, mortuary numbers have been below an alert level and this has ensured that alternative resources have not been required during peak periods to date.

Mortality and Morbidity Meetings have reduced in frequency due to COVID-19 and associated pressures. This has caused a backlog of cases for discussion. We have asked that SJR requests prompted by Medical Examiners, the Serious Incident Review Group and the complaints function will be prioritised for Medicine. As rotas started to revert to our 'new normal' in June, we are planning for the criteria of SJR reviews to widen once again. Surgery and Women's Health will continue to review all of their deaths.

HM Coroner is only holding inquests (virtually) that had a previously agreed date, where the next of kin had no concerns or where he is able to proceed as 'read only'. All other inquests will have new dates set in due course. This will then have a significant impact on the Trust due to the high volumes. At one point it was suggested that all COVID-19 related deaths may be subject to Inquest with jury: clearly, in the current context this seems neither approprioate nor achievable.

All new coroner referrals are being processed as per usual, with the recognition that the timeframe for receiving clinicians' statements may be longer than as agreed in the standard operating procedure (SOP).

Central Medical Examiner funding has been approved for 2019/20.

Mortality Platform – The Clinical Outcome Review System (CORS) has been approved and is currently in the initial phase of template design. This information and record keeping system will assist in recording the process and outcome of Medical Examiner reviews and, crucially, assist in organisational learning.

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
Data period: Mar 2019 – Feb 2020

Key Highlights:

- HSMR relative risk for 12 month period = 96.2 ‘as expected’ range.
- Crude mortality rate within HSMR basket = 3.0% (MK peer group rate 3.5%).
- 1 outlier diagnosis was identified within the HSMR basket for this period (‘other upper respiratory diseases’).
- Palliative Care 6.0% (Peer Rate 4.8%) for non-elective spells in the HSMR basket.

Divisional HSMR performance for rolling year
Data period Mar 2019 – Feb 2020

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.

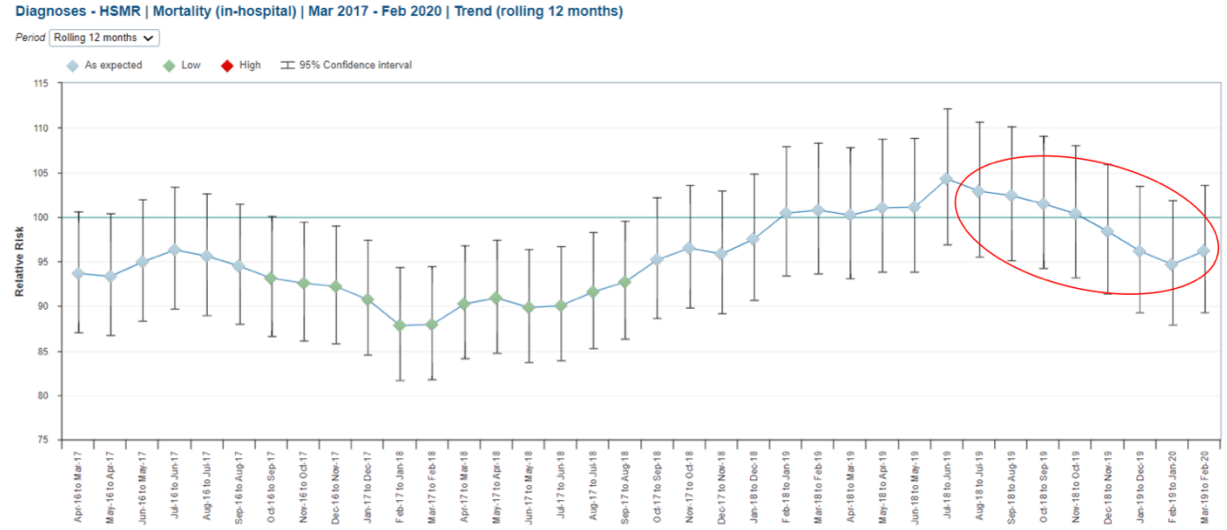
Medical Division RR = 98.4 ‘as expected’. There were 0 negative outliers (by diagnosis group) (i.e. significantly higher than expected deaths).

Surgical Division RR = 86.2 ‘as expected’. There were 0 negative outliers.

Women’s and Children’s Division RR = 46.9 ‘below expected’. There were 0 negative outliers.

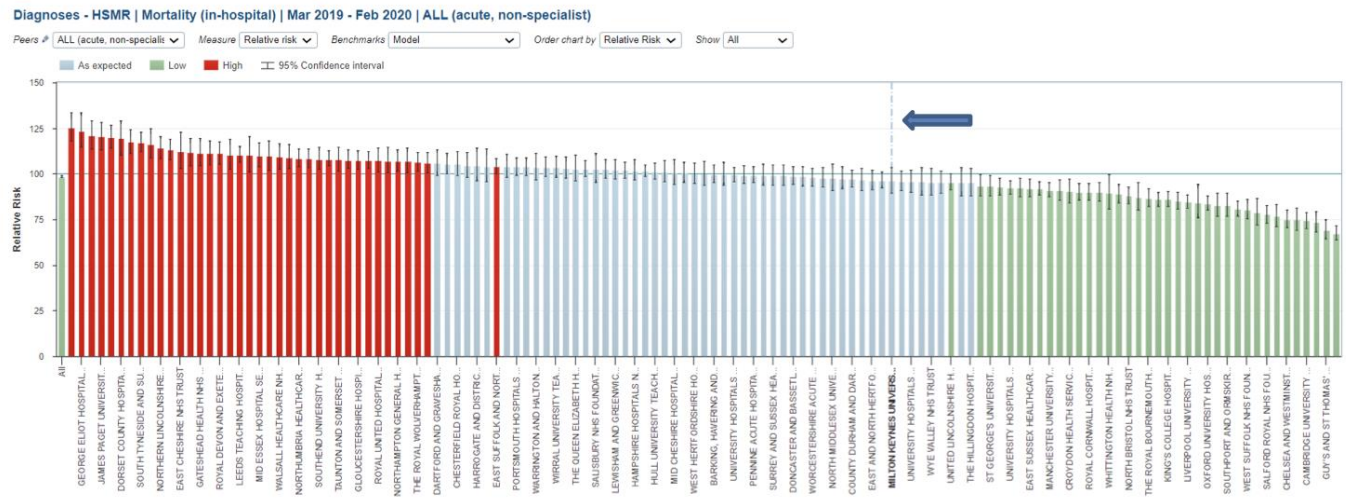
HSMR Rolling Trend
Data period Mar 2017 - Feb 2020

Figure 1.1: HSMR – Trend (Rolling 12 months) last 36 months



HSMR vs National Peers
Data period Mar 2017 – Feb 2020

Figure 2.2 – HSMR vs national peers



SHMI

Feb 2019 – Jan 2020

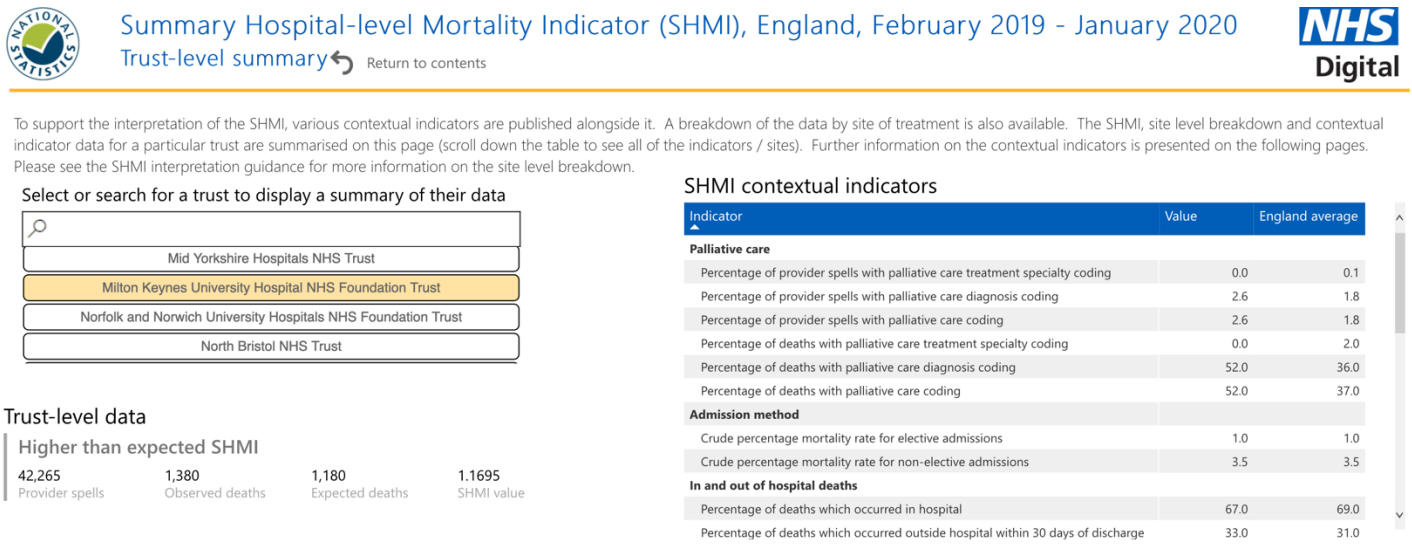
The Summary Hospital-level Mortality Indicator (SHMI), which includes out of hospital deaths occurring within 30 days of discharge, is measured by the Health and Social Care Information Centre (HSCIC). The SHMI relative risk is the ratio between the actual number of patients who die following treatment 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. For the period, February 2019 to January 2020, the Trust SHMI was 1.16 ('higher than expected'). This is the first time in recent years that SHMI has breached the upper control limit.

SHMI is not itself a measure of quality of care. A higher then expected SHMI should be viewed as a 'screening flag' which requires further investigation. SHMI is currently higher then expected at Trust level and there are a number of factors which may account for this:

1. Palliative care coding MKUH 52% vs National 37% (MKUH falls into the list of top ten Trusts recording higher than national average). If one were to assume that palliative care involvement and death should be associated, then this might imply that the patient group was indeed expected to have poorer outcomes (in ways not otherwise accounted for by the statistical model).

2. Invalid Diagnosis MKUH 1.4% vs National 0.5% (MKUH falls into the top ten Trusts recording higher levels than national average). This may indicate a data quality issue. A possible issue noted by the coding team are patient moves in e-care. This is due to the user incorrectly discharging patient for ward moves (rather than 'transfering') therefore closing the provider spell. Another potential explanation is that epsiodes of care delivered in the seated observation unit (SOU), emergency surgery clinic (ESC) and Ambulatory Emergency Care Unit (AECU) are regarded as 'admissions' whereas in reality they are more analogous to outpatient encounters. As such, a discharge diagnosis is not coded leading to a higher rate of 'invalid diagnoses' in the submitted data set and an adverse benchmarked SHMI performance.

3. Mean depth of coding is defined as number of secondary diagnoses for each record in the data. Elective - mean depth of Coding MKUH 4.3 Vs mean depth of Coding National 5.0. Non- Elective - mean depth of Coding MKUH 4.7 vs mean depth of Coding National 5.1.



Summary Hospital-level Mortality Indicator (SHMI), England, February 2019 - January 2020

Trust-level summary Return to contents

NHS Digital

To support the interpretation of the SHMI, various contextual indicators are published alongside it. A breakdown of the data by site of treatment is also available. The SHMI, site level breakdown and contextual indicator data for a particular trust are summarised on this page (scroll down the table to see all of the indicators / sites). Further information on the contextual indicators is presented on the following pages. Please see the SHMI interpretation guidance for more information on the site level breakdown.

Select or search for a trust to display a summary of their data

Mid Yorkshire Hospitals NHS Trust
Milton Keynes University Hospital NHS Foundation Trust
Norfolk and Norwich University Hospitals NHS Foundation Trust
North Bristol NHS Trust

Trust-level data

Higher than expected SHMI

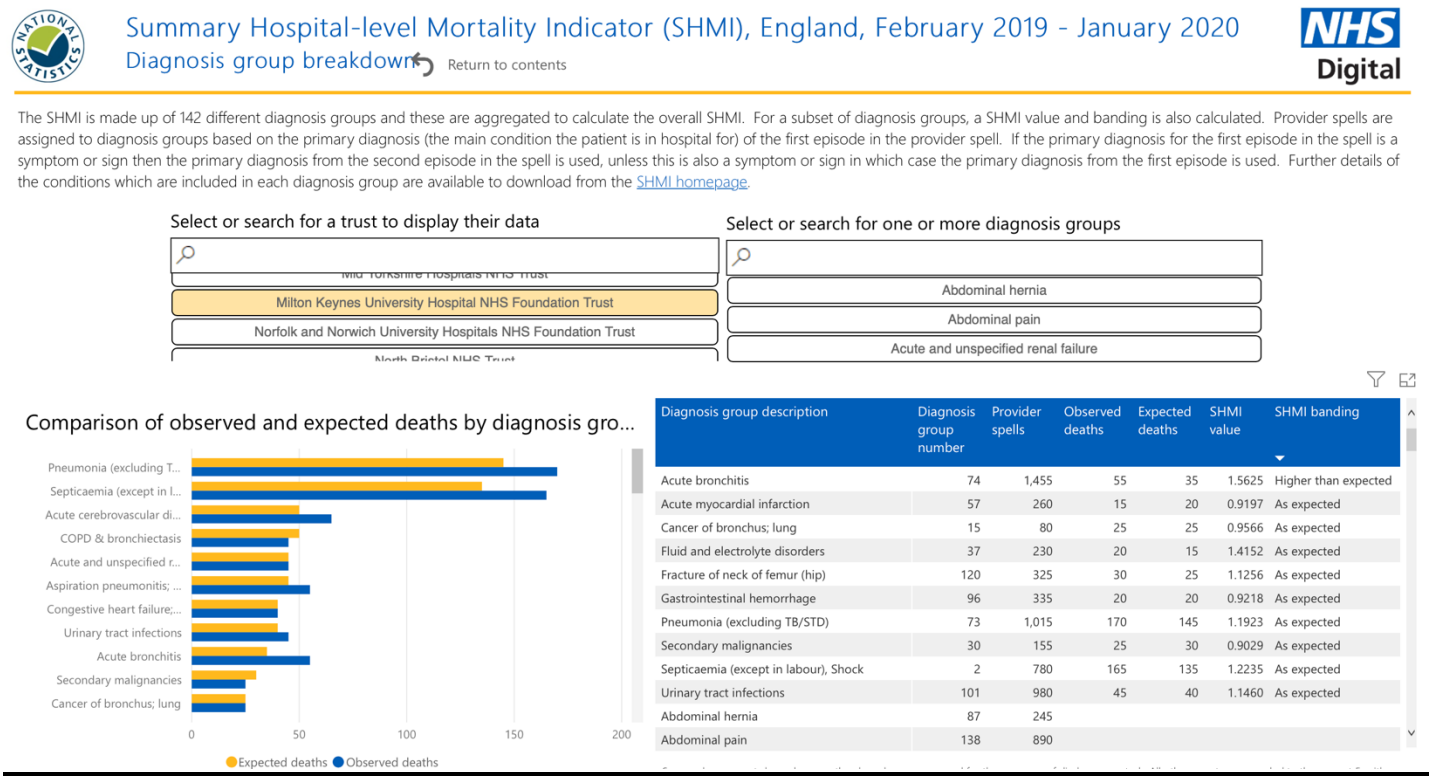
42,265	1,380	1,180	1.1695
Provider spells	Observed deaths	Expected deaths	SHMI value

SHMI contextual indicators

Indicator	Value	England average
Palliative care		
Percentage of provider spells with palliative care treatment specialty coding	0.0	0.1
Percentage of provider spells with palliative care diagnosis coding	2.6	1.8
Percentage of provider spells with palliative care coding	2.6	1.8
Percentage of deaths with palliative care treatment specialty coding	0.0	2.0
Percentage of deaths with palliative care diagnosis coding	52.0	36.0
Percentage of deaths with palliative care coding	52.0	37.0
Admission method		
Crude percentage mortality rate for elective admissions	1.0	1.0
Crude percentage mortality rate for non-elective admissions	3.5	3.5
In and out of hospital deaths		
Percentage of deaths which occurred in hospital	67.0	69.0
Percentage of deaths which occurred outside hospital within 30 days of discharge	33.0	31.0

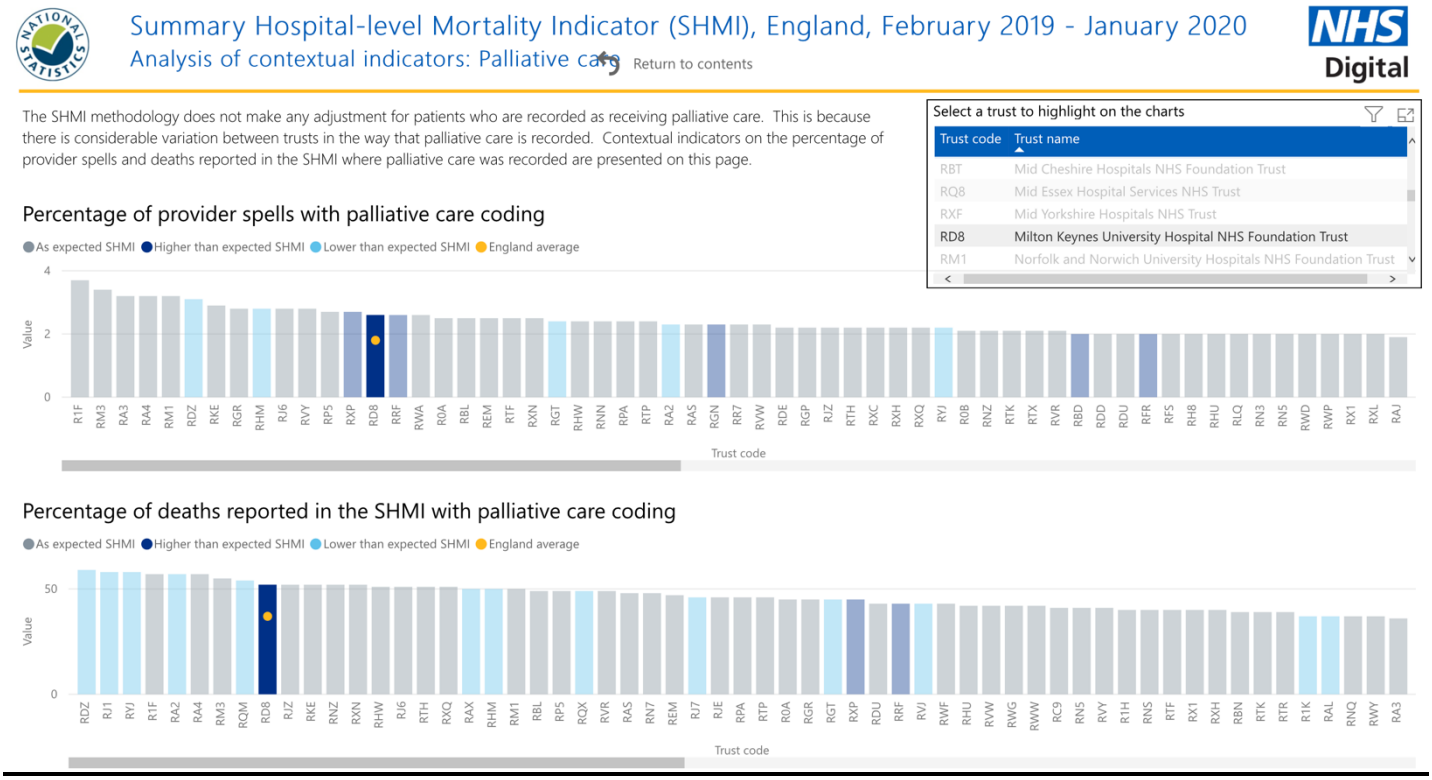
SHMI Diagnosis Breakdown

For the subset diagnosis group only Acute Bronchitis has a SHMI banding of 'Higher than expected'

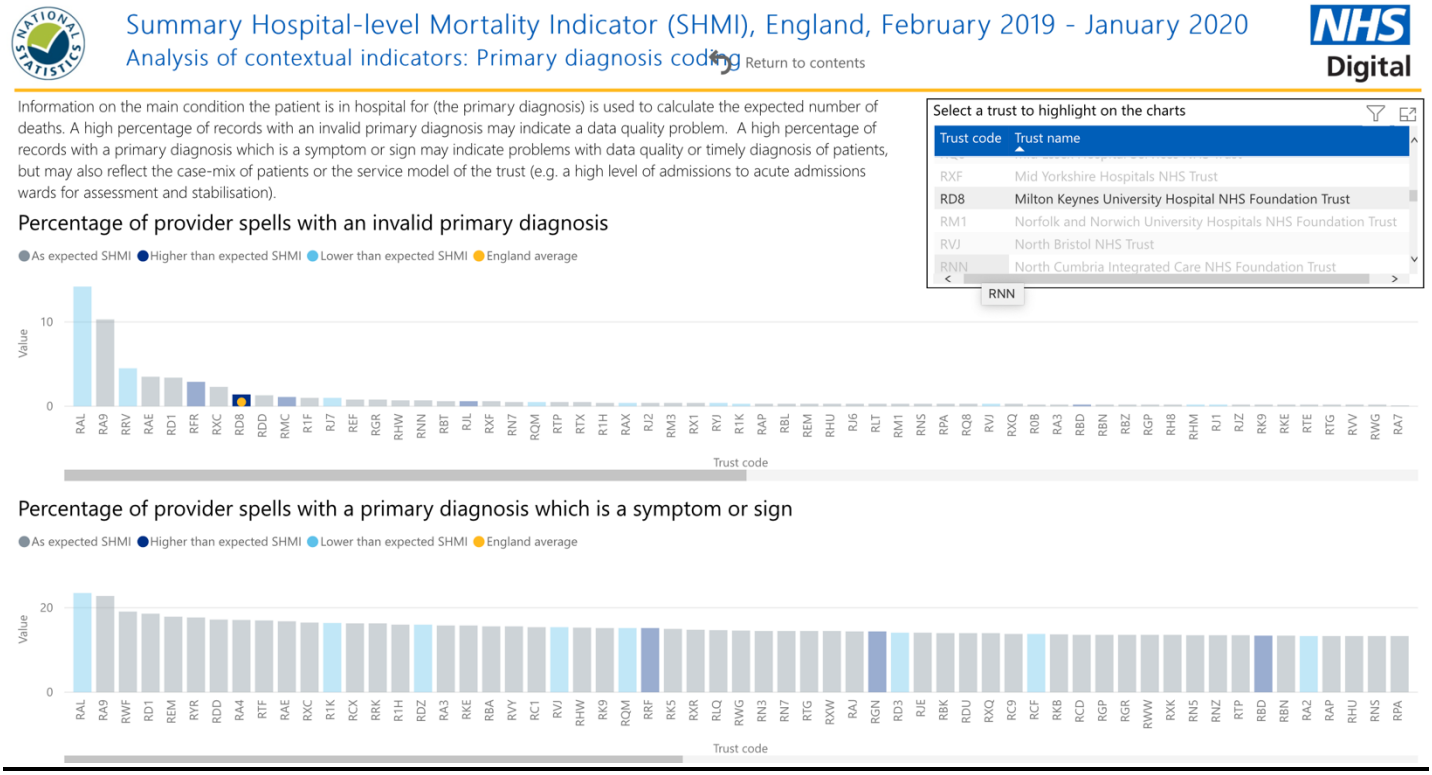


Diagnosis group description	Diagnosis group number	Provider spells	Observed deaths	Expected deaths	SHMI value	SHMI banding
Acute bronchitis	74	1,455	55	35	1.5625	Higher than expected
Acute myocardial infarction	57	260	15	20	0.9197	As expected
Cancer of bronchus; lung	15	80	25	25	0.9566	As expected
Fluid and electrolyte disorders	37	230	20	15	1.4152	As expected
Fracture of neck of femur (hip)	120	325	30	25	1.1256	As expected
Gastrointestinal hemorrhage	96	335	20	20	0.9218	As expected
Pneumonia (excluding TB/STD)	73	1,015	170	145	1.1923	As expected
Secondary malignancies	30	155	25	30	0.9029	As expected
Septicaemia (except in labour), Shock	2	780	165	135	1.2235	As expected
Urinary tract infections	101	980	45	40	1.1460	As expected
Abdominal hernia	87	245				
Abdominal pain	138	890				

Palliative Care Coding MKUH 52% Vs England Average 37%

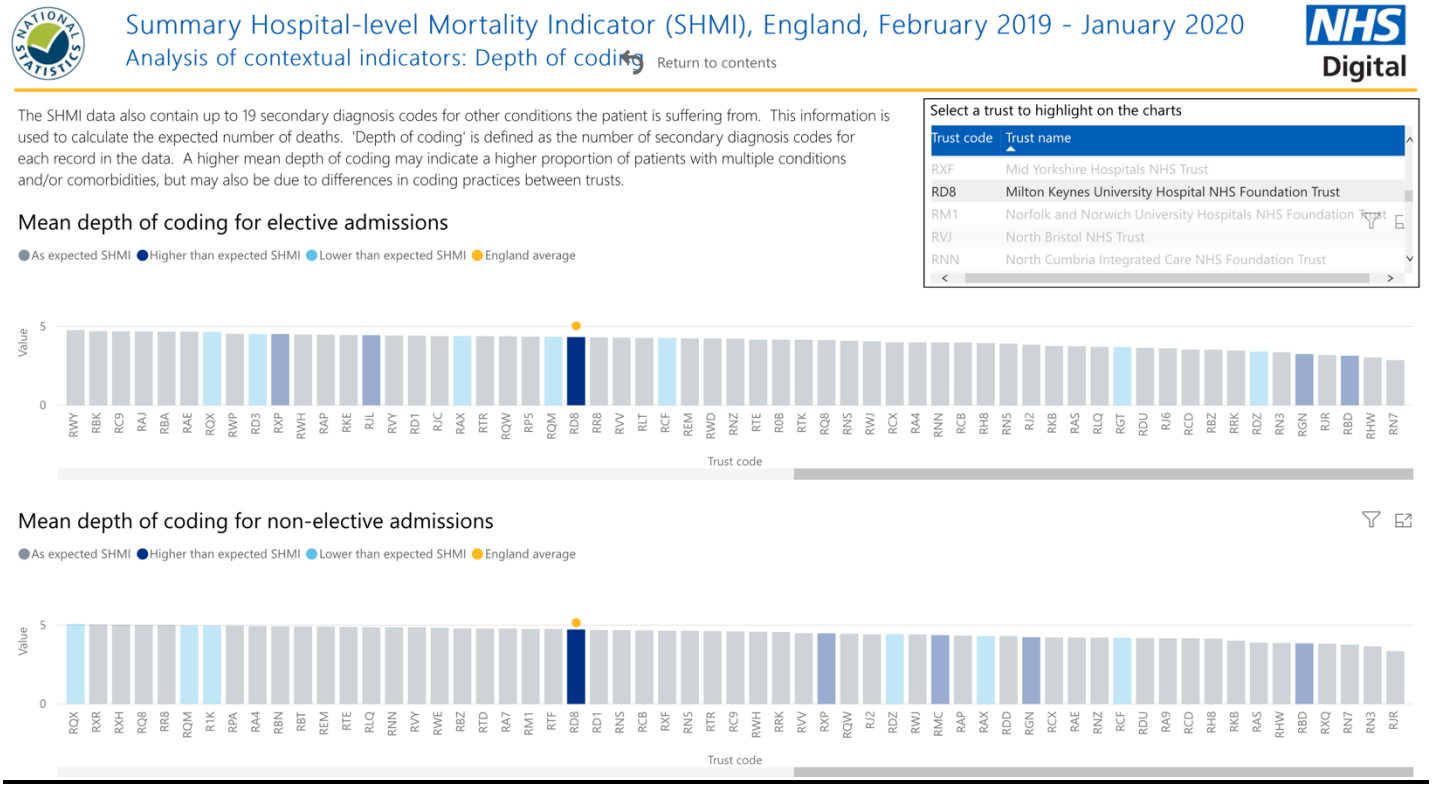


Percentage of provider spells with an Invalid primary diagnosis MKUH 1.4% Vs 0.5%



Mean depth of coding for elective admissions MKUH 4.3 Vs 5.0

Mean depth of coding for non-elective admissions MKUH 4.7 Vs 5.1



COVID 19

To date (26 June), a total of 133 patients who had a positive COVID-19 swab result subsequently died at MKUH, although at least another 13 deaths were thought to be due to COVID-19 but swabs were negative (typical radiological findings). Swabs are know to have a not insignificant 'false negative' rate.

Investigation of Deaths

The data for Q1, Q2, Q3 and provisional Q4 are illustrated in the table below.

All deaths undergo review by the Medical Examiner System. The system will offer a point of contact for bereaved families or clinical teams to raise concerns about care prior to the death. Concerns can also be raised by the Medical Examiner following Medical Record review. Deaths with concerns will undergo a formal Structured Judgement Review.

Structured Judgement Reviews are carried out by trained reviewers who look at the medical records in a critical manner and comment on all specific phases of care. The Stuctured Judgement Review is presented at the Mortality and Morbidity Meetings. If a death is deemed avoidable a 2nd Structured Judgement Review is carried out at which point this will be graded to judge avoidability of death score (Score of 3 or less). This form will conclude with key learning messages from the case and actions to be followed.

Score 1 Definitely avoidable
Score 2 Strong evidence of avoidability
Score 3 Probably avoidable (more than 50:50)
Score 4 Possibly avoidable but not very likely (less than 50:50)
Score 5 Slight evidence of avoidability
Score 6 Definitely not avoidable

Investigations of Deaths

	Q1 Apr-Jun 2019/20	**Q2 Jul-Sep**	**Q3 Oct-Dec**	**Q4 Jan-Mar**	**Q1 Apr-Jun 2020/2021**
No. of deaths	298	261	247	302	260*
No. of deaths reviewed by Medical Examiner†	199 (67%)	100%	100%	100%	100%
No. of investigations (% of total)	152 (51%)	58 (22%)	31 (13%)	16(5%)*	0*
No of Coroner Referrals (%of total)	32.5%	38.3%	25.9%	18.5%	23.0%*
No. of deaths with Care Quality concerns (%)	2	1	0	0*	0*
No. of potentially avoidable deaths (%)	1	0	0	0*	0*

† All deaths reviewed by Medical Examiner Scrutiny process

* Q4 and Q1 data are provisional and are still subject to further modification (as formal review processes occur within the Trust's clinical divisions)

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Trust Board	Date 02 July 2020
Report title:	Serious Incidents (April to June)	Agenda item: 3.4
Lead directors **Report author Sponsor(s)**	Ian Reckless Kate Burke Tina Worth	Medical Director Director of Corporate Affairs Head of Risk and Clinical Governance
FoI status:	Public document	

Report summary	This report provides a quarterly overview of Risk Management processes/systems in relation to serious incidents.			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** x	**Decision** ☐
Recommendation	The Committee is asked to note the contents of the report.			

Strategic objectives links	Refer to main objective and link to others 1. Improve Patient Safety 3. Improve Clinical Effectiveness 4. Deliver Key Targets 7. Become Well-Governed and Financially Viable
Board Assurance Framework links	Lack of learning from incidents is a key risk identified on the BAF.
CQC outcome/ regulation links	This report relates to CQC: Regulation 12 – Safe care & treatment Regulation 17 – Good governance Regulation 20 – Duty of Candour
Identified risks and risk management actions	Lack of learning from incidents is a key risk identified on the BAF.
Resource implications	Breaches in respect of SI submission incur a £1000 penalty fine Breaches in respect of the Duty of Candour have potential for penalty fine of £2,500 if taken forward from a legislative perspective and up to £10,000 from a Commissioning contract perspective.
Legal implications including equality and diversity assessment	Contractual and regulatory reporting requirements.

Report history	Weekly reports to SIRG (Thursdays). A version of this paper was also considered by QCRC at its meeting on 22 June 2020.
Appendices	Appendix 1 - SI log for Q1

Quarterly review April – June (Q1)

Executive summary

This report summarises the position from a Trust perspective in relation to serious incidents (SIs) and any concerns raised by HM Coroner in relation to the Trust (where relevant for the period), detailing SI and inquest activity throughout the first quarter (up to 13 June) of the financial year 20/21, including noted trends, learning and concerns. Any SIs reported after the 13 June will be reported in the quarter 2 report. Two further SIs from quarter 4 are included in the appendix 1 – SI log.

There were 82 SIs on the live log as of 13 June broken down as follows:

- Pending action plan evidence submission/approval – 49
- Ongoing – 15
- Further information request - 9
- RCA with the CCG for review – 4
- Other - 5

There were 21 SIs in total this quarter reported via STEIS.

The 21 SIs can be broken down by month reported as follows:

- April - 8
- May - 10
- June - 3

The Health and Safety Investigation Brach (HSIB) have provided a draft report on the SI that they are investigating in relation to a baby born at MKUH who required therapeutic cooling, for a factual accuracy check. This provided no safety recommendations and supported the Trust's findings in it's initial 72hr report. As the HSIB investigations have progressed, HSIB have agreed a firm timeframe with DHSC to complete investigations within six months, the starting date being the date of submission of referral from the Trust. This will significantly improve the turnaround times of their investigations.

It is noted that **all** SI reports during this quarter were submitted within deadline and the Trust had **no penalty breaches**. The Trust has also not received any penalty breaches with regards to the Duty of Candour contractual requirements.

The Trust received no Preventing Future Death (PFD) reports from HM Coroner. However, it should be noted that due to Covid 19 the only inquests held (virtually) were those where the next of kin/HM Coroner had no concerns.

Definitions

Datix - Leading supplier of patient safety, healthcare and risk management software systems for incident and adverse events reporting

Serious incident - Serious incidents are events in healthcare where there is the potential for learning or the consequences to patients, families, carers, staff or organisations are so significant that they warrant using additional resources to mount a comprehensive response.

'Never Events' - Serious Incidents that are 'serious largely preventable patient safety incidents that should not occur if the available preventative measure had been implemented by healthcare providers'

'Being Open' - Being open is a set of principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident in which the patient was harmed. A culture of openness, honesty and transparency, includes apologising and explaining what happened to patients, carers and relatives.

Duty of Candour - The duty of candour requires all health and adult social care providers registered with CQC to be open with people when things go wrong

STEIS - Strategic Executive Incident System (STEIS) is a single reporting structure which allows for management information to be shared across the country and for organisations to benchmark its performance against others

Stop clock guidance - A stop clock request can be made to the CCG where there are circumstances that make a timely completion of the RCA investigation within the set time frame per the commissioning contract difficult or not possible to comply with

RIDDOR – Work related accidents and injuries. The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

Down grade request – Where investigation has highlighted that the incident was unavoidable (e.g. hospital acquired pressure ulcer) or where the Trust's involvement did not have any correlation to the incident and was in line with best practice (e.g. child deaths in the Emergency Department), SIs can be downgraded and removed from the Trust's SI log

Trust's Serious Incident Review Group (SIRG) – The Trust's SI review group consisting of executive and senior staff who ensure a systematic, holistic, multi-disciplinary and proactive approach to the management of SIs and who hold divisions to account for non-compliance

Root Cause Analysis (RCA) – A problem solving investigation process designed to identify the contributory factors and ultimate root cause of an incident and facilitate appropriate actions based on the evident learning. The Trust uses standard templates for RCA investigations

Preventing Future Death (PFD) report – The Coroners and Justice Act 2009, places a statutory duty on coroners to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be undertaken to prevent future deaths

Main Report

Serious Incidents Reported (April - June 2020)

There have been 21 SIs reported this quarter. For further details of specific SIs, please refer to appendix 1.

Chart 1 shows the SIs reported in this quarter by category, and Chart 2 the trend analysis over 2019 – 2020 for the top reported categories.

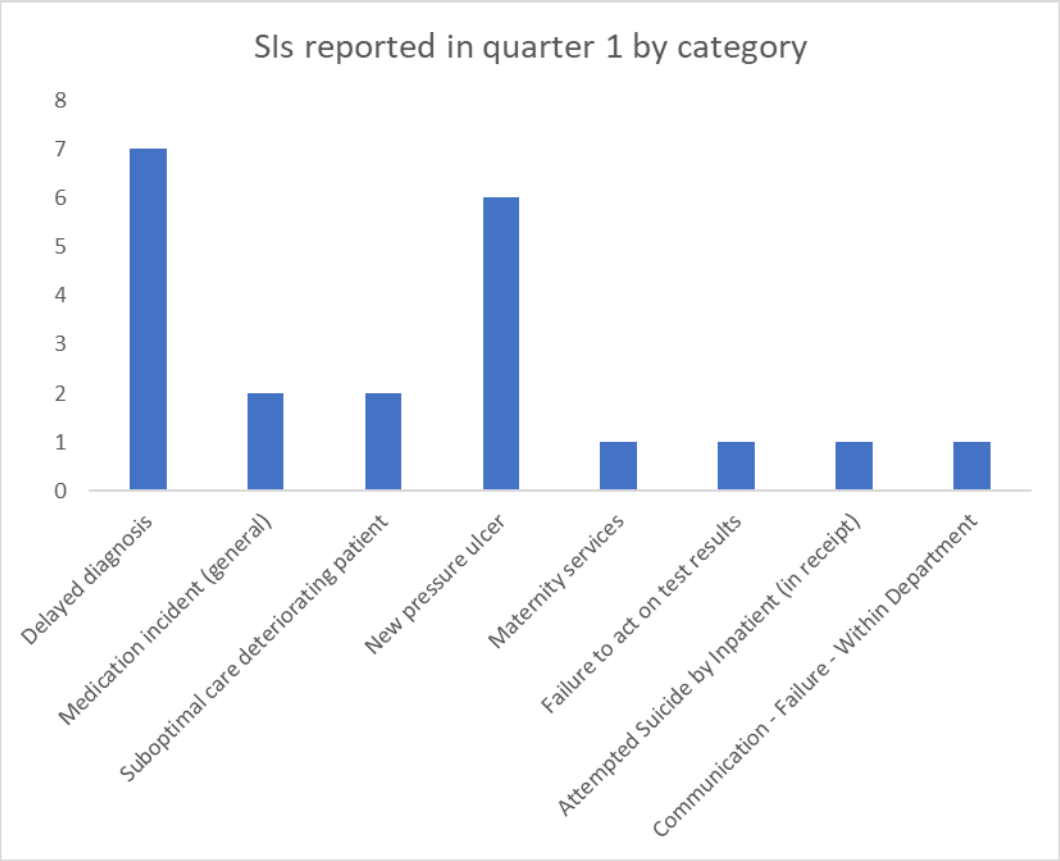


Chart 1 – SIs reported on STEIS by quarter 1 (April - June 13, 2020)

The top reported category (as seen in chart 1) is delayed diagnosis (7), followed by new pressure ulcers (6) with other categories of SI being reported only once or twice across the period. These two categories alone accounted for over 50% of all reported SIs.

In respect of delayed diagnosis these were reported across various specialties, but a potential pattern relates to the follow through of results and responsibility for this, especially when patients have multiple concurrent pathways under various specialties. Results endorsement is now set up on eCARE with the ability for reports showing compliance by consultant and specialty and is monitored at the Clinical Advisory Group (CAG). Result endorsement rates are on a improving trajectory following much work on profile, data quality and reporting. One of the delayed diagnoses was associated with the Covid-19 pathway. Initial review of the patient's pathway in the Emergency Department (ED) has highlighted

that the clinicians' focus was very much on Covid-19: a slightly blinkered approach led to a failure to consider other differential diagnoses, or premature exclusion of such alternatives.

Associations with Covid-19 have been recognised in other SIs although this is perhaps not surprising given the proportion of the Trust's work which has been connected to this. It is recognised that with the pandemic adaptations were brought in very quickly (albeit with supporting information and guidance for staff). Simultaneously, dealing with Covid-19 – as a novel and highly infectious disease - understandably causes additional anxiety for staff. In addition, some staff were redeployed and therefore needed to adapt to working with different colleagues, in different ways and using different skills sets. This was particularly the case in the Intensive Care Unit (ICU) where a 'buddy' approach was used with ICU substantive staff being paired with redeployed staff to ensure support was in place and local training was provided as required.

New pressure ulcers have also been within the 'most frequent' category for SIs in preceding quarters. This quarter, the influence of Covid-19 was recognised especially where proning was used in ICU as part of patient's treatment and in relation to how unwell these patients were. The recurring theme of deep tissue injuries to heels has also been noted. The Tissue Viability Nurses (TVN) provided additional guidance on how best to manage skin deterioration in the context of Covid-19, noting this was a nationally recognised trend (an tapping in to emerging national consensus thinking). This was further referenced in the TVN report reviewed by QCRC at its meeting on 22 June, highlighting the ongoing work in relation to the monitoring of heels and preventative measures available.

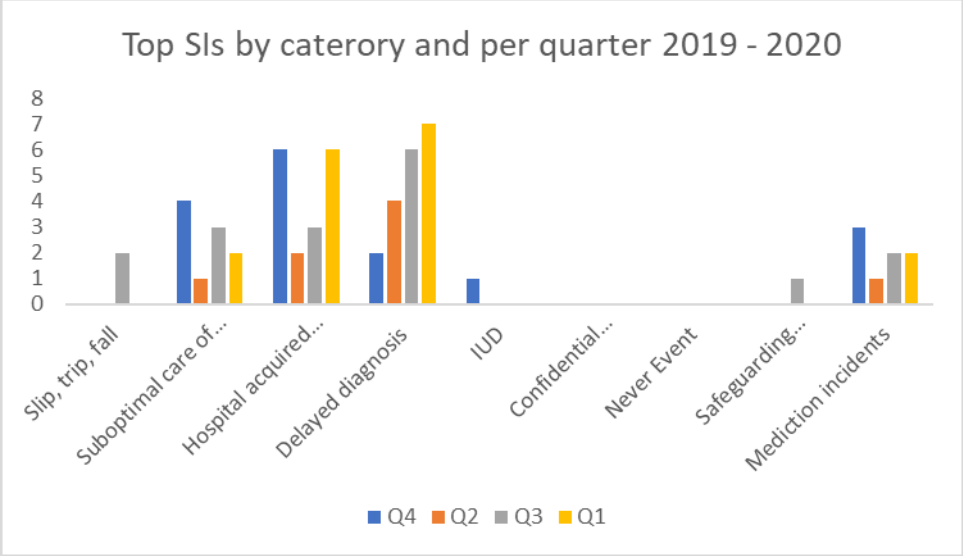


Chart 2 Frequency of SI category by quarter (Q2 July to September 2019, Q3 October to December 2019, Q4 January to March 2020, Q1 April to 13 June 2020)

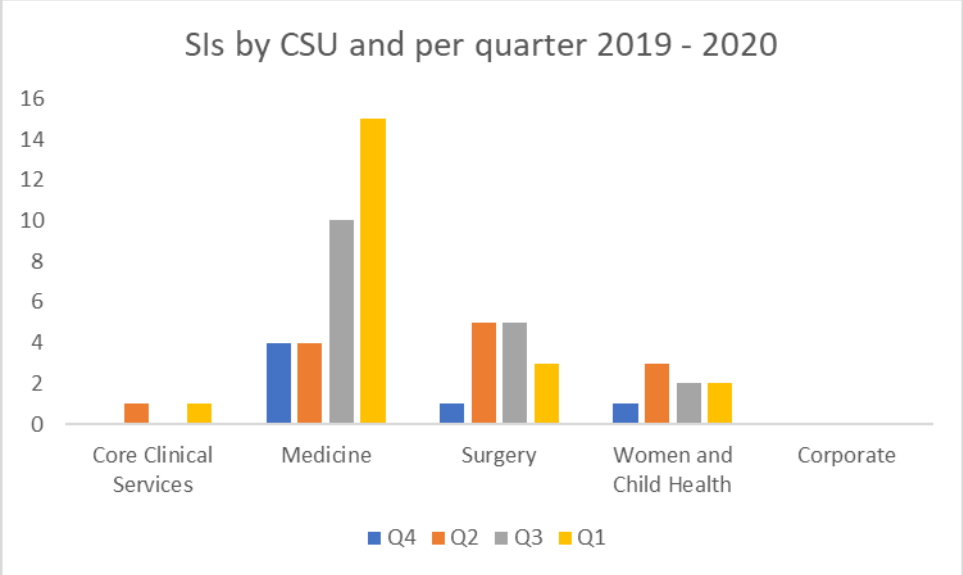


Chart 3 – Serious Incidents by CSU, by quarter

As shown in chart 3 (above), just under 75% (15) of the SIs occurred across Medicine. This is to be expected given the disproportionate impact of Covid-19 on the Medicine Division services, and general activity levels in the hospital over this period.

Learning and breached SI action plan evidence

The Trust recognises that given the incident and investigation dates it is not favourable or to the standard the Trust seeks to achieve to have these outstanding at this late stage. Historically there was not the current level of scrutiny of RCA actions plans to ensure that actions were SMART & could be evidenced in due course. SIRG now has oversight & challenges RCA leads to ensure that there is a high level of assurance on required actions & that they cross reference against the contributory factors.

The Risk Management Team has started a newsletter 'Governance Round Up' sharing key learning from incidents/SIs etc.

Duty of Candour

The Trust is required to report compliance to the CCG for each quarter in relation to both elements of the ruling (initial discussion and formal written follow up) on all SIs. Compliance requires both stages of the regulations to be completed, or a penalty fine could be imposed from a contractual and legislative perspective. For a contractual breach this would be recovery of the cost of the episode of care or £10,000 if the cost of the episode of care is unknown and for a legislative breach this would be £2,500 if the Trust was convicted. The Trust reported 100% compliance for quarter 4.

Specific Serious Incidents

2020/6763

Serious Incidents (April to June 2020)

Delayed diagnosis of a pulmonary embolism (PE). Patient attended the Emergency department (ED) with shortness of breath and some chest pain having seen GP earlier in the month. After a few hours, patient was discharged and told to self-isolate as staff thought that symptoms were consistent with Covid-19. The patient returned to the ED 2 days later where a CT scan diagnosed a PE. The patient subsequently died.

The investigator found that for the first ED admission the clinical history and blood gas findings would have supported the possibility of a PE as part of the diagnostic differential. As Covid-19 was the main concern our health system around that time (and all others), a 'blinkered approach' had developed which meant that the team failed to give adequate consideration to another diagnosis. Had Covid-19 not been part of the thinking, it is likely that the (ultimately) correct diagnosis would have received additional consideration.

Recommendations:

- Teaching in the ED about gas blood interpretation in the context of dyspnoea, especially when there is hypocapnia.
- Review and refinement of the suspected Covid-19 CT pathway (given learning during the pandemic that Covid-19 is heavily associated with pulmonary embolism).

2020/6969

Suboptimal care of a deteriorating patient. A patient with known diabetes was not prescribed his usual insulin and did not have regular blood glucose checks undertaken. Patient developed diabetic ketoacidosis (DKA) requiring additional care. The respiratory assessment unit (RAU) was being used an interim assessment venue for patients presenting with Covid-19 symptoms.

The investigator found that this is a human error incident leading to suboptimal diabetes management in an acute setting. The rapid set-up of the unit and a new service delivery model with a high-risk cohort of Covid-19 patients had increased the level of anxiety amongst staff.

Recommendations:

- Diabetes specialist nurses to organise additional training sessions.
- Electronic prompts to ensure that diabetic patients have a baseline blood sugar documented.

2020/8057

Inpatient suicide. A patient with haematological malignancy was known to mental health services and was transferred across to the acute hospital.

An RCA investigation is being undertaken in collaboration with the Mental Health Team and will be completed in due course. The case has been referred to HM Coroner.

Serious Incidents (April to June 2020)

Appendix 1 Serious Incident Log for Quarter 1 (to 13 June 2020)

SI reference no.	Location/specialty	Category	Description
2020/5256	Emergency Department (ED)	New pressure ulcer	Grade 3 pressure ulcer to left heel. Patient was a high-risk patient for pressure damage due to NIDDM (diabetes) and neuropathy. However, over 2 shifts, we failed to provide optimal care.
2020/6050	Emergency Department (ED)	Delayed diagnosis	Patient admitted following a fall. Knee X-rayed but not hip. 5 days later unable to weight bear due to pain. Hip X-ray showed fractured neck of femur requiring surgery.
2020/6761	Ward 16	New pressure ulcer	Purple non-blanching pressure ulcer on right heel.
2020/6762	Labour Ward	Drug incident (general)	Magnesium Sulphate not given prior to lower segment caesarean section (LSCS) for severe foetal growth restriction (FGR) 31+6 weeks.
2020/6763	ED	Delayed diagnosis	Patient attended the ED with shortness of breath and chest pain. See report narrative for further detail.
2020/6764	ED	Sub-optimal care of the deteriorating patient	The patient was placed in the ED Observation Unit (OU). The patient later suffered cardiac arrest due to bilateral pulmonary emboli and died in the Intensive Care Unit (ICU). OU was being used for patients who were showing symptoms of Covid-19.
2020/6965	Ophthalmology Eye Clinic	Delayed diagnosis	Patient was seen in the Medical Retina clinic complaining of pain in eyes. Eye pressures not taken and 6 month follow-up requested. Patient returned 3 months later with persistent pain and reduced visual acuity. Found to have florid neovascular glaucoma and evidence of glaucomatous irreversible damage to both eyes. Patient needed surgical intervention to prevent further glaucoma damage.
2020/6969	Respiratory Assessment Unit (RAU)	Sub-optimal care of the deteriorating patient	Patient with known diabetes was not prescribed usual insulin and did not have regular blood glucose checks undertaken. Patient developed diabetic ketoacidosis (DKA) requiring additional care. RAU was being

			used an interim respiratory assessment unit for patients presenting with Covid 19 symptoms. See report narrative for further detail.
2020/7599	ED	Delayed diagnosis	Patient attended the ED twice with abdominal pain and on the second occasion “having had a vomiting episode with the perceived odour of faeces”. Impression was one of gastritis and the patient was discharged with plans for an ultrasound scan (USS) of his abdomen (on second occasion). The patient’s case was not referred or discussed with the surgical team. Reattended 24 hours later with strangulated small bowel loop in an incisional hernia sac, accompanied by perforation and peritonitis. He was operated on as soon as possible after initial resuscitation, but sadly died.
2020/7788	Obstetric Outpatients	Maternity services	The patient had a history of preterm birth at 33 weeks (PPROM) but this risk was not adequately addressed on the subsequent pregnancy. The appropriate treatment was not offered (Cyclogest) and a transvaginal scan was not requested. The patient presented at 28 weeks with ruptured membranes, had chorioamnionitis and needed a caesarean section.
2020/8057	Ward 25	Inpatient suicide	See report narrative for further detail. Covid-19 positive.
2020/8058	Multiple	Delayed diagnosis	This patient had a painful left shoulder that was investigated in November 2019 and was treated as a humeral head infection. He was assessed by various teams and had various hospital admissions from November to April. On his last admission it became clear that the left humeral lesion was a metastasis and not an infection. He had a skin biopsy of one of his skin lesions. He died and after his death the skin biopsy showed malignancy. The clinical case was very complex, but the patient and family experience was suboptimal.
2020/8059	Haematology	Delayed diagnosis	The patient was sent for a CT as part of haematology investigations. Report identified at least two indeterminate liver lesions. The recommendation was for magnetic resonance imaging (MRI) of the liver. This however was not picked up until a routine haematology appointment. MRI suggested the lesions could represent metastatic

			disease. No action was taken until a cancer of unknown primary referral was generated by the GP.
2020/8060	Ward 22	New pressure ulcer	Deep tissue injury left hip.
2020/8061	Ward 25	New pressure ulcer	Deep tissue injury heel.
2020/8976	Ward 2	New pressure ulcer	Deep tissue injury to heel.
2020/8977	Pathology	Delayed diagnosis	Patient recently biopsied for residual disease post radiotherapy. Current biopsy has shown a neuroendocrine carcinoma. Histopathology subsequently reviewed original biopsy from prior to radiotherapy and carried out further tests. Now established that this was likely a neuroendocrine tumour at that time.
2020/8978	Surgical Team	Delayed diagnosis	CT scan performed in March 2020 which highlighted a potential malignancy and recommended a CT Thorax and MRI spine. This was highlighted to the requesting physician. A CT thorax was subsequently requested and scheduled for 17 March. The patient did not attend and a letter was sent to the patient's GP to follow-up if deemed appropriate. The patient was not told about findings on CT scan and it appears no further follow up was made.
2020/9482	Ward 25	New pressure ulcer	Deep tissue injury to heels.
2020/9483	Intensive Care Unit (ICU)	Drug incident (general)	A nurse disconnected an infusion from a central line and did not realise that the connector was removed at the same time and that the clip was open. Shortly afterwards, the patient became breathless and his saturations dropped to 55%. Desaturation likely due to an air embolism. Nurse had been re-deployed to assist during Covid 19
2020/10385	Cardiology	Unexpected death (failure to follow through tests results)	Patient was seen in rapid access chest pain clinic initially with chest pain, referred for coronary angiogram, which was done on the 12/04/19 and revealed significant coronary artery disease. The plan was to discuss the patient at a cardiology MDT for possible coronary stenting. This did not occur. 31/03/20 patient presented following an out of hospital (OOH) cardiac arrest. This might potentially have been preventable.
2020/10487	ED	Infection control related	A doctor had bought 50 respirator type masks (JSP FORCE 8) and a

			number of ED staff had purchased them (at cost) and had been wearing them during an early phase in the Covid-19 pandemic. The masks had not been procured through the Trust or cleared for use by Infection Prevention and Control (IPC) at this time. Of note, these masks are in use in other Trusts.
2020/10890	Ward 18	New pressure ulcer	Deep tissue injury to heel.

Those in green have been carried forward from the previous quarter's report and relate to quarter 4 in 2019 - 2020.

Reference to Covid 19 in red is where it appears that Covid had some impact on the incident and will be explored further in the root cause analysis investigations.

Board Performance Report 2020/21
May 2020 (M02)

Milton Keynes University Hospital NHS Foundation Trust

OBJECTIVE 1 - PATIENT SAFETY

ID	Indicator	DQ Assurance	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
1.1	Mortality - (HSMR)		100	100		96.2	✓	▼		
1.2	Mortality - (SHMI)		100	100		115.8	✗	▼		
1.3	Never Events		0	0	0	0	✓	▬	✓	
1.4	Clostridium Difficile		15	<3	0	0	✓	▬	✓	
1.5	MRSA bacteraemia (avoidable)		0	0	0	0	✓	▬	✓	
1.6	Falls with harm (per 1,000 bed days)		0.12	0.12	0.16	0.00	✓	▲	✗	
1.7	Midwife : Birth Ratio		28	28	27	27	✓	▼	✓	
1.8	Incident Rate (per 1,000 bed days)		40	40	75.31	78.32	✓	▲	✓	
1.9	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▬	✓	
1.10	E-Coli		20	<4	2	1	✓	▬		
1.11	MSSA		8		1	1		▼		
1.12	VTE Assessment		95%	95%	98.5%	98.8%	✓	▲	✓	

OBJECTIVE 2 - PATIENT EXPERIENCE

ID	Indicator	DQ Assurance	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.2	RED Complaints Received				0	0		▬		
2.3	Complaints response in agreed time		90%	90%	93.1%	97.0%	✓	▲	✓	
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.3%	0.1%	✓	▲	✓	
2.5	Over 75s Ward Moves at Night		2,000	333	90	38	✓	▲	✓	
2.6	Mixed Sex Breaches		0	0	0	0	✓	▬	✓	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS

ID	Indicator	DQ Assurance	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	57.0%	59.8%	✓	▼	✓	
3.2	Ward Discharges by Midday		27%	27%	22.5%	22.3%	✗	▼	✗	
3.3	Weekend Discharges		70%	70%	63.3%	59.0%	✗	▼	✗	
3.4	30 day readmissions				7.0%	10.3%		▼		
3.5	Follow Up Ratio		1.50	1.50	2.22	2.08	✗	▲	✗	
3.6.1	Number of Stranded Patients (LOS>=7 Days)		198	198		99	✓	▼		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		53	53		23	✓	▼		
3.7	Delayed Transfers of Care		25	25		9	✓	▼		
3.8	Discharges from PDU (%)		15%	15%	9.1%	9.5%	✗	▲	✗	
3.9	Ambulance Handovers >30 mins (%)		5%	5%	2.3%	2.7%	✓	▼	✓	

OBJECTIVE 4 - KEY TARGETS

ID	Indicator	DQ Assurance	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1	ED 4 hour target (includes UCS)		90.0%	90.0%	97.7%	99.1%	✓	▲	✓	
4.2	RTT Incomplete Pathways <18 weeks		79.0%	59.0%		56.9%	✗	▼		
4.4	RTT Total Open Pathways		18,878	23,104		23,305	✗	▼		
4.5	RTT Patients waiting over 52 weeks			0		58	✗	▼		
4.6	Diagnostic Waits <6 weeks		99%	99%		70.1%	✗	▲		
4.7	All 2 week wait all cancers (Quarterly) ✎		93.0%	93.0%		87.6%	✗	▼		
4.8	31 days Diagnosis to Treatment (Quarterly) ✎		96.2%	96.2%		96.7%	✓	▼		
4.9	62 day standard (Quarterly) ✎		85.5%	85.5%		82.7%	✗	▼		

OBJECTIVE 5 - SUSTAINABILITY

ID	Indicator	DQ Assurance	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
5.1	GP Referrals Received		Not Available		3,809	2,229		▼		
5.2	A&E Attendances				9,261	5,646		▼		
5.3	Elective Spells (PBR)				896	373		▲		
5.4	Non-Elective Spells (PBR)				3,643	1,779		▲		
5.5	OP Attendances / Procs (Total)				25,406	13,909		▼		
5.6	Outpatient DNA Rate				7.9%	3.1%		▲		

OBJECTIVE 7 - FINANCIAL PERFORMANCE

ID	Indicator	DQ Assurance	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
7.1	Income £'000		Not Available							
7.2	Pay £'000									
7.3	Non-pay £'000									
7.4	Non-operating costs £'000									
7.5	I&E Total £'000									
7.6	Cash Balance £'000									
7.7	Savings Delivered £'000									
7.8	Capital Expenditure £'000									

OBJECTIVE 8 - WORKFORCE PERFORMANCE

ID	Indicator	DQ Assurance	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
8.1	Staff Vacancies % of establishment		10%	10%	Not Available					
8.2	Agency Expenditure %		4.1%	4.1%						
8.3	Staff sickness - % of days lost		4%	4%		4.4%	✗	▼		
8.4	Appraisals		90%	90%		90.0%	✓	▬		
8.5	Statutory Mandatory training		90%	90%		93.0%	✓	▼		
8.6	Substantive Staff Turnover		10%	10%		9.2%	✓	▲		

OBJECTIVES - OTHER

ID	Indicator	DQ Assurance	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
O.1	Total Number of NICE Breaches		10	10		36	✗	▼		
O.2	Rebooked cancelled OPs - 28 day rule		95%	95%	81.9%	75.0%	✗	▼	✗	
O.4	Overdue Datix Incidents >1 month		0	0		18	✗	▲		
O.5	Serious Incidents		45	<8	18	10	✗	▼	✗	
O.8	Completed Job Plans (Consultants)		90%	90%		88%	✗	▲		

Key: Monthly/Quarterly Change

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

YTD Position

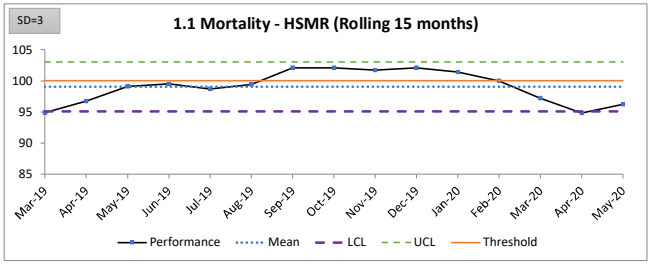
✓	Achieving YTD Target
	Within Agreed Tolerance*
✗	Not achieving YTD Target
	Annual Target breached

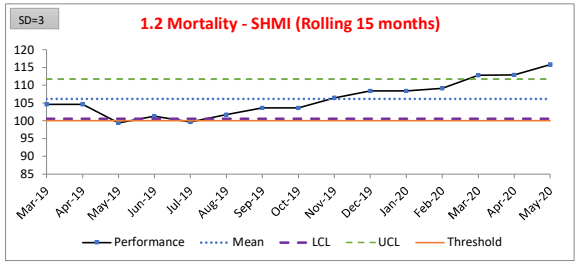
Data Quality Assurance Definitions

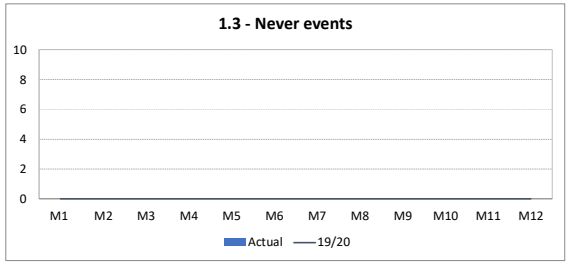
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory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

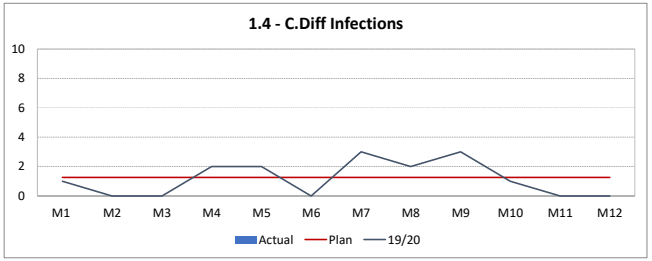
* Independently Audited – refers to an independent audit undertaken by either the Internal Auditor, External Auditors or the Data Quality Audit team.

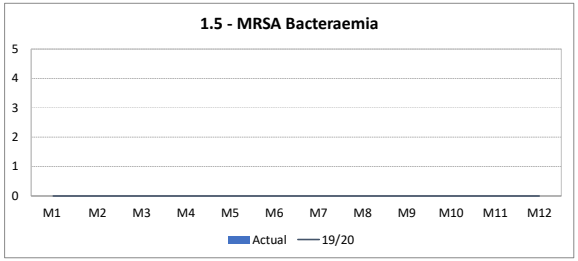
Date Produced: 12/06/2020

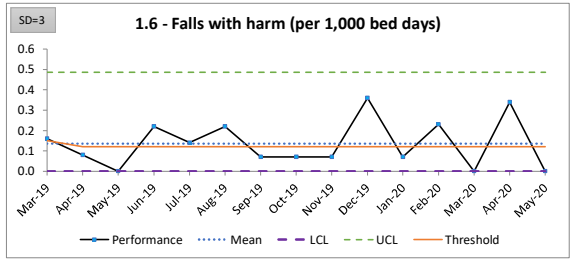


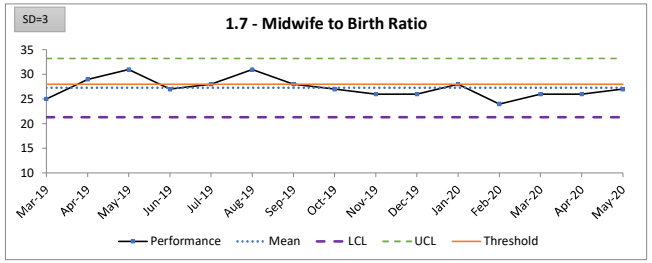


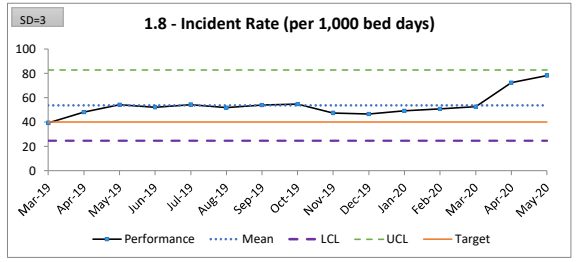


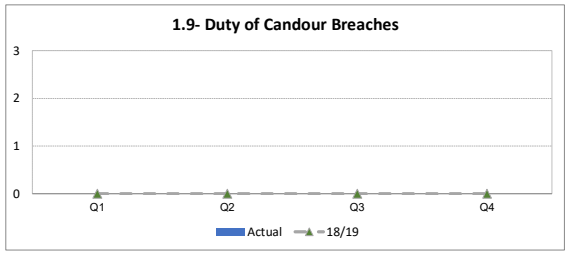


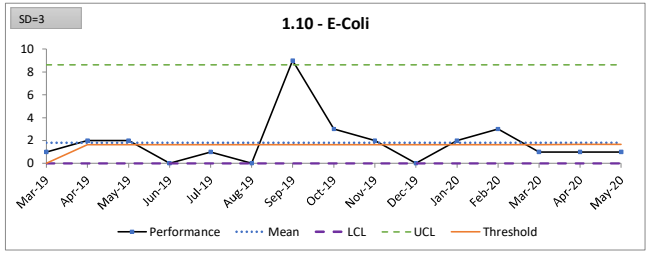


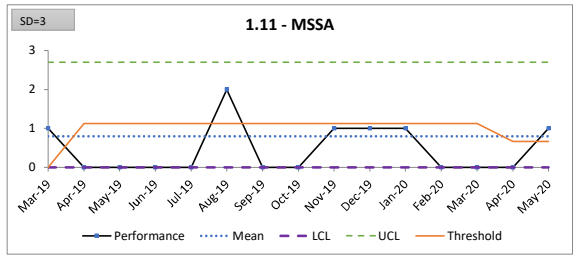


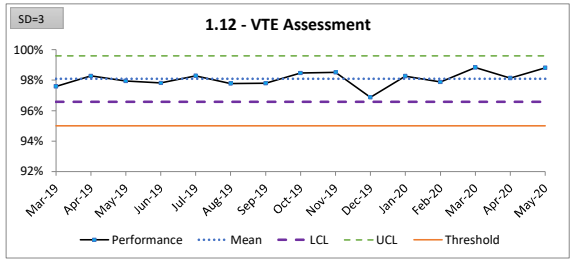








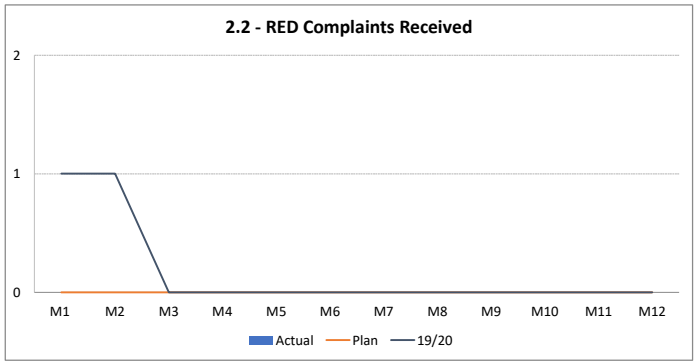


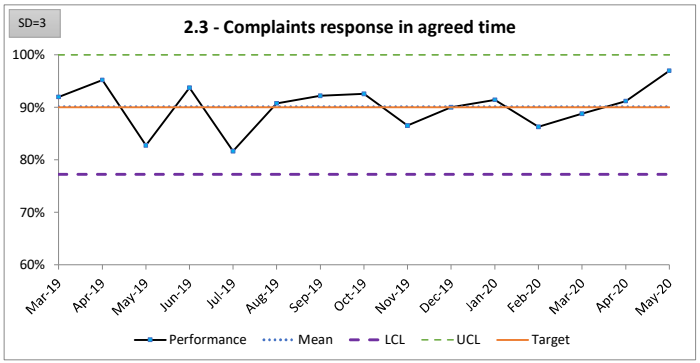


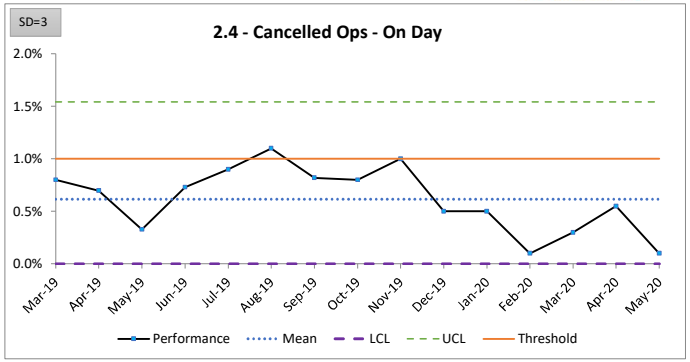
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

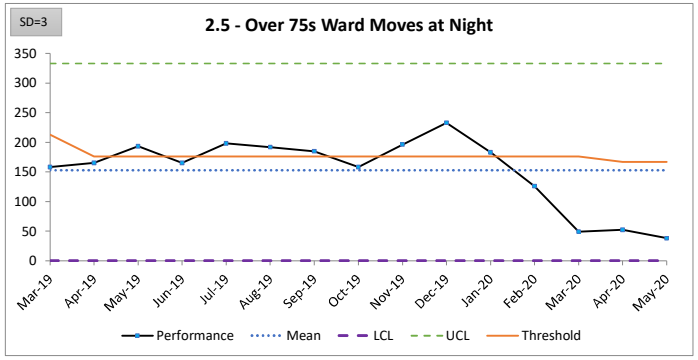
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

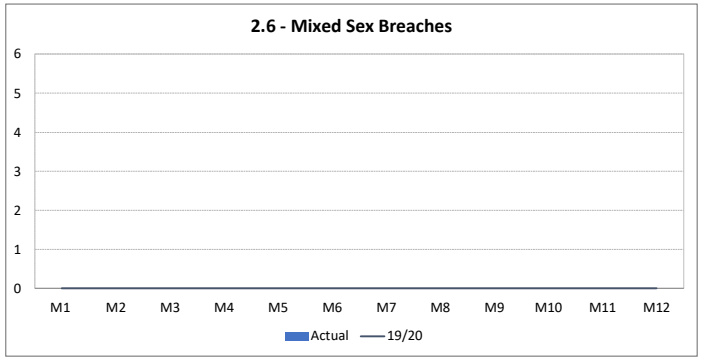
OBJECTIVE 2 - PATIENT EXPERIENCE











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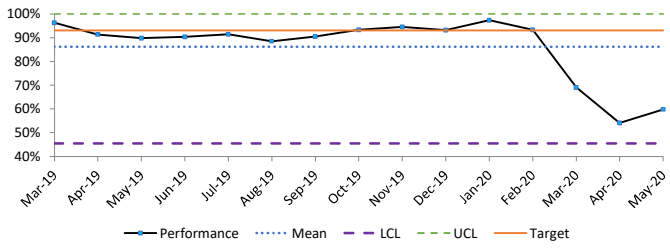
If the UCL is greater than 100% it is set to 100%.

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

OBJECTIVE 3 - CLINICAL EFFECTIVENESS

SD=3

3.1 - Overnight bed occupancy rate



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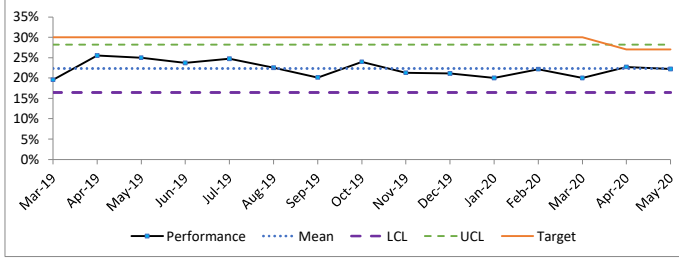
3.2 - Ward Discharges by Midday



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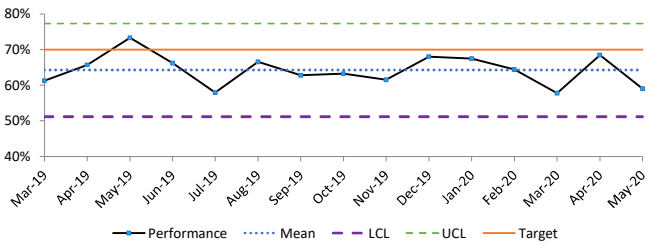
3.3 - Weekend Discharges



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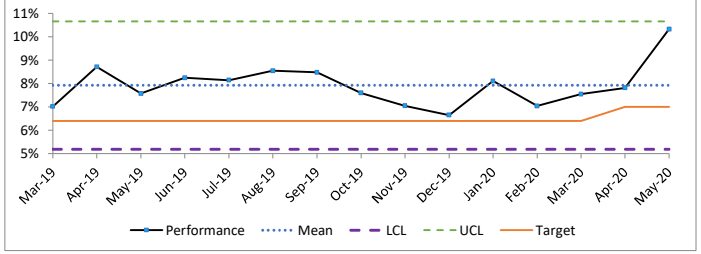
3.4 - 30 Day Readmissions



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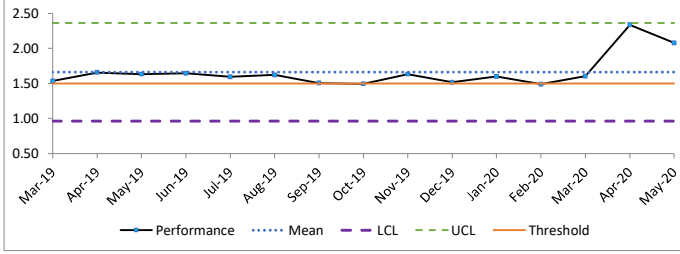
3.5 - Follow-up Ratio



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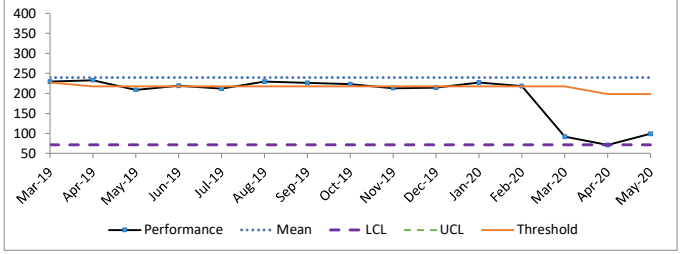
3.6.1 - Number of Stranded Patients (LOS>=7 Days)



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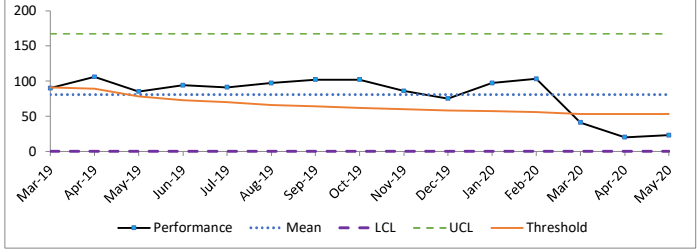
3.6.2 - Number of Super Stranded Patients (LOS>=21 Days)



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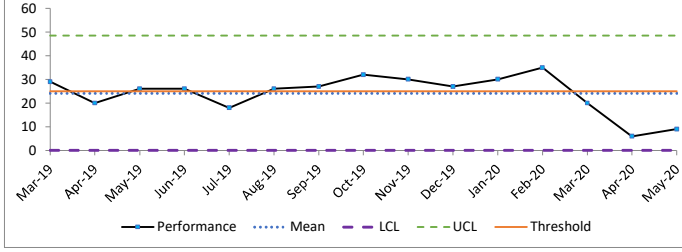
3.7 - Delayed Transfers of Care



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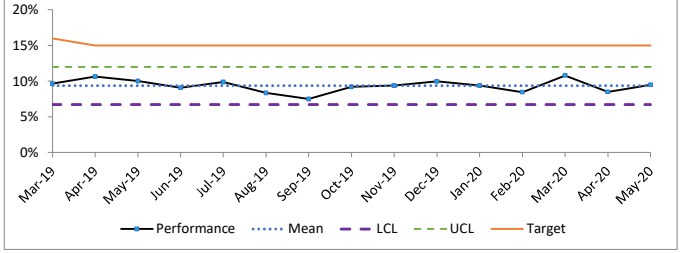
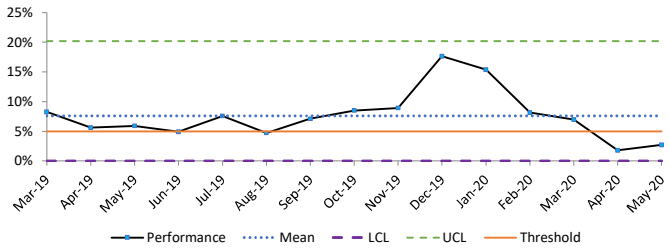
3.8 - Discharges from PDU (%)



SD=3

3.9 - Ambulance Handover > 30 mins(%)



If the LCL is negative (less than zero) it is set to zero.
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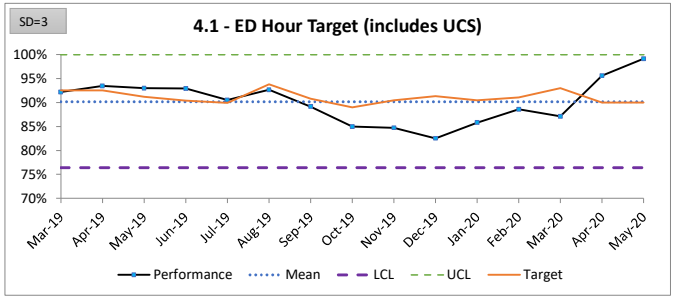
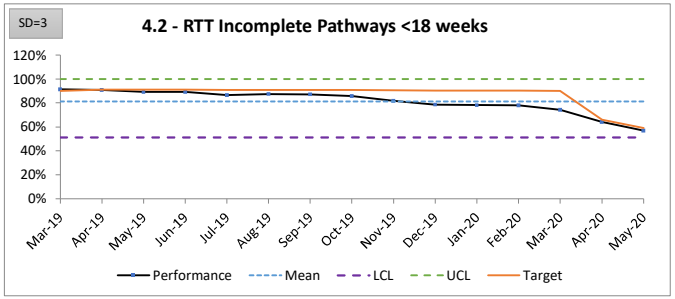
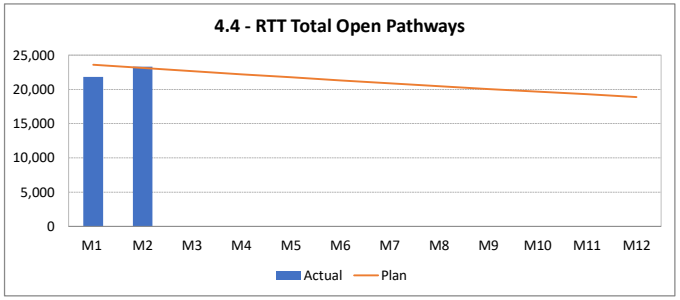
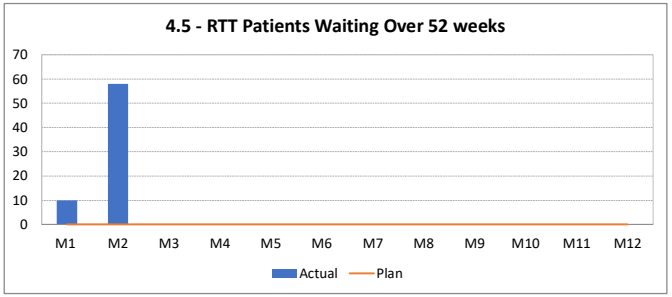
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

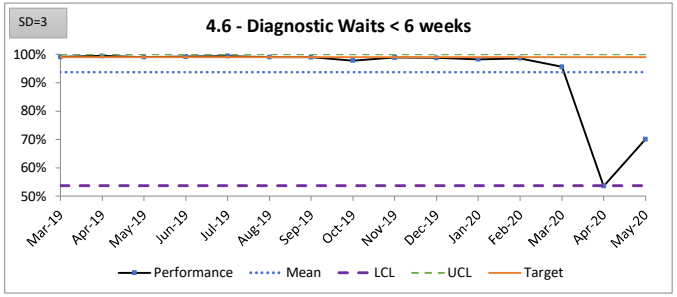
OBJECTIVE 4 - KEY TARGETS

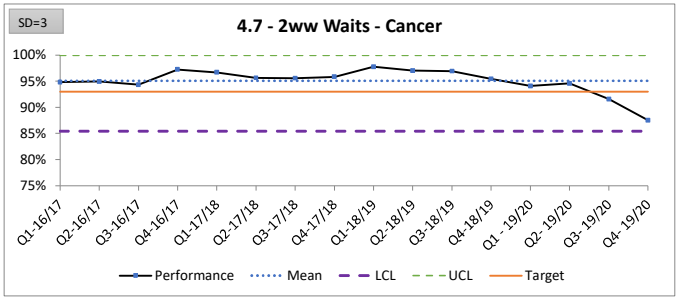


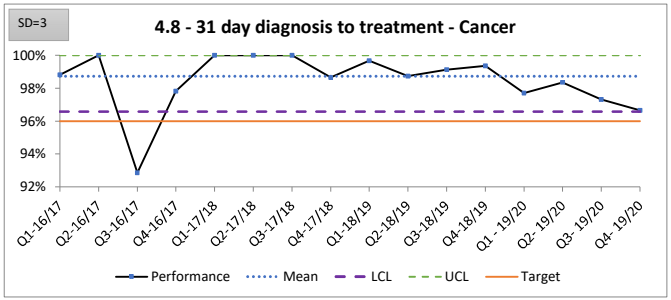


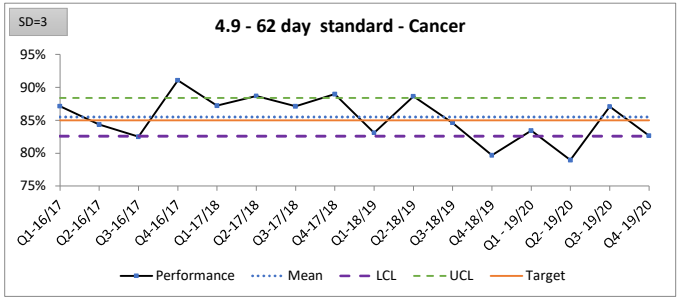












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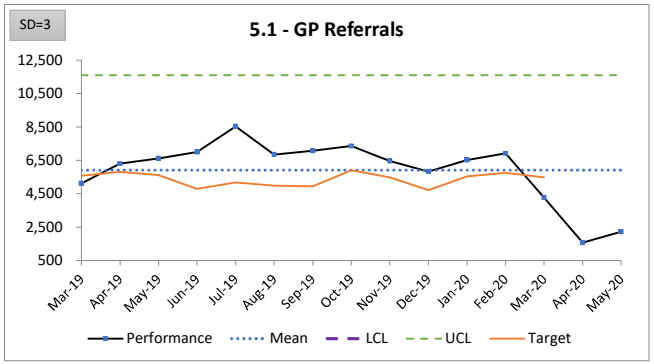

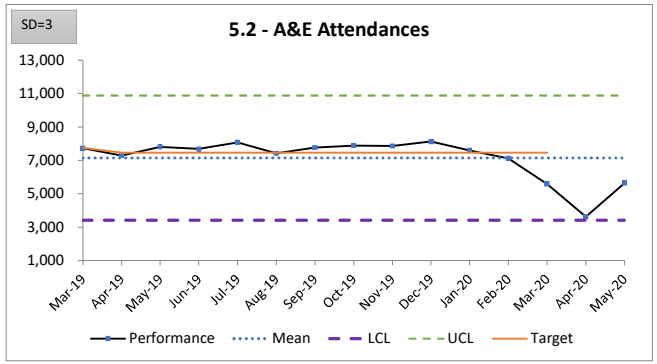

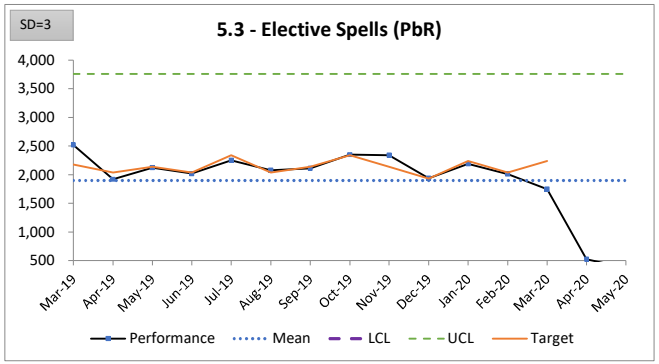

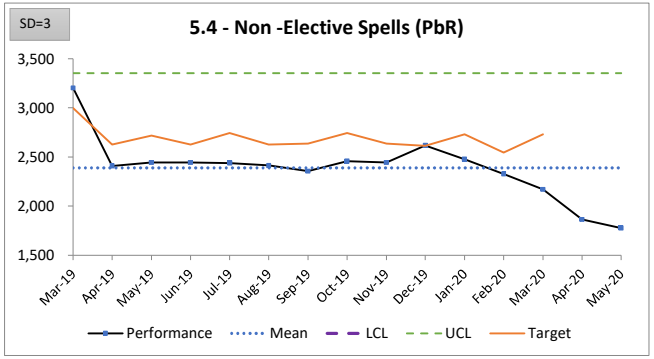

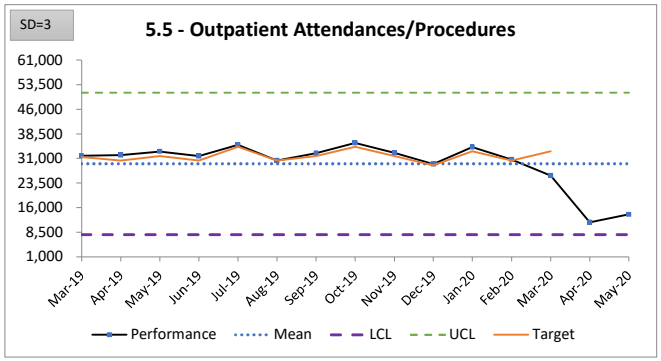

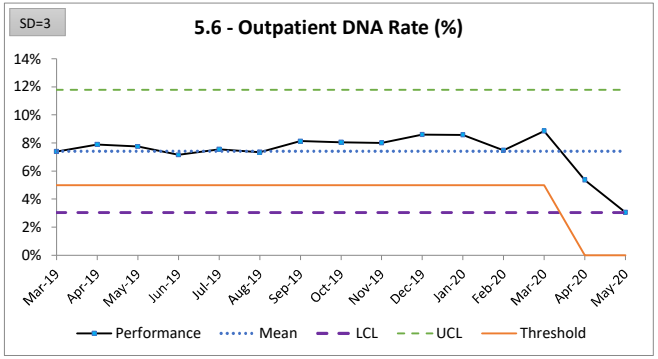

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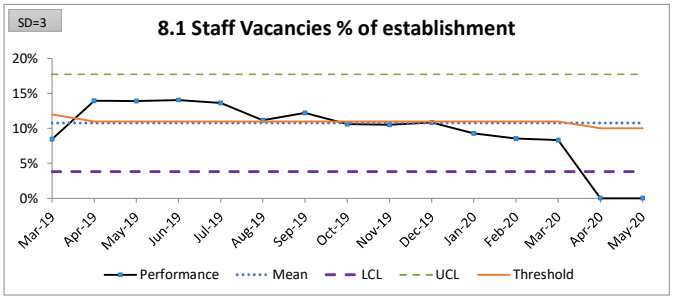
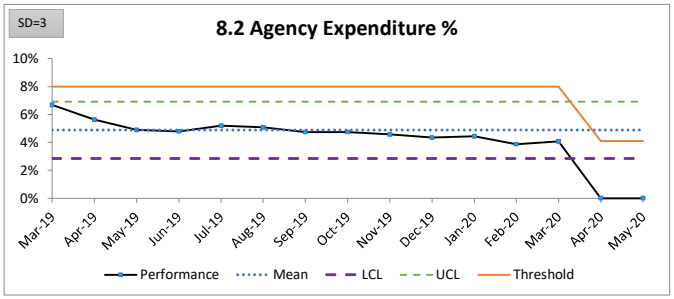
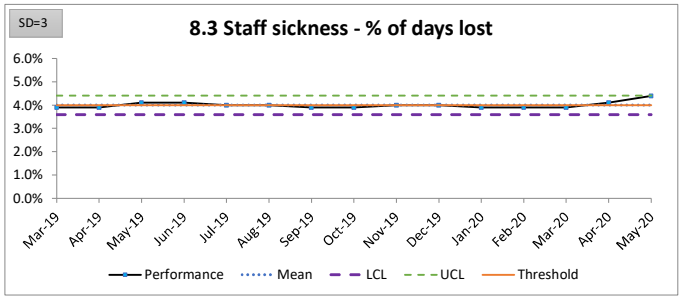
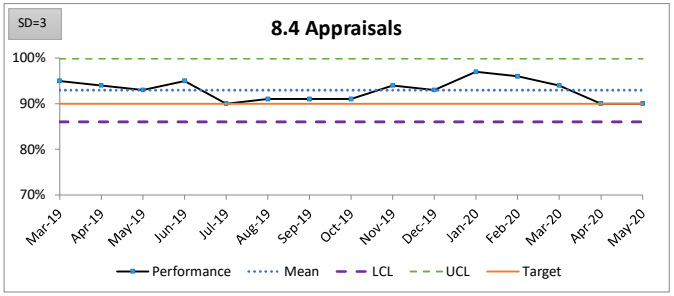
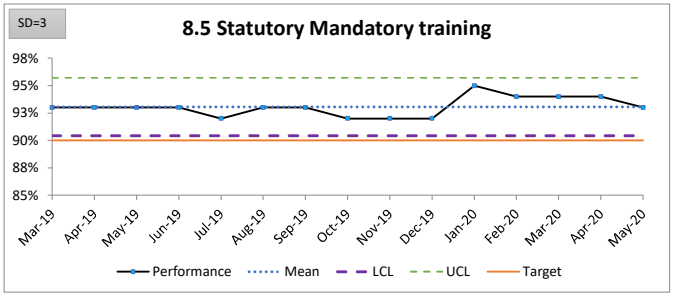
OBJECTIVE 8 - WORKFORCE PERFORMANCE

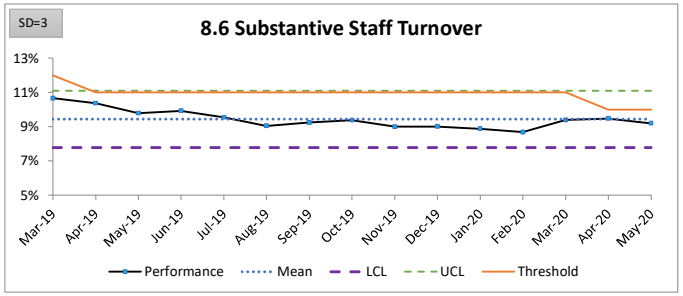












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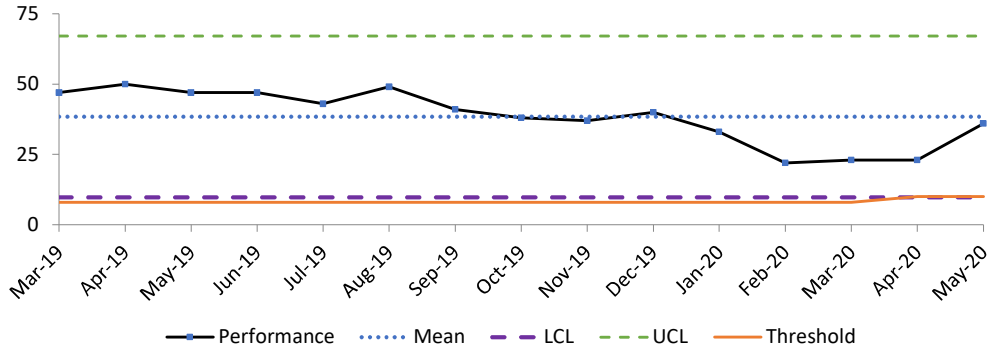
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

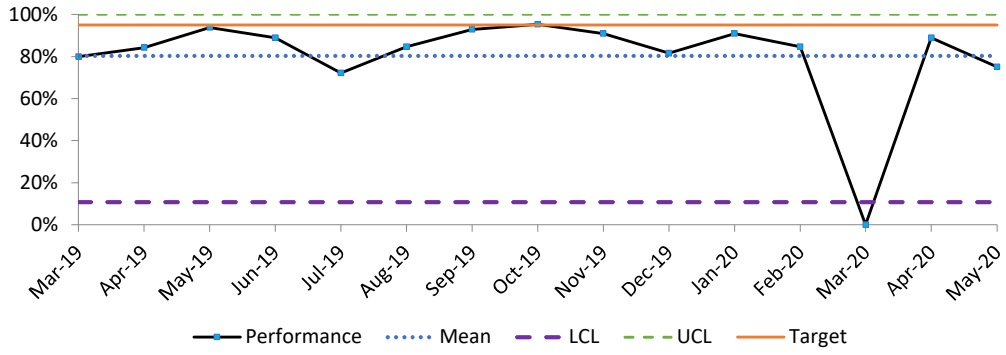
SD=3

O.1 - Total Number of Nice Breaches

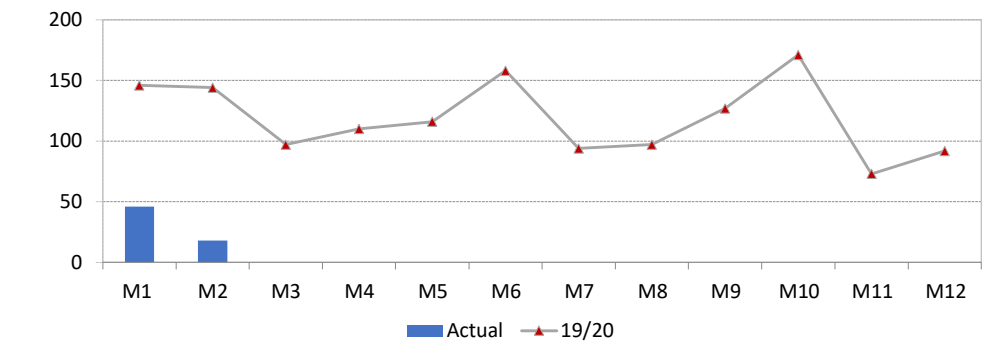


SD=3

O.2 - Rebooked cancelled OPs - 28 day rule

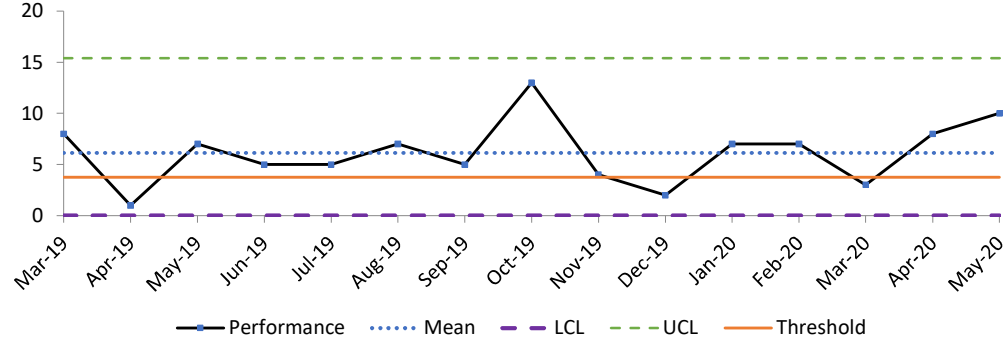


O.4 - Overdue Datix incidents >1 month



SD=3

O.5 - Serious Incidents



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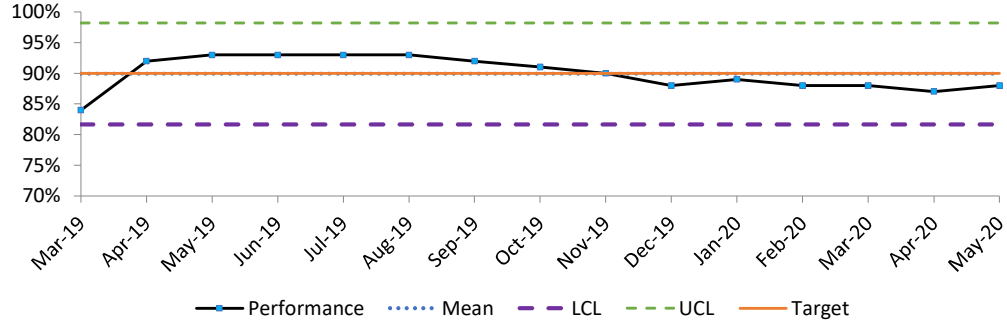
Targets/Thresholds/NHSI Trajectories

SD=3

O.8 - Completed Job Plans (Consultants)



Trust Performance Summary: M02 (May 2020)

1.0 Summary

This report summarises performance at the end of May 2020 for key performance indicators and provides an update on actions to sustain or improve upon Trust and system-wide performance. This commentary is intended only to highlight areas of performance that have changed or are in some way noteworthy. It is important to highlight that the NHS Constitution Targets remain in situ and are highlighted in the table below.

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

However, given the impact of COVID-19 the performance of certain key NHS targets for May 2020 have been directly impacted. To ensure this is reflected, the monthly trajectory of these targets have been amended to ensure the revised trajectory is reasonable and reflect a level of recovery for the Trust to achieve and sustain the target set out in the NHS Constitution over the next 12 months.

2.0 Sustainability and Transformation Fund (STF)

Performance Improvement Trajectories

May 2020 performance against the Service Development and Improvement Plans (SDIP):

ID	Indicator	DQ Assurance	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1	ED 4 hour target (includes UCS)		90.0%	90.0%	97.7%	99.1%	✓	▲	✓	
4.2	RTT Incomplete Pathways <18 weeks		79.0%	59.0%		56.9%	x	▼		
4.9	62 day standard (Quarterly)		85.5%	85.5%		82.7%	x	▼		

In May 2020, ED performance of 99.1% was above the 95% national standard and the 90.0% NHS Improvement trajectory, this is the second consecutive month in the financial year 2020/21 that the Trust has met the 95% national target. Although this key performance indicator is likely to have been directly influenced by the recent circumstances in the hospital as a result of Covid-19, it was noted that the Trust's performance improved from 95.6% in April 2020 to 99.1% in May 2020 in spite of the total number of A&E attendances increasing from 5068 in April 2020 to 7783 in May 2020.

When comparing the Trust's ED performance in May 2020, MKUH was better than the national overall performance of 93.5%. (see Appendix for details). MKUH compared favourably across the Peer Group comparator, outperforming its peers in May 2020.

The Trust's RTT Incomplete Pathways <18 weeks at the end of May 2020 was 56.9% against a national target of 92%. The performance of this key performance indicator is certain to have been directly influenced by the recent circumstances in the hospital as a result of Covid-19. This resulted in the cancellation of non-urgent activity and treatment for patients on an incomplete RTT pathway.

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

For Q4 2019/20, the Trust's provisional 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) was 82.7% against a national target of 85%.

The provisional performance of the percentage of patients who started treatment within 31 days of a decision to treat was 96.7% against a national target of 96% and the percentage of patients who attended an outpatient appointment within two weeks of an urgent referral by their GP for suspected cancer was 87.6% against a national target of 93%.

3.0 Urgent and Emergency Care

In May 2020 two out of six measured key performance indicators showed an improvement in their performance in urgent and emergency:

ID	Indicator	DQ Assurance	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.3%	0.1%	✓	▲	✓	
3.2	Ward Discharges by Midday		27%	27%	22.5%	22.3%	x	▼	x	
3.4	30 day readmissions				7.0%	10.3%		▼		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		53	53		23	✓	▼		
3.9	Ambulance Handovers >30 mins (%)		5%	5%	2.3%	2.7%	✓	▼	✓	
4.1	ED 4 hour target (includes UCS)		90.0%	90.0%	97.7%	99.1%	✓	▲	✓	

Cancelled Operations on the Day

In May 2020 the number of operations cancelled on the day for non-clinical reasons was 0.1% of all planned elective operations in the calendar month.

Readmissions

The Trust 30-day emergency readmission rate was 10.3% in May 2020 (the readmission rate in May 2020 may include patients readmitted with Covid-19). This was an increase on the April 2020 readmission rate of 6.3%.

Delayed Transfers of Care (DTOC)

The number of DTOC patients reported at midnight on the last Thursday of May 2020 was nine, all of which were in Medicine.

Although this was an increase on the April 2020 value of six DTOC patients, this was a notable reduction compared to previous months and likely to have been directly influenced by the recent circumstances in the hospital as a result of Covid-19.

Length of Stay (Stranded and Super Stranded Patients)

The number of super stranded patients (length of stay of 21 days or more) at the end of the month was 23. Although this was an increase on the April 2020 value of 20 super stranded patients, it is a notable reduction compared to previous months and likely to have been directly influenced by the recent circumstances in the hospital as a result of Covid-19.

Ambulance Handovers

In May 2020, the percentage of ambulance handovers to the Emergency Department taking more than 30 minutes was 2.7%.This was an increase to the April 2020 percentage of 1.8%, however it was

a notable reduction compared to previous months and likely to have been directly influenced by the recent circumstances in the hospital as a result of Covid-19.

4.0 Elective Pathways

ID	Indicator	DQ Assurance	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	57.0%	59.8%	✓	▼	✓	
3.5	Follow Up Ratio		1.50	1.50	2.22	2.08	x	▲	x	
4.2	RTT Incomplete Pathways <18 weeks		79.0%	59.0%		56.9%	x	▼		

Overnight Bed Occupancy

Overnight bed occupancy was 59.8% in May 2020. This was an increase compared to April 2020, but still represents a notable reduction compared to previous months and likely to have been directly influenced by the recent circumstances in the hospital as a result of Covid-19.

Follow up Ratio

The Trust follow up ratio in May 2020 was 2.08. This which was an improvement on the April 2020 ratio of 2.34, however it was a notable increment compared to previous months and likely to have been directly influenced by the recent circumstances in the hospital as a result of Covid-19.

RTT Incomplete Pathways

The Trust's RTT Incomplete Pathways <18 weeks at the end of May 2020 was 56.9% which was lower than the April 2020 value of 64.1%. At the end of May 2020, the number of patients waiting more than 52 weeks without being treated was 58. These patients were in Surgery (57 patients) and Medicine (1 patient).

The performance of this key performance indicator is likely to have been directly influenced by the recent circumstances in the hospital as a result of Covid-19.

Diagnostic Waits <6 weeks

The Trust again did not meet the national standard of fewer than 1% of patients waiting six weeks or more for their diagnostic test at the end of May 2020, with a performance of 70.1%. This was an improvement on the previous month and the volume of diagnostic tests undertaken had increased substantially.

5.0 Patient Safety

Infection Control

In May 2020 there was one case of E. coli reported in Medicine (Ward 25) and one case of MSSA reported in ICU. There were no reported cases of MRSA or Clostridium difficile (C. diff).

8.0 Workforce

In month staff absence

In May 2020 there was in month staff absence of 4.5% compared to 3.7% for the same month in 2019. However, 1.3% of staff were reported as being absent due to Covid (down from 3.7% in April 2020).

ENDS

Appendix 1: ED Performance - Peer Group Comparison

The following Trusts have been historically viewed as peers of MKUH for the purpose of Dr Foster:

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

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

March to May 2020 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	Mar-20	Apr-20	May-20
Milton Keynes University Hospital NHS Foundation Trust	86.91%	95.46%	99.12%
Mid Cheshire Hospitals NHS Foundation Trust	86.03%	98.30%	95.91%
Southport And Ormskirk Hospital NHS Trust	86.55%	92.83%	95.77%
Homerton University Hospital NHS Foundation Trust	91.98%	94.01%	94.94%
Barnsley Hospital NHS Foundation Trust	91.03%	95.28%	94.25%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	83.56%	92.71%	94.03%
The Princess Alexandra Hospital NHS Trust	79.68%	88.92%	92.86%
Oxford University Hospitals NHS Foundation Trust	80.19%	84.60%	92.62%
North Middlesex University Hospital NHS Trust	75.64%	81.79%	92.34%
Northampton General Hospital NHS Trust	80.88%	91.21%	92.02%
Buckinghamshire Healthcare NHS Trust	83.43%	86.73%	89.41%
The Hillingdon Hospitals NHS Foundation Trust	81.45%	80.96%	86.68%
Bedford Hospital NHS Trust	85.54%	n/a	n/a
Kettering General Hospital NHS Foundation Trust	n/a	n/a	n/a
Luton And Dunstable University Hospital NHS Foundation Trust	n/a	n/a	n/a

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

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Meeting title	**Public Board**	**Date: 2 July 2020**
Report title:	**Finance Paper Month 2 2020-21**	**Agenda item: 5.2**
Lead director **Report authors**	Mike Keech Chris Panes	Director of Finance Head of Management Accounts
FoI status:	Public document	

Report summary	**An update on the financial position of the Trust at Month 2 (May 2020)**			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** X	**Decision** ☐
Recommendation	The Trust Board to note the contents of the paper.			

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

Report history	None
Next steps	None
Appendices	1 to 3

FINANCE REPORT FOR THE MONTH TO 31st MAY 2020

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. Due to COVID-19 (covid) the Trust's previously submitted budget has been suspended and the Trust is being funded by a national block payment from April to July. The block payment is made up of three components; a fixed amount based on run rate from last year (£18.6m per month), a top up amount to address a deficit from the block (£3.1m per month) and a covid top up by return for additional covid related costs (allowing the Trust to report a breakeven position).

3. *Income and expenditure* –The Trust has reported a breakeven position for May 2020 against the revised block funding arrangement. Within this position the Trust has claimed an additional £0.7m (£1.5m YTD) of income over and above the £3.1m (£6.2m YTD) top-up in order to deliver a breakeven position as required by national rules.

4. Cash and capital position – the cash balance as at the end of May 2020 was £43.3m, which was £42.3m above plan due to the block payment for June paid on account in May, receipt of £9m PSF/FRF funding for 2019/20 and the timing of capital expenditure.

    The Trust has spent £1.9m on capital up to month 2 which relates patient safety and clinically urgent capital expenditure.

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

6. *Cost savings* –In response to COVID-19 work on tracking and delivering cost improvement plans has been temporary suspended with the focus instead on recovery planning.

INCOME AND EXPENDITURE

7. In its reporting to NHSI, the Trust is required to report against the income and costs included within the national modelling for the Trust (based on historical actuals uplifted for inflation but with no adjustments for growth). However, in order for the Trust to get a better understanding of the Trust's cost base and how this has been impact by COVID-19, the Trust is also monitoring performance against a planned position that would meet the original financial control total. The tables below summarises performance against the national modelling and the Trust's original plan. For the purposes of the report, the narrative discusses performance against the Trust's original plan.

National modelling:

All Figures in £'000	Month 2 Plan	Month 2 Actual	Month 2 Var	Month 2 YTD Plan	Month 2 YTD Actual	Month 2 YTD Var
Clinical Revenue	18,585	18,209	(376)	37,170	36,409	(761)
Other Revenue	1,393	1,108	(285)	2,786	2,429	(357)
Total Income	19,978	19,318	(660)	39,956	38,838	(1,118)
Pay	(14,988)	(15,949)	(961)	(29,976)	(32,019)	(2,043)
Non Pay	(7,064)	(5,960)	1,104	(14,128)	(12,064)	2,064
Total Operational Expend	(22,052)	(21,910)	142	(44,104)	(44,083)	21
EBITDA	(2,074)	(2,592)	(518)	(4,148)	(5,245)	(1,097)
Financing & Non-Op. Costs	(981)	(1,167)	(186)	(1,962)	(2,327)	(365)
Control Total Deficit (excl. top up)	**(3,055)**	**(3,759)**	**(704)**	**(6,110)**	**(7,572)**	**(1,462)**
Adjustments excl. from control total:						
FRF	0	0	0	0	0	0
MRET	0	0	0	0	0	0
National Block	0	0	0	0	0	0
National Top up	3,055	3,055	0	6,110	6,110	0
COVID Top up	0	704	704	0	1,462	1,462
Control Total Deficit (incl. top up)	**0**	**0**	**0**	**0**	**(0)**	**(0)**
Donated income	0	0	0	0	0	0
Donated asset depreciation	0	(68)	(68)	0	(136)	(136)
Impairments & Rounding	0	0	0	0	0	0
Reported deficit/surplus	**0**	**(68)**	**(68)**	**0**	**(136)**	**(136)**

Performance against original internal plan:

All Figures in £'000	Month 2 Plan	Month 2 Actual	Month 2 Var	Month 2 YTD Plan	Month 2 YTD Actual	Month 2 YTD Var	Full Year Plan	Full Year Forecast	Full Year Var
Clinical Revenue	18,878	11,799	(7,079)	37,903	22,126	(15,777)	233,455	233,455	0
Other Revenue	1,626	1,108	(518)	3,524	2,429	(1,095)	19,295	19,295	0
Total Income	20,504	12,908	(7,597)	41,427	24,555	(16,872)	252,749	252,749	0
Pay	(15,156)	(15,949)	(793)	(30,317)	(32,019)	(1,702)	(180,692)	(180,692)	0
Non Pay	(6,896)	(5,960)	935	(13,774)	(12,064)	1,709	(82,026)	(82,026)	0
Total Operational Expend	(22,052)	(21,910)	142	(44,091)	(44,083)	8	(262,718)	(262,718)	0
EBITDA	(1,548)	(9,002)	(7,454)	(2,663)	(19,528)	(16,864)	(9,969)	(9,969)	0
Financing & Non-Op. Costs	(1,191)	(1,167)	24	(2,382)	(2,327)	55	(14,299)	(14,299)	0
Control Total Deficit (excl. PSF)	**(2,739)**	**(10,169)**	**(7,430)**	**(5,046)**	**(21,855)**	**(16,809)**	**(24,268)**	**(24,268)**	**0**
Adjustments excl. from control total:									
FRF	0	0	0	0	0	0	19,788	19,788	0
MRET	269	0	(269)	269	0	(269)	3,238	3,238	0
National Block	0	6,410	6,410	0	14,283	14,283	0	0	0
National Top up	0	3,055	3,055	0	6,110	6,110	0	0	0
COVID Top up	0	704	704	0	1,462	1,462	0	0	0
Control Total Deficit (incl. PSF)	**(2,470)**	**0**	**2,470**	**(4,777)**	**(0)**	**4,777**	**(1,242)**	**(1,242)**	**0**
Donated income	0	0	0	0	0	0	1,000	1,000	0
Donated asset depreciation	(68)	(68)	0	(136)	(136)	0	(816)	(816)	0
Impairments & Rounding	0	0	0	0	0	0	0	0	0
Reported deficit/surplus	**(2,538)**	**(68)**	**2,470**	**(4,913)**	**(136)**	**4,777**	**(1,058)**	**(1,058)**	**0**

Monthly and year to date review

8. The **deficit excluding central funding (top up) and donated income** in month 2 is £10,169k which is £7,430k adverse to the Trust's original plan; this is due to a combination of:
    - The national block contract income being lower than clinical income assumed in the internal plan (and agreed as part of the heads of terms with Milton Keynes CCG;
    - Lower non-clinical income streams due to lower activity volumes (e.g. parking income);
    - The impact of COVID-19 on the Trust's cost base.

    However, after the block payment and top up income the Trust has reported a breakeven position for the month. Included within this position is £2,088k YTD of direct COVID-19 costs (excluding loss of non-clinical income which is outside the scope of provider claims) against which the Trust expects to receive an additional £704k (£1,462k YTD) top-up (lower than the actual costs of COVID-19 as all providers are being advised to report a breakeven position).

9. On a payment by results basis, **income (excluding block, top up and donations effect)** is £7,597k adverse to plan in May and £16,872k YTD with significant reductions in non-elective activity and suspension of non-urgent elective activity (clinical income is £7,079k adverse to plan in month and £15,777k YTD).

   However, the shortfall on clinical income is offset by the top-up payments which act as both a) a replacement of the financial recovery fund that would otherwise have been in place; and b) additional payments to cover shortfalls on clinical income as a result of the impact of covid.

10. **Operational costs** in May are favourable to plan by £142k in month and £8k YTD

11. **Pay costs** are £793k adverse to budget in Month 2 and £1,702k YTD. High costs against substantive and bank include direct COVID-19 related costs due to changes in rotas, additional hours and cover of sickness/self-isolation. Of the £2,481k of COVID-19 costs £2,088k have been incurred against pay.

12. **Non-pay** costs were £935k favourable to plan in month and £1,709k YTD. Positive variances can be seen across most non-pay categories with reduction expenditure due to lower than normal activity levels.

13. Non-operational costs are marginally favourable in month and YTD

    Further analysis of the costs can be found in appendix 1

COST SAVINGS

14. Due to COVID-19, focus on capture and recording of cost improvement plans has been temporary suspended and instead resources have been directed to recovery planning; however the Trust will be expected to deliver productivity improvements and efficiencies over the remainder of the year.

15. In month 2 budgets have been reduced by £917k (1,834k YTD) as part of the original planned £11m CIP target

CASH AND CAPITAL

16. The cash balance at the end of May 2020 was £43.3m, which was £42.3m above plan due to the block payment for June paid on account in May, receipt of £9m PSF/FRF funding for 2019/20 and the timing of capital expenditure.

17. On 2 April 2020, the Secretary of State for Health and Social Care, announced that over £13bn of debt will be written off as part of a major financial reset for NHS providers. As a result, the Trust's Department of Health and Social Care interim revenue support and capital loans (totalling £131.1m as at 31 March 2020) will be converted to PDC during the financial year 20/21 and replaced with Public Dividend Capital for which there is no repayment obligation.

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 £31.8m; this is mainly driven by the revaluation of the Trust estate in 2018/19 and 2019/20.

- Current assets are above plan by £50.2m, this is due to cash £42.3m, inventories £0.2m and receivables £7.7m above plan.

- Current liabilities are above plan by £168m. This is being driven by borrowings £129.2m which were not expected to be repaid, (driven by revenue and capital DHSC borrowings becoming due and transferred from non-current assets. There were already £1.9m of loans in the plan for repayment. These are due to be converted to PDC in 2020/21), deferred income £25m and Trade and Other Creditors £13.8m above plan.

- Non-Current Liabilities are below plan by £22.3m. This is being driven by borrowings £23.1 (driven by the inclusion of capital DHSC borrowings becoming due and transferred from non-current assets) offset by provisions £0.8m above plan.

The Trust has spent £1.9m on capital up to month 2 which relates patient safety and clinically urgent capital expenditure.

The key performance indicators have been met with the exception of, capital spend due to timing of projects and creditor and debtor days.

RISK REGISTER

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

a) Constraints on the NHS Capital Departmental Expenditure Limit (CDEL) may lead to delays in the Trust receiving its required capital funding or other restrictions being placed on the Trust's capital programme.

The Trust has revised its capital plan to operate within the CDEL limit set for the Bedfordshire, Luton and Milton Keynes ICS. Schemes are progressing and funding sources have been identified.

b) As a result of Covid-19, the trust incurs additional costs and/or has a reduction in income that leads to its financial position becoming unsustainable.

PBR contracts have been replaced with block contracts (set nationally until July) and top-up payments available where covid-19 leads to costs over block amounts. Trust is in constant dialogue with NHSI/E regarding funding post July.

c) Risk that the Guaranteed income contract, following Covid-19 arrangements does not deliver the expected benefits

The Trust has in place clearly defined monitoring of the monthly activity performance and maintains an ongoing dialogue with commissioners and NHSI/E regarding funding arrangements going forward in 20/21

RECOMMENDATIONS TO BOARD

20. The Trust Board is asked to note the financial position of the Trust as at 31st May 2020 and the proposed actions and risks therein.

Appendix 1

Milton Keynes Hospital NHS Foundation Trust
Statement of Comprehensive Income
For the period ending 31st May 2020

	May 2020			Year to Date			Full year
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME							
Outpatients	3,982	1,883	(2,099)	8,165	3,223	(4,943)	51,328
Elective admissions	2,206	498	(1,708)	4,529	927	(3,602)	29,148
Emergency admissions	6,300	3,698	(2,602)	12,398	7,764	(4,633)	73,776
Emergency adm's marginal rate (MRET)	(277)	(277)	0	(544)	(544)	0	(3,238)
Readmissions Penalty	0	0	0	0	0	0	0
A&E	1,343	973	(370)	2,617	1,596	(1,021)	15,489
Other Admissions	266	197	(70)	523	273	(251)	3,114
Maternity	1,726	1,867	141	3,452	3,255	(197)	21,186
Critical Care & Neonatal	561	807	245	1,104	1,240	135	6,572
Excess bed days	0	0	0	0	0	0	0
Imaging	439	175	(263)	901	322	(579)	5,799
Direct access Pathology	378	180	(198)	775	315	(460)	4,987
Non Tariff Drugs (high cost/individual drugs)	1,480	1,336	(144)	3,021	2,766	(255)	19,348
Other	473	461	(12)	961	989	(133)	5,946
National Block Top Up	0	3,355	3,355	0	14,283	14,283	0
Clinical Income	**18,878**	**15,154**	**(3,724)**	**37,903**	**36,409**	**(1,494)**	**233,455**
Non-Patient Income	**1,895**	**7,922**	**6,027**	**3,793**	**10,001**	**6,208**	**43,321**
TOTAL INCOME	**20,773**	**23,077**	**2,303**	**41,696**	**46,410**	**4,714**	**276,775**
EXPENDITURE							
Total Pay	**(15,156)**	**(15,949)**	**(793)**	**(30,317)**	**(32,019)**	**(1,702)**	**(180,692)**
Non Pay	(5,416)	(4,624)	792	(10,752)	(9,298)	1,454	(62,678)
Non Tariff Drugs (high cost/individual drugs)	(1,480)	(1,336)	144	(3,021)	(2,766)	255	(19,348)
Non Pay	**(6,896)**	**(5,960)**	**935**	**(13,774)**	**(12,064)**	**1,709**	**(82,026)**
TOTAL EXPENDITURE	**(22,052)**	**(21,910)**	**142**	**(44,091)**	**(44,083)**	**8**	**(262,718)**
EBITDA*	**(1,279)**	**1,167**	**2,446**	**(2,394)**	**2,327**	**4,722**	**14,057**
Depreciation and non-operating costs	(999)	(975)	24	(1,998)	(1,943)	55	(11,995)
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**(2,278)**	**192**	**2,470**	**(4,393)**	**383**	**4,777**	**2,063**
Public Dividends Payable	(260)	(260)	0	(520)	(520)	0	(3,120)
OPERATING DEFICIT AFTER DIVIDENDS	**(2,538)**	**(68)**	**2,470**	**(4,913)**	**(136)**	**4,778**	**(1,058)**
Adjustments to reach control total							
Donated Income	0	0	0	0	0	0	(1,000)
Donated Assets Depreciation	68	68	(0)	136	136	(0)	816
Control Total Rounding	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
PSF/FRF/MRET	(269)	0	269	(538)	0	538	(23,026)
CONTROL TOTAL DEFICIT	**(2,739)**	**0**	**2,739**	**(5,315)**	**0**	**5,316**	**(24,268)**

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

Appendix 2

Milton Keynes Hospital NHS Foundation Trust
Statement of Cash Flow
As at 31st May 2020

	Mth 2 £000	Mth 1 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	426	279	147
Operating surplus/(deficit) of discontinued operations			
Operating (deficit)	**426**	**279**	**147**
Non-cash income and expense:			
Depreciation and amortisation	1901	950	951
Impairments	0	0	0
(Increase)/Decrease in Trade and Other Receivables	(1,507)	(8,394)	6,887
(Increase)/Decrease in Inventories	(7)	(10)	3
Increase/(Decrease) in Trade and Other Payables	4,025	2,778	1,247
Increase/(Decrease) in Other Liabilities	24,368	22,958	1,410
Increase/(Decrease) in Provisions	(125)	(125)	0
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	0	0	0
Other movements in operating cash flows	(2)	(3)	1
NET CASH GENERATED FROM OPERATIONS	**29,079**	**18,433**	**10,646**
Cash flows from investing activities			
Interest received	4	3	1
Purchase of financial assets	0	0	0
Purchase of intangible assets	(3,364)	(2,969)	(395)
Purchase of Property, Plant and Equipment, Intangibles	1,409	2,477	(1,068)
Sales of Property, Plant and Equipment			0
Net cash generated (used in) investing activities	**(1,951)**	**(489)**	**(1,462)**
Cash flows from financing activities			
Public dividend capital received	0	0	0
Loans received from Department of Health	0	0	0
Loans repaid to Department of Health	0	0	0
Capital element of finance lease rental payments	(37)	(19)	(18)
Interest paid	0	0	0
Interest element of finance lease	(47)	(22)	(25)
PDC Dividend paid	0	0	0
Receipt of cash donations to purchase capital assets	0	0	0
Net cash generated from/(used in) financing activities	**(84)**	**(41)**	**(43)**
Increase/(decrease) in cash and cash equivalents	**27,044**	**17,903**	9,141
Opening Cash and Cash equivalents	**16,286**	**16,286**	10,111
Closing Cash and Cash equivalents	**43,330**	**34,189**	**19,252**

Appendix 3

Milton Keynes Hospital NHS Foundation Trust
Statement of Financial Position as at 31st May 2020

	Audited Mar-20	May-20 YTD Plan	May-20 YTD Actual	In Mth Mvmt	YTD Mvmt	% Variance
Assets Non-Current						
Tangible Assets	143.2	178.4	143.5	(34.9)	0.3	0.2%
Intangible Assets	16.1	13.1	15.9	2.8	(0.2)	(1.2%)
Other Assets	0.9	0.6	0.9	0.3	0.0	0.0%
Total Non Current Assets	**160.2**	**192.1**	**160.3**	**(31.8)**	**0.1**	**0.1%**
Assets Current						
Inventory	3.4	3.2	3.4	0.2	0.0	0.0%
NHS Receivables	18.7	16.8	14.1	(2.7)	(4.6)	(24.6%)
Other Receivables	6.9	2.6	13.0	10.4	6.1	88.4%
Cash	16.3	1.0	43.3	42.3	27.0	165.6%
Total Current Assets	**45.3**	**23.6**	**73.8**	**50.2**	**28.5**	**62.9%**
Liabilities Current						
Interest -bearing borrowings	(131.3)	(2.1)	(131.3)	(129.2)	0.0	0.0%
Deferred Income	(2.3)	(1.6)	(26.6)	(25.0)	(24.3)	1056.5%
Provisions	(1.5)	(1.4)	(1.4)	0.0	0.1	-6.7%
Trade & other Creditors (incl NHS)	(38.9)	(29.6)	(43.4)	(13.8)	(4.5)	11.6%
Total Current Liabilities	**(174.0)**	**(34.7)**	**(202.7)**	**(168.0)**	**(28.7)**	16.5%
Net current assets	**(128.7)**	**(11.1)**	**(128.9)**	**(117.8)**	**(0.2)**	**0.1%**
Liabilities Non-Current						
Long-term Interest bearing borrowings	(5.8)	(28.9)	(5.8)	23.1	0.0	0.0%
Provisions for liabilities and charges	(1.6)	(0.8)	(1.6)	(0.8)	0.0	0.0%
Total non-current liabilities	**(7.4)**	**(29.7)**	**(7.4)**	**22.3**	**0.0**	0.0%
Total Assets Employed	**24.1**	**151.3**	**24.0**	**(127.0)**	**(0.1)**	**(0.3%)**
Taxpayers Equity						
Public Dividend Capital (PDC)	105.3	221.5	105.3	(116.2)	0.0	0.0%
Revaluation Reserve	48.4	57.7	48.4	(9.3)	0.0	0.0%
I&E Reserve	(129.6)	(127.9)	(129.7)	(1.8)	(0.1)	0.1%
Total Taxpayers Equity	**24.1**	**151.3**	**24.0**	**(127.3)**	**(0.1)**	**(0.4%)**

Meeting title	**Trust Board**	**Date: 2 July 2020**
Report title:	**Workforce report**	**Agenda item: 5.3**
Lead director **Report author**	**Name: Danielle Petch** **Name: Paul Sukhu**	**Title: Director of Workforce** **Title: Deputy Director of Workforce**
FoI status:	**Public**	

Report summary	This report provides a summary of workforce Key Performance Indicators for the full year ending 31 May 2020 (Month 2).			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [x]	**Decision** [ ]
Recommendation	Trust Board is asked to note the Workforce report. Trust Board is also asked to note that a format change to this report is currently progressing through the Workforce Governance structure. It is envisaged that this will form the basis of future corporate workforce information reporting.			

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	Trust Board, May 2020
Next steps	
Appendices	

Workforce report – Month 2, 2020/21

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators for the full year ending 31 May 2020 (Month 2).

2. Staff in post

2.1. The Trust's staff in post by whole time equivalent (WTE) was 3238.8 as at 31 May 2020; an increase of 155.8 WTE since May 2019.

2.2. The Trust's headcount is 3723, an increase of 162 since May 2019.

3. Vacancy rate

3.1. The Trust's overall vacancy rate is 12.4% this has decreased from 13.9% on 30 April 2020 (M1).

4. Turnover

4.1. The Trust's leaver turnover rate was lower throughout 2019/20 than it was in 2018/19 and this trend has continued into Q1 of 2020/21. The leaver turnover rate for the 12 months to 31 May 2020 was 9.4%, slightly down from the M1 position of 9.5%.

5. Temporary staffing

5.1. The temporary staff usage (bank + agency) for the year was 5787.6 WTE, which was 13.6% of total WTE staff employed.

5.2. Agency staff usage was 2.7% of the total WTE staff employed for the year but was 4.8% of the total annual staff expenditure.

5.3. The Trust target for Agency Staff Expenditure for 2019/20 is 8.0% (2018/19 is 8.0%)

6. Sickness absence

6.1. The sickness absence rate (N.B. 12 months to M1, 30 April 2020) is 4.42% against the Trust target of 4.0% (2.12 % short term and 2.3% long term).

6.2. The rolling 12-month figure reported in 6.1 includes Covid-19 related absence. Covid-19 related absence will be separated out in future reports so as to clarify the true levels of standard and pandemic absence.

6.3. Overall, the Trust's sickness absence levels remain lower than the same period for the last two financial years.

7. Statutory and mandatory training

7.1. Statutory and mandatory training compliance as at 31 May 2020 was at 93% against the Trust target of 90%. This has reduced by 1% since M1.

Training Compliance by Division	
Core Clinical	94%
Corporate Services	95%
Medicines Unplanned Care	91%
Surgical Planned Care	92%
Women's and Children's	94%
Trust Total Compliance	**93%**

7.2. Individual letters are being sent to individuals and managers to ensure that compliance improves as the Trust moves into its Covid-19 recovery stages.

8. Appraisal compliance

8.1. Trust-wide appraisal compliance as at 31 May 2020 is 90%, against the Trust target of 90% - equal to compliance level reported to 30 April 2020.

8.2. Routine reminders and a series of letters to responsible managers from the Director of Workforce are now sent in order to support a culture of sustainability of the level of appraisals undertaken.

Appraisal Completion by Division	
Core Clinical	95%
Corporate Services	87%
Medicines Unplanned Care	90%
Surgical Planned Care	84%
Women's and Children's	90%
Total Trust	**90%**

9. Covid Response

9.1. The welfare of our workforce has been at the forefront of our minds during this time. A number of initiatives have been put in place and sustained in order to ensure our staff are looked after and cared for while they are looking after and caring for our patients.

9.2. Activity levels were anticipated and were much higher during the peak. Services have been scaled back where the requirement for support has diminished (e.g. Covid Staff Health phone lines). At the time of reporting, 46 colleagues were self-isolating and absent through sickness absence. A total of 1257 colleagues had returned to work following self-isolation and 177 of 913 colleagues who had an antigen test (swab) had tested positive since the start of the pandemic.

9.3. Over the past month, the Directorate has supported the Trust's participation in two research based antibody screening programmes. Close to 1300 staff were screened in the first programme (PHE), followed by a further 2700 staff whose samples have been taken since 17 June.

9.4. As the Trust moves into its recovery stages, some of this support will now need to evolve in order to support colleagues to return to the workplace, many of whom have become used to their shielding arrangements and or working from home. It is believed that this may be a particularly difficult process for many colleagues.

9.5. Of equal importance is the requirement to support managers to ensure that they are able to deal with workplace pressure of the recovery stages in addition to supporting the health, wellbeing and needs of colleagues who are pivotal to service delivery.

9.6. Staff engagement programmes are being developed across a number of platforms, both in person and electronically, to support the recovery phases that the Trust is now in. This will ensure that colleagues and their managers can re-enter the workplace in a controlled manner that takes account of their concerns.

9.7. Policy development is ongoing at pace to support remote working, quarantine arrangements post travel and domestic violence. The Trust is implementing at pace policy changes to support the initiatives of government and national NHS bodies such as NHS England/Improvement and NHS Employers.

9.8. During the pandemic, the Director of Workforce established weekly meetings with local and regional staff side colleagues which leaves the Trust well positioned to agree such changes as scale and pace. These have been well received and appreciated by staff side colleagues.

9.9. To date, the Trust's Coronavirus Staff At Risk Panel has received and processed close to 1000 forms for colleagues. The individual risk assessments process has been communicated extensively and the Directorate is in the process of writing to all colleagues to ensure any staff who need to but have not yet submitted a form, or have experienced changes to their circumstances, can be appropriately supported. In addition to supporting the development of the workplace risk assessments, the Directorate has already been able to achieve Covid-19 Secure status in a number of its own offices.

10. Recommendations

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

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Board of Directors**	**Date: 2 July 2020**
Report title:	**Infection Prevention and Control Board Assurance Framework**	**Agenda item: 6.1**
Lead director Report author Sponsor(s)	**Kate Jarman**	**Director of Corporate Affairs**
FoI status:	**Disclosable**	

Report summary	The assurance framework reflects current direction for effective self-assessment of the MKUH compliance with Public Health England (PHE) and other COVID-19-related infection prevention and control guidance and to identify risks. This framework sets out the proposed activities of the infection prevention and control service that can be used to provide evidence. It also serves as an improvement tool to optimise activities and interventions. The obligation is to be met through raising awareness of infection prevention and control through education and training and reducing the incidence of Health Care Associated Infection (HCAI). It also supports the Trusts continuing registration with the Care Quality Commission (CQC). The framework is structured around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection, which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.			
Purpose *(tick one box only)*	**Information** ☐	**Approval** x	**Discussion** ☐	**Decision** ☐
Recommendation	That the Board reviews and approves the IPC BAF.			

Strategic objectives links	Objectives 1, 2, 3
Board Assurance Framework links	BAF
CQC regulations	Regulation 12
Identified risks and risk management actions	Within BAF
Resource implications	Within individual risk action plans
Legal implications including equality and	Pursuant to individual risks

diversity assessment	

Report history	First presentation to the Board
Next steps	Review as required (every six months as part of overall risk profile review)
Appendices	Papers follow

Board Assurance and Risk Register Reports

The Sub-Committees of the Trust Board (Quality and Clinical Risk, Finance and Investment, Workforce Assurance, Audit) are required under their terms of reference to discuss, in detail, the risks on the Board Assurance Framework pursuant to their areas of business, and escalate any matters of concern for Board attention.

The Audit Committee also reviews the Trust's risk registers; and the Quality and Clinical Risk Committee reviews the Trust's clinical risk registers. The Board also has oversight of the Significant Risk Register on a quarterly basis – this month, the risks presented are those with a residual (current) risk rating of 16 or above according to the 5x5 risk matrix (detailed in the Trust's risk management strategy).

The BAF has been updated in the month by Executive Risk Owners.

The Board is asked to discuss the risks contained on the Board Assurance Framework, with Committee Chairs and Executive Risk Owners required to escalate any matter for the Board's attention following detailed discussion of risks in relevant Board Sub-Committees.

The Board is asked to review the Significant Risk Register (for the Board this is risks with a current risk score above 16 on the Trust's corporate and divisional risk registers).

Infection Prevention and Control Board Assurance

1. Executive summary

The assurance framework reflects current direction for effective self-assessment of the MKUH compliance with Public Health England (PHE) and other COVID-19-related infection prevention and control guidance and to identify risks. This framework sets out the proposed activities of the infection prevention and control service that can be used to provide evidence. It also serves as an improvement tool to optimise activities and interventions. The obligation is to be met through raising awareness of infection prevention and control through education and training and reducing the incidence of Health Care Associated Infection (HCAI). It also supports the Trusts continuing registration with the Care Quality Commission (CQC).

The framework is structured around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection, which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning from incidents, complaints, root cause analysis (RCA) and observation of care audits continues to contribute to this programme.

2. Overall Objectives

- To sustain and further develop an enhanced programme to focus on promoting the ownership of infection prevention and control by all Trust employees.
- To provide assurance that the organisation is committed to a further reduction in the incidence of HCAIs.
- To meet our key performance targets agreed with commissioners and improve services year on year.
- To give patients, public and staff confidence in the organisations commitment to preventing HCAI's.

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users It is vital that there are clear lines of ownership and accountability for Infection Prevention and Control within the organisation. Ownership at a more local level will promote the engagement of clinical teams and therefore increase the commitment to infection prevention and control.					
Key lines of enquiry	**Evidence**	**Lead**	**Gaps in Assurance**	**Mitigating Action(s)**	**Date to be achieved / updated**
Systems and processes are in place to ensure:					
infection risk is assessed at the front door and this is documented in patient notes	eCare- COVID-19 & Sepsis. Assessment area/pathways. Includes all services: adult, maternity & paediatrics. Electronic flag visible to clinical staff prompting sepsis activity and or denoting HCAI (present and past). Open chart alert – identifying patient awaiting COVID result or positive. Available resource: IPC manual, AMS, on call/on site Consultant Micro & IPCT, PHE. Power BI COVID19 DASHBOARD.	Chief Clinical Information Officer/Chief Nursing Information Officer	eCare not live across all areas, e.g. paediatrics. Cerner “next build” (Phase C) continues to be explored by all relevant parties	Daily reports of COVID did include paediatrics	Complete
patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	Appropriate receiving area initiated at decision to admit. Subsequent transfer is undertaken via Step down/up criterion in place, reviewed 24/7 – includes patient presenting/altering condition, single room availability, speciality required. 24-hour senior presence (clinical and managerial to support process/risk)	Chief Operating Officer: Ops Lead, Clinical Site Managers / Bed Managers			

compliance with the national guidance around discharge or transfer of COVID- 19 positive patients	Discharge guidance/letters amended to reflect COVID activity and agreed/monitored by MKCCG – wide communication – includes transport/other healthcare providers. Screening/rescreening prompt on BI system (communicated daily by 08.00 to Trust Leads)	Chief Operating Officer	Frequency of mandatory update for non-clinical staff to be reviewed	Silver/Gold Command appraised of compliance / gaps	Complete
all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	Core element of IPC education for all disciplines of staff. Education, further training sessions tailored to staff shift patterns, bespoke to different services/exposure, return to practice, redeployment, return from self- isolation etc.	Chief Operating Officer	Ability to cover all areas and disseminate information to all members of staff	Introduction of a Trust WhatsApp Broadcast group for those who may not check emails and posters throughout Trust	Complete
national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	Posters and podcasts, daily updates via intranet and safety huddles via TEAMs. Signed off by Gold Command prior to any change communicated across hospital. 24/7 advice/reassurance available (acute user email/CEO letters) Comms working with the senior nursing team to disseminate messages to staff	Director of Corporate Affairs			
changes to guidance are brought to the attention of boards and any risks and	Signed off by Gold Command. Posters and podcasts, daily updates via intranet and safety huddles via TEAMs. Dedicated PPE store and team led by Transformation	Medical Director/ Chief Nurse/ Chief Operating Officer			

mitigating actions are highlighted	Gold command →Silver Regular reporting to Board				
Risks are reflected in risk registers and the board assurance framework where appropriate	Governance flow is robust with approval of IPC related risk assessments and documents pertaining to Covid to ensure consultation with relevant staff/departments and formal approval against the Trust's governance framework. The serious incident framework with weekly Serious Incident Review Group (SIRG) with multidisciplinary team representation to ensure formal review and approval of incidents and serious incidents in line with local and national governance frameworks. Oversight of all incidents reported on Datix by the Head of Risk & Clinical Governance and inbuilt Datix communications to ensure relevant incidents relevant with IPC Team audit database for registration of audits. Inclusion of IPC as standing agenda item in CSU governance reports/at meetings. As per business continuity plan Influenza and gastroenteritis screening not affected – containment measures exercised for patients admitted with transmissible infection.	Director of Corporate Affairs			
robust IPC risk assessment processes and practices are in place for non-COVID-19 infections and pathogens	Surveillance of reportable HCAI continues as per obligation. Thresholds set for 2020/21 – agreed by MK CCG.	Chief Nurse		All urgent, routine and referral services have continued except for	

	Daily review of all inpatients continues by IPCT via ECARE and Winpath.			limited urine microscopy (currently urgent request only) and detection of Giardia and Cryptosporidium	

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Key lines of enquiry	Evidence	Lead	Gaps in Assurance	Mitigating Action(s)	Date to be achieved / update
Systems and processes are in place to ensure:					
designated teams with appropriate training assigned to care for and treat patients in COVID-19 isolation or cohort areas	FIT test programme accelerated to capture all staff – compliance visible Electronic Staff Record (ESR) and eRoster Preparedness included adhering to level of PPE described for the area, Donning, Doffing and Disposal of PPE – posters, e-learning to support changes to national guidance/local stock requisition. Waste streams amended, Hand Hygiene products, availability, and access to, re-aligned in support of increasing frequency of hand hygiene. Medical, Nursing, Therapy and Midwifery Staff teams realigned to work with Covid/Non Covid where practicable.	Chief Nurse/ Medical Director/ Deputy Chief Executive: ADO Core Clinical Services: Hotel Services Manager/Teams			

designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to COVID-19 isolation or cohort areas	Domestic staff working in these areas trained on cleaning tasks with IPCT support. Staff allocation sheets.	Deputy Chief Executive: ADO Core Clinical Services: Hotel Services Manager/Teams	Training records specific to COVID-19 cleaning	New staff training package being developed with clear working instructions (SOPs).	
decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	Following decontamination visual check with handover to clinical staff carried out. Supported by IPCT	Deputy Chief Executive: ADO Core Clinical Services: Hotel Services Manager/Teams			
increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	Domestic/Support Staff from closed departments / wards utilised to support increased frequency of cleaning.	Deputy Chief Executive: ADO Core Clinical Services: Hotel Services Manager/Teams		Domestic hours adjusted as teams / departments move out/back into service	
attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	All toilet/bathroom cleaning carried out as per cleaning policy frequencies and responsibilities. Sufficient staffing in place to cover all areas by functional risk	Deputy Chief Executive: ADO Core Clinical Services: Hotel Services Manager/Teams			
cleaning is carried out with neutral detergent, a chlorine-	Cleaning is carried out with a neutral detergent. Two chlorine-based disinfectants used (area	Deputy Chief Executive: ADO			

based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses.	specific). Frequency is increased to reflect outbreak containment measures. All chemicals used in accordance with manufacturers' guidance, IPC, and H&S sign off. Formal cleaning audits and daily supervisory tasking carried out.	Core Clinical Services: Hotel Services Manager/Teams			
manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products	As above: All chemicals used in accordance with manufacturers guidance, IPC, and H&S sign off.	Deputy Chief Executive: ADO Core Clinical Services: Hotel Services Manager/Teams			
as per national guidance: • 'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids contaminated with	Core element of domestic education – subject to audit Winter cleaning programme in motion prior to COVID. In house domestic team, nursing, and midwifery responsibility Shared responsibility – domestic, nursing and midwifery (near patient equipment)	Deputy Chief Executive: ADO Core Clinical Services: Hotel Services Manager/Teams			

secretions, excretions or body fluids • electronic equipment, e.g. mobile phones, desk phones, tablets, desktops, and keyboards should be cleaned at least twice daily • rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily) • linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	In place for clinical and non-clinical areas Waste and linen pick up, cleaning of areas adjusted in line with service activity. All Staff aware of the need to keep the environment free of clutter and clean. Basic requirement of outbreak/transmission avoidance -	Deputy Chief Executive: ADO Core Clinical Services: Hotel Services Manager/Teams			
single use items are used where possible and according to single use policy	In place where possible	Deputy Chief Executive: ADO Core Clinical Services: Hotel Services Manager/Teams			
reusable equipment is appropriately	Stock levels shared daily	Deputy Chief Executive: ADO			

decontaminated in line with local and PHE and other national guidance	Visors/goggles – individual use – cleaned in between uses – disposed of if cracked or visibility compromised	Core Clinical Services: Hotel Services Manager/Teams			
review and ensure good ventilation in admission and waiting areas to minimize opportunistic airborne transmission	All wall mounted or ceiling cassette AC units to be switched off unless risk of high temperatures become greater than the risk of spreading infection – to be risk assessed area by operational area. Consideration of use of mobile ventilation aligned to HSE, NHSE&I and PHE national guidance against potential COVID-19 air transmission, which is captured in the Trust COVID-19 corporate risk register.	Deputy Chief Executive Officer / Head of Estates and Facilities	No national guidance on use.	All portable AC unit delivered to clinical areas are accompanied with infection control advice to ensure safety measures are taken i.e. cleaning regiment, with further H&S warning label.	
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance					
Key lines of enquiry	**Evidence**	**Lead**	**Gaps in Assurance**	**Mitigating Action(s)**	**Date to be achieved / update**
Systems and processes are in place to ensure:					
arrangements around antimicrobial stewardship are maintained	Antimicrobial Stewardship Group meet quarterly: Review of antimicrobial prescribing via audits as per pharmacy audit programme. ICD and Lead ICN core members of AMSG group	Medical Director as Chair	eCARE audit function	Prescribing audit reports to AMSG, IPCC, joint meetings	Quarterly

mandatory reporting requirements are adhered to and boards continue to maintain oversight	who monitor compliance in correct antimicrobial prescribing in support of meeting 50% improvement in appropriate usage by March 2021. Ward rounds undertaken by Consultant Microbiologist and Lead antimicrobial pharmacist – involves patient and medical team.			and CQUIN as evidence	

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion

Key lines of enquiry	Evidence	Lead	Gaps in Assurance	Mitigating Action(s)	Date to be achieved / update
Systems and processes are in place to ensure:					
implementation of national guidance on visiting patients in a care setting	All national guidance implemented with significant internal and external communications and engagement activity	Director of Corporate Affairs	Available in English only	Ability to translate hospital website to several other languages	
areas in which suspected or confirmed COVID-19 patients are being treated are clearly marked with appropriate signage and have restricted access	Floor plans/door signs			Images indicated the PPE required on all posters	

information and guidance on COVID-19 is available on all trust websites with easy read versions infection status is communicated to receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	As per national guidance – amended by comms team to support understanding/reduce anxiety			Ability to translate hospital website to several other languages	
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people					
Key lines of enquiry	**Evidence**	**Lead**	**Gaps in Assurance**	**Mitigating Action(s)**	**Date to be achieved / update**
Systems and processes are in place to ensure:					
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non-COVID-19 cases to minimise the risk of cross-infection, as per national guidance • mask usage is emphasized for suspected individuals • ideally segregation should be with separate spaces,	• ED is currently divided into Red Zone and Green Zone areas. Red Zone is for suspected COVID patients and has been separated by physical bearers. Green Zone is for patients for non-COVID attendances. The doctors and the nursing staff are regularly updated on PHE guidelines regarding COVID. • ED is following PHE guidelines. Any patient whose 'shielding' is provided masks on arrival or mask provided by ambulance crew if brought in by ambulance. Staff members are following National Guidelines regarding	Chief Operating Officer	There are no active gaps, however this is being reviewed regularly according to the PHE guidelines.	Continue to monitor systems and process to comply and adapt to change as per PHE guidelines. Regular education and communication is in place all Medical Staff	

but there is potential to use screens, e.g. to protect reception staff • for patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible • patients with suspected COVID-19 are tested promptly • patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced	PPE • Yes screens and also an indicative 2 m distance are being used at reception and streaming areas. Yellow lines are placed on the floor to meet social distancing requirements. Risk assessment of all ED areas in place. • Appropriate guidance is provided to patients with new-onset symptoms as per PHE guidelines and red flags symptoms are explained and safety net is in place. • All patients with suspected COVID/who are admitted to hospital are tested as per PHE guidelines. • Yes they are as per guidance issued by PHE			working in ED or any specialties coming in the ED.	
patients who attend for routine appointments and who display symptoms of COVID-19 are managed appropriately	As above	Chief Operating Officer			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

Key lines of enquiry	Evidence	Lead	Gaps in Assurance	Mitigating Action(s)	Date to be achieved / update
Systems and processes are in place to ensure:					
all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	Implemented new guidance on personal protective equipment (PPE) for NHS staff who are likely to encounter patients with COVID-19. As per the guidance agreed by the four UK Chief Medical Officers, Chief Nursing Officers and Chief Dental Officers and endorsed by the Academy of Medical Royal Colleges.	Director of Workforce/ Chief Nurse			
all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it a record of staff training is maintained	Yes – record maintained in ESR	Director of Workforce/ Chief Nurse			
appropriate arrangements are in place so that any reuse of PPE in line with the CAS alert is properly monitored and managed	Sessional use and reuse of personal protective equipment (PPE) considered only in the event of severe shortages of supply. 24/7 support in place to mitigate risk.	Director of Workforce/ Chief Nurse			

any incidents relating to the re-use of PPE are monitored and appropriate action taken	Daily sit rep of PPE supply V demand part of Silver discussions with escalation to Gold	Director of Workforce/ Chief Nurse			
adherence to PHE national guidance on the use of PPE is regularly audited	Using sit rep to inform level of risk – guide activity to resolve.				
staff regularly undertake hand hygiene and observe standard infection control precautions	Review of areas/numbers undertaken – switch to paper towel dispenser and bin in progress	Chief Nurse			
hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	Hand drying regimen to be added to the “how to wash hands” Paper towels available in toilets	Chief Nurse			
guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as	As above	Chief Nurse			

staff areas					
staff understand the requirements for uniform laundering where this is not provided on site	In place, covered in CEO letter, intranet COVID-19 and uniform and dress code	Chief Nurse			
all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance, if they or a member of their household displays any of the symptoms	Daily surveillance of staff fed up to Gold via Silver command. Please see SHWB entry.	Chief Nurse/ Medical Director/ Chief Operating Officer			
7. Provide or secure adequate isolation facilities					
Key lines of enquiry	**Evidence**	**Lead**	**Gaps in Assurance**	**Mitigating Action(s)**	**Date to be achieved / update**
Systems and processes are in place to ensure:					
patients with possible or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	Compliance/Safety and all associated risk reviewed 24/7.	Chief Operating Officer			
areas used to cohort patients with possible or confirmed COVID-19 are compliant with	Appropriate use of bed stock/patient movement part of daily assurance via Silver command – signed off by Gold.	Chief Operating Officer			

the environmental requirements set out in the current PHE national guidance					
patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Electronic bed board interrogated x 2 daily by IPC to ensure isolation/containment met for these patients	Chief Operating Officer			
8. Secure adequate access to laboratory support as appropriate – (Cambridge, Oxford reference laboratories)					
Key lines of enquiry	**Evidence**	**Lead**	**Gaps in Assurance**	**Mitigating Action(s)**	**Date to be achieved / update**
Systems and processes are in place to ensure:					
testing is undertaken by competent and trained individuals patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance screening for other potential infections takes place	All laboratory staff trained to process high risk specimens. In-house COVID19 test not available yet. Cambridge laboratory used in the first few weeks, switching to Oxford as demand increased 24 – 36 hours turnaround time Sepsis screening for or management of not affected	Clinical Director - Pathology	Turnaround time can fluctuate due to high demand	High suspicion/CT/ Blood picture – patient remains isolated with staff in full PPE	
In addition: The water quality is monitored in the Trust to	Water quality testing is undertaken as per national testing regimes and results reported/escalated as	Water Safety Group supported by the Consultant		IPCC Minutes Water safety group minutes	Quarterly

ensure it meets national standards and requirements	required, providing Trust assurance of water standards Compliance with national standards minimising risk of infection transmission Non-compliant results reported immediately, and action taken to safeguard patients, staff, and visitors made evident with completion timescales.	Microbiologist / Infection Control Doctor			
9. Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control infections					
Key lines of enquiry	**Evidence**	**Lead**	**Gaps in Assurance**	**Mitigating Action(s)**	**Date to be achieved / update**
Systems and processes are in place to ensure:					
staff are supported in adhering to all IPC policies, including those for other alert organisms any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff all clinical waste related to confirmed or possible COVID-19 cases is handled, stored	Core element of IPC education As before: wide communication using a variety of strategies to ensure the message is heard, understood, and implemented by all	Director of Workforce/ Director of Corporate Affairs/ Deputy CEO			

and managed in accordance with current national guidance					
PPE stock is appropriately stored and accessible to staff who require it	Transformation team took on the role of the PPE team which included storage, distribution, review of products, stock control, linking with key stakeholders: procurement, IPCT, senior nursing team, Practice Development and the Divisions meeting the obligation of Health & Safety Executive under the Personal Protective Equipment Regulations 2002 and The Personal Protective Equipment at Work Regulations 1992 as amended.	Finance Director			
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection					
Key lines of enquiry	**Evidence**	**Lead**	**Gaps in Assurance**	**Mitigating Action(s)**	**Date to be achieved / update**
Systems and processes are in place to ensure:					
staff in 'at-risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported	At risk policy, flowchart, and assessment form (all users emails; newsletter and intranet) Updates as new guidance is released. Daily at-Risk Panel outcomes and spreadsheet. Minutes of staff side meetings/consultations Spreadsheet: emails to managers auditing compliance with outcomes Redeployment group Sources of psychological support issued in all users' emails, newsletter, and intranet)	Director of Workforce			
staff absence and wellbeing are monitored	Helpline for staff to report symptoms, seek advice and book testing	Director of Workforce			

and staff who are self-isolating are supported and able to access testing staff who test positive have adequate information and support to aid their recovery and return to work	Daily testing schedule Daily welfare calls to those off sick/self-isolating Sources of support promoted through helplines, intranet etc COVID absence recorded separately Daily statistical reports of the above Management of sickness absence (policy, referrals to SHWB)				
staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	As before	Chief Nurse/ Medica Director/ Director of Workforce			
consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	Skill mix/staff allocation tailored to meet service need, isolation requirement and outbreak avoidance. Rotas interrogated/flexed as staffing numbers affected by self-isolation/absence due to COVID19.	Chief Operating Officer			

all staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	We introduced our 'Be Smart, Stay Apart' campaign to prompt staff, visitors, and patients to maintain a safe two metre distance between people from other households. Staff are expected to set an example to members of the public and adhere to the two metre distance rules wherever possible. Wipeable floor stickers and banners installed to promote the campaign.	Chief Operating Officer/ Director of Workforce/ Director of Corporate Affairs			
consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	Access/use of Restaurant and shop on site adjusted to meet the distancing where able – suspension of public/patient use in place.	Chief Operating Officer			

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Board of Directors**	**Date: 2 July 2020**
Report title:	**Use of Trust Seal**	**Agenda item: 7.1**
Lead director **Report author** **Sponsor(s)**	**Name: Kate Jarman** **Name: Alison Marlow**	**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 May2020						

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

Report history	None
Next steps	None
Appendices	

Use of Trust Seal

1. Purpose of the Report

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

2. Context

The Trust Seal was executed on:

- 14 May 2020 for the contract for the Redevelopment of Pharmacy

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Agenda item 7.2
Public Board 02/07/20

Meeting of the Finance and Investment Committee held on 1 June 2020

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

No matters were approved by the Committee.

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 month one

The Committee discussed the operational performance of the Trust in month one, noting the significant impact of covid-19 on the organisation. It was agreed that given the significant changes in activity volumes, the impact of covid-19 on waiting times, and on changes in operational productivity compared to pre-covid-19 levels, that remodelling of trajectories (including financial measures) would be undertaken over the next 6-8 weeks.

2. Board Assurance Framework

The Committee discussed the BAF, noting the significant impact of covid-19 and changes in the financial regime on several of the BAF items. The Committee asked the Director of Finance, supported by colleagues, to update the risks in light of covid-19 and the uncertainty about the financial regime.

3. Finance Report M1

The Director of Finance highlighted the difficulties of reporting in the current climate and outlined the two summary tables that reflected 1) the central NHS Improvement modelling of expected costs for the organisation; and 2) the original internal plan. He highlighted that in accordance with the national modelling, the Trust is receiving a financial top-up to allow the Trust to deliver a breakeven position.

4. Agency update

The Director of Finance noted that there had been a reduction in agency spend in April 2020 which reflects changes in rotas which increased the clinical cover provided by the Trust's substantive staff in response to covid-19.

5. BLMK ICS Provider Capital Control Limits

The changes in the capital regime that require systems (STPs/ICSs) to operate within a capital limit were presented to the Committee. The Director of Finance noted that the changes meant that the Trust's capital plan could not be delivered in full, requiring instead the Trust to limit capital spend by £6m compared to original plans.

Milton Keynes University Hospital NHS Foundation Trust

Agenda item 7.2
Public Board 02/07/20

Meeting of the Quality & Clinical Risk Committee held on 22 June 2020

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

No matters were approved by the Committee.

Matters referred to the Board for final approval:

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

Summary of matters considered at the meeting:

Post Covid-19 re-establishment of services, particularly elective
Preparedness for the next Covid-19 wave
Impact of Covid-19 on waiting lists
PPE
Board Assurance Framework - resilience of the hospital during Covid-19
Positives from Mat/Neo project
Assurance from Obstetric & Gynaecology Consultants
Patient experience/pressure ulcer meeting to be convened with NBM and nursing team
Learning from Covid-19
Gradual cultural shift on quality improvement

1. Quarterly highlight report
   All items were directly or indirectly Covid-19 related with particular challenges around

   - Responding to large volumes of government guidance and adapting internal communications
   - PPE supplies in relation to increasing surgical activity and the requirement for all staff to wear face masks
   - The impact on nursing teams of establishing separate areas and patient pathways for suspected Covid-19 and non-Covid-19 cases
   - The difficulties of separating ITU (Intensive Therapy Unit) into red (Covid-19) and green (non-Covid-19) areas.

   It was reported that ITU (Ward 6) has decanted to Day Surgery enabling estates work of around £400k to be undertaken on Ward 6 which should be ready by the autumn and will maintain an enhanced degree of Covid-19 resilience.

   Numbers of potential Covid-19 patients has recently increased following a few weeks of low numbers. All patients are tested on admission and time to receipt of test results was discussed. The approach to staff testing evolves and the organisation is participating in Public Health England antibody testing with between 250 and 300 staff tested daily. The

Committee considered the aspects of staff competency and staff fatigue in relation to the organisation's ability to respond to another spike and it was confirmed that staff are participating in discussions on how to manage these issues, including anxiety over childcare throughout the summer holidays.

Operationally, there is an assumption nationally that theatre efficiency is expected naturally to reduce by 30-50% and some specialties will need to adapt their practices more radically than others. Referral rates have not returned to normal levels having dropped by up to 80% in April and some patients have elected not to have treatment at all while some have deferred treatment for the time being. The Trust has been asked to set out capital requirements to return to normal and proposals of circa £50m have been put forward.

Patient visiting is expected to begin again shortly and it was explained that during the pandemic patients have been encouraged to use electronic devices to stay in touch with friends and family.

2. Quality and clinical risks on the Board Assurance Framework
   It was acknowledged that risks have been managed and regularly discussed throughout the pandemic. And the BAF will be the focus of a detailed discussion at Board Seminar in July.

3. Quality dashboard
   The increase in NICE breaches was highlighted and it was explained that NICE guidance is produced in batches meaning that the number of breaches fluctuates. The continuing focus on discharge processes to reduce length of stay was also noted.

4. Quarterly Trust wide progress report on serious incidents
   Two cases of patients who died from pulmonary embolism were highlighted with one of these relating to a potential misdiagnosis due to an assumption the patient was Covid-19 positive. Pressure ulcers predominantly related to heels were discussed and a detailed discussion with the senior nursing team was proposed.

5. Mortality report
   It was reported that Summary Hospital-level Mortality Indicator (SHMI) had moved into an adverse position and three reasons were put forward to explain this.
   - Poor capture of comorbidity information since the implementation of eCARE
   - The quality of data reviewed which equates to the first two of potentially 15 spells of a patient's care
   - Recording of outpatients seen in inpatient settings but coded as admissions on the national system but with no coded diagnosis. This is being addressed but will take time to resolve

   Assurance is provided by the role played by medical examiners that there is nothing of additional concern underlying this trend.

6. Patient Experience Quarter 4 report
   In the absence of nursing representation, a separate meeting with the nurse management team will be convened to discuss the content of the report.

7. Clinical quality updates and minutes
   Minutes were noted from

- Patient Safety Board from 29 April 2020
- Patient Experience Board from 13 May 2020

8. Exception reports

The organisation's involvement in the 2019/20 MatNeo project in maternity was presented by the Lead Midwife for Risk and Quality Improvement and the Lead Nurse for the Neonatal Unit who spoke of their quality improvement journey and the issues they had overcome and their successes.

The Clinical Management Team for Obstetrics & Gynaecology fed back on their efforts to change the culture within the specialty following training concerns. They described how they are fostering good commitment towards, and motivation to support, the trainees. The Committee requested an analysis of serious incidents and poor outcomes at night is undertaken as part of a review into the impact of current night staffing arrangements.

9. Proposed Screening Programme Board

The proposed Board will oversee and monitor the five screening programmes commissioned by Public Health England.

10. Annual Reports

The Committee received and considered the following reports

- Clinical Audit
- Falls
- Pressure ulcers
- Research & Development
- Claims

Discussions included the following.

It was explained that clinical audit is governed through the Clinical Audit & Effectiveness Board. Statutory audits are the primary focus for the organisation.

It was agreed that the Board would explore how the executive team seeks assurance on falls. It was highlighted that the Trust is working with the Clinical Commissioning Group on a CQUIN (Commissioning for Quality & Innovation) of no monetary value to address the issue of falls on Ward 18 with the expectation that mitigating measures will be rolled out across the Trust in due course.

The pressure ulcer report will be included in the discussion with the nurse management team.

An overall increase in claims was noted but these are not necessarily Covid-19 related.

Agenda item 7.2
Public Board 02/07/20

Meeting of the Audit Committee held on 22 June 2020

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

The Counter Fraud plan for 2020/21 and write offs detailed in the Financial Controller report were approved by the Committee.

Matters referred to the Board for final approval:

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

Matters considered at the meeting:

Progress with Internal Audit and Counter Fraud planning work was noted

1. Internal Audit
   The 2020-22 plan was presented and the Committee agreed the levels of flexibility within the plan in light of the potential impacts of Covid-19.

   The progress report was discussed with particular reference to the Cyber Essentials Security Review where 19 open actions are near closure.

   The action tracking report was discussed and the Committee informed that the Management of Conflicts of Interest actions are expected to be closed by the next meeting. It was agreed that the report was largely positive and this was felt to be due to the culture of engagement coupled with good management support.

2. Annual clinical audit report 2019/20
   The Committee was advised that while clinical audit is improving continuing focus is needed particularly on statutory audits.

3. Counter Fraud
   The 2020/21 plan was presented and the planned review of overseas visitors to assure on awareness throughout the Trust was highlighted. Also of note was the National Fraud Initiative adapted to take into account fraud related to the Covid-19 pandemic. The plan was approved by the Committee recognising that it will be subject to change in view of the changing environment.

4. Financial Controller Report
   Discussion points from the report included:

- Salary over-payments pursued by Counter Fraud. An action to establish whether professional registration bodies are informed where formal proceedings prove necessary
- Losses and special payments in relation to pharmacy which will be discussed with the department
- Credit notes and tender waivers where assurance was provided that requests for the latter were scrutinised to assess and ensure value for money

Write offs were approved.

5. It was agreed that Audit Committee BAF risks would undergo a review at the Board in Seminar in July

6. The Health & Safety report for Quarter 4 of 2019/20 was reviewed and the high incidence of violence and aggression was discussed. It was agreed that this will be reviewed in 6 months' time after mitigations have been rolled out and a benchmarking exercise has been completed.

Agenda item 7.2
Public Board 02/07/20

Meeting of the Charitable Funds Committee held on 10 June 2020

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

There were no matters approved by the Committee.

Matters referred to the Board for final approval:

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

Matters considered at the meeting:

1. Fundraising update
   Local and national support had been overwhelming over the last few months and the function of the fundraising team changed dramatically as a result, as they undertook logistics planning, sourced accommodation and forged greater links with teams throughout the hospital. All donations have been recorded and will be declared as per requirement. The team are committed to ensuring funds are spent appropriately in areas for which they were donated such as refurbishment of staff rooms. Plans include purchase of additional devices to help patients to maintain contact with friends and family. Further grants have been applied for and more detail will be shared with the Committee when available. The fundraising team were thanked and congratulated for embracing the functional changes required whilst maintaining good governance.

2. Charitable funds finance updates
   - Just under £400k was received in year towards the Cancer Centre Appeal which is £500k adverse to plan. The Committee supported the proposal to merge remaining funds with non-appeal funds on the proviso that a 'lessons learned' log would be shared at the next meeting to guide future appeals
   - With regard to non-appeal funds, year end figures and planned income for 2019/20 were in line with the previous 3 years.
     - The detrimental effect of the Cancer Centre Appeal was noted.
     - It is difficult to predict what will happen over the next six months as all events have been cancelled for the rest of the year but it is anticipated that income for 2020/21 will be lower than last years and the next two years will be very challenging. In light of this it was felt that the Charity Strategy should be reassessed to optimise the use of available resources
     - Non-appeal targets and forecast for 2020/21 will be shared at the next meeting and the Committee will consider the form and shape of the charity going forward

3. Arts for Health funding
   It was proposed that the arrangement with Arts for Health, who receive an annual grant from the Trust to deliver its art programme and who also curate some of the courtyards, is formalised. Value for money and impact reporting processes will be put in place and a regular breakdown of expenditure provided to the Committee. A paper on other options to deliver the art programme will be presented to the next Committee.

4. Charitable Funds risk on the Board Assurance Framework
   The risk was noted.

5. The charity's accounts will be circulated for comment in July