Board of Directors
Public Meeting Agenda

Meeting to be held at 10am on Thursday 06 May 2021 remotely via Teams in line with social distancing

Item No.	Title	Purpose	Type and Ref.	Lead
1. Introduction and Administration				
1.1	Apologies	Receive	Verbal	Chair
1.2	Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda	Noting	Verbal	Chair
1.3	Minutes of the meeting held in Public on 11 March 2021	Approve	Pg. 4	Chair
1.4	Matters Arising	Receive	Verbal	Chair
2. Chair and Chief Executive Strategic Updates				
2.1	Chair's Report	Receive and Discuss	Verbal	Chair
2.2	Chief Executive's Report	Receive and Discuss	Verbal	Chief Executive
3. Quality				
3.1	Patient Story	Receive and Discuss	Presentation To Follow	Director of Patient Care and Chief Nurse
3.2	Maternity Staffing Update	Receive and Discuss	Pg. 11	Director of Operations
3.3	Incident, Improvement and Learning Report	Receive and Discuss	Pg. 15	Medical Director/ Director of Corporate Affairs
3.4	Nursing Staff Update	Receive and Discuss	Pg. 25	Director of Patient Care and Chief Nurse
4. Workforce				
4.1	Workforce Report Month 12	Receive and Discuss	Pg. 32	Director of Workforce
4.2	2020 Staff Survey Report	Receive and Discuss	Presentation To Follow	Director of Workforce
4.3	Annual Report on Clinical Excellence Awards	Receive and Discuss	Pg. 38	Medical Director

Item No.	Title	Purpose	Type and Ref.	Lead
5. Performance and Finance				
5.1	Performance Report Month 12	Receive and Discuss	Pg. 43	Deputy Chief Executive
5.2	Elective Performance Update	Receive and Discuss	To Follow	Deputy Chief Executive
5.3	Finance Report Month 12	Receive and Discuss	Pg. 44	Director of Finance
6. Strategy and Investment				
6.1	BLMK ICS Strategic Priorities	For Ratification	Pg. 54	Chief Executive
7. Assurance and Statutory items				
7.1	Significant Risk Register	For Information	Pg. 59	Director of Corporate Affairs
7.2	Board Assurance Framework	Receive and Discuss	Pg. 78	Director of Corporate Affairs
7.3	(Summary Reports) Audit Committee – 23 March 2021	For Information	Pg. 138	Chair of Committee
7.4	(Summary Reports) Finance and Investment Committee – 29 March 2021	For Information	Pg. 139	Chair of Committee
7.5	(Summary Report) Charitable Funds Committee – 22 April 2021	For Information	Pg. 140	Chair of Committee
7.6	(Summary Report) Quality and Clinical Risk Committee – 23 March 2021	For Information	Pg. 141	Chair of Committee
7.7	(Summary Report) Workforce and Development Assurance Committee – 21 April 2021	For Information	Pg. 142	Chair of Committee
7.8	Use of Trust Seal	Ratify	Pg. 144	Director of Corporate Affairs
8. Administration and Closing				
8.1	Questions from Members of the Public	Receive and Respond	Verbal	Chair
8.2	Motion to Close the Meeting	Receive	Verbal	Chair

Item No.	Title	Purpose	Type and Ref.	Lead
8.3	Resolution to Exclude the Press and Public	Approve	Resolution to Exclude the Press and Public The Chair to request the Board pass the following resolution to exclude the press and public and move into private session to consider private business: “That representatives of the press and members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted	

BOARD OF DIRECTORS MEETING

Minutes of the Public Trust Board of Directors Meeting held on Thursday, 11 March 2021 at 10.00 hours via Teams

Present:		
Alison Davis	Chair	(AD)
Professor Joe Harrison	Chief Executive	(JH)
Andrew Blakeman	Senior Independent Director / Non-Executive Director	(AB)
Heidi Travis	Non-Executive Director (from 11.15am)	(HT)
Helen Smart	Non-Executive Director	(HS)
Nicky McLeod	Non-Executive Director	(NMc)
Haider Husain	Non-Executive Director	(HH)
John Lisle	Non-Executive Director	(JL)
John Blakesley	Deputy Chief Executive	(JB)
Dr Ian Reckless	Medical Director & Deputy Chief Executive	(IR)
Terry Whittle	Director of Finance	(TW)
Danielle Petch	Director of Workforce	(DP)
Nicky Burns-Muir	Director of Patient Care and Chief Nurse	(NBM)
Emma Livesley	Director of Operations	(EL)

In attendance:		
Dr Luke James	Associate Non-Executive Director	(LJ)
Kate Jarman	Director of Corporate Affairs	(KJ)
Sally Burnie	Head of Cancer Services and Lead Cancer Nurse (For item 3.1)	(SB)
Samantha Timmins	Advanced Nurse Practitioner, Cancer (For item 3.1)	(ST)
Philip Ball	Freedom to Speak Up Guardian (For item 3.6)	(PB)
Alice Fiancet	Communications Officer	(AF)
Kwame Mensa-Bonsu	Trust Secretary (Minutes)	(KMB)

1 Welcome

1.1.1 AD welcomed all present to the meeting.

1.2 Apologies

1.2.1 There were no apologies.

1.3 Declarations of interest

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

1.4 Minutes of the meeting held on 14 January 2021

1.4.1 The minutes of the Public Board meeting held on 14 January 2021 were reviewed and **approved** by the Board.

2.1 Chair's Update

2.1.1 AD expressed her appreciation for the warm welcome which had been extended to her from all colleagues since she joined the Trust in February 2021. AD noted she had been conducting meetings with several individuals, and had also chaired a Consultant Appointment Panel which had been very informative. AD stated that she had also attended a meeting organised by the Bedfordshire, Luton and Milton Keynes Integrated Care System (BLMK ICS), and had on 08 March 2021, participated in the International Women's Day.

The Board **noted** the update.

2.2 Chief Executive's Update

2.2.1 JH welcomed the Chair to her first Public Board meeting, and wished her a successful tenure as Chair of the Trust Board. JH also welcomed TW to the Trust, and to his first Public Board meeting as the substantive Director of Finance. JH referenced a localised flooding incident in February 2021, and stated that a mains water pipe had burst during development work at the hospital. JH thanked Anglian Water and the Trust's Estate Team for helping restore the Trust's water supplies, and noted that patients had been unaffected by the incident. JH referenced an IT system outage in March 2021, and noted that this had also been resolved by the IT Team without patient care being impacted.

2.2.2 JH stated that the eCARE, the hospital's new electronic patient record system, was having a transformative effect on patient care, and noted that patients were receiving letters on their future clinical care on their electronic devices before they had even left the hospital's grounds. JH stated that over 70k patients had so far received clinical letters electronically instead of via the post, and this number would continue to grow.

2.2.3 JH informed the Board that the Trust had been very well represented at the International Women's Day event, and added that with a 50:50 gender parity on the Board, the Trust was punching well above its weight. The Chair noted that, though a lot of work still needed to be done around the advancement of women, the event had been very encouraging due to the progress which had been achieved in the Trust. JH noted the presence of KMB at his first public meeting, and welcomed him to his role as the Trust's Company Secretary.

2.2.4 JH advised that the Trust had commenced elective care activity, and were providing treatment for the most urgent patients with a plan to increase activity from April 2021. JH stated that, in relation to the COVID-19 pandemic, 47 COVID-19 patients were identified on admission, while the Trust had progressed significantly with the COVID-19 vaccination programme having vaccinated 20k people. JH advised that the cohort of people who were currently being provided with the COVID-19 vaccine were those with underlying health conditions from the 18 to 64 year age range. In response to HS's query around the future of the Trust's vaccination programme, JH stated that this would close at the end of March 2021 and the capacity transferred to the public vaccination programme in the centre of Milton Keynes. HS congratulated the Trust for being able to provide 20k people with the COVID vaccine.

The Board **noted** the update.

3 Quality

3.1 Patient Story

3.1.1 ST presented the story, which highlighted the significant improvement in the experience of patients since the Cancer Centre was opened in March 2020. ST stated that the results of a National Patient Survey, which had placed the Trust in the bottom 10 nationally for cancer care, had shown the organisation that it needed a modern centre to improve the experience of its cancer patients. ST advised that the Centre had enabled the Trust to improve patient experience through the provision of, among others:

- A clean, bright and spacious environment
- All Cancer services under one roof
- Purpose-built rooms
- Closer working with ward 25
- On site pharmacy.

3.1.2 IR noted that next to the Cancer Centre was a car park which was the planned site for a radiotherapy building, and this needed to be developed as soon as possible. AD stated that she planned to visit the Cancer Centre to meet the staff, and thanked them for the actions they took in response to the COVID-19 pandemic while continuing with the provision of cancer care.

The Board **noted** the patient story.

3.2 Serious Incident (SI) Report

3.2.1 IR presented a report which provided an overview of the types of SIs reported in January and February 2021, the trends and a brief summary of linked programmes of work in response to the incidents. IR stated that the reporting format was developed in response to a recommendation in the December 2020 Ockendon Report which asked NHS providers to be transparent in their reporting of SIs. IR advised that though the incidents have been designated as "Significant", some may be downgraded after investigations had been concluded.

3.2.2 IR noted that of the 19 SIs, 8 of them had occurred at various points on the Maternity pathway, which did not indicate that there should be concerns about any particular point on the pathway. IR stated that all 6 babies, involved in the Maternity pathway incidents, were safe and well at home with their mothers. In response to HS's query around the 4 pressure ulcer SIs, NBM stated that these had occurred in areas where there had been previous incidents and more corrective steps were being undertaken to ensure staff understood the need to provide better patient care. NBM added that the Tissue Viability Nurse had returned to their own practice, after redeployment during the peak of the pandemic, and was providing pressure ulcer prevention training and circulating lessons to the various teams.

3.2.3 In response to AB's query around the process for reporting incidents, IR stated that though the rate of reporting was middle of the pack in comparison to peer NHS providers, the practice was to encourage staff to report all incidents on Datix. IR added that the preference of the Trust was to have lots of incidents to be reported and for SIs to be low. IR advised that in terms of the management of SIs, incidents which caused harm were robustly reviewed at weekly multidisciplinary Serious Incident Review Group (SIRG) meetings. IR stated that staff presented draft root cause analyses (RCAs) reports into these incidents for members of the SIRG to review and determine whether they were SIs or not. IR added that SIRG also took steps to ensure that the action plans of the RCAs they approved were implemented and embedded in practice. SIRG also reviewed incidents with moderate harm, and duty of candour letters forwarded to the patients involved.

3.2.4 In response to JL's query around incidents related to the Ophthalmology pathway, IR advised that a full investigation was being undertaken and the results of that would be submitted to the Quality and Clinical Governance Committee. NBM stated that the Trust was a learning organisation, and this attitude was exhibited at SIRG meetings, where the reviews, discussions and debates were challenging, honest and robust. HS advised that she had in the recent past followed the governance process for SIRG, and had found it to be assuring because it was appropriately robust and constructive.

The Board **noted** the SI report.

3.3 Nursing Staffing Report

3.3.1 NBM presented the report and highlighted the following:

- The Trust had, out of a requirement to fill 61 whole time equivalent (WTE) Healthcare Support Worker (HCSW) posts, recruited 60 WTEs since January 2021;
- The Trust was taking comprehensive steps to recruit staff to fill 70 WTE Band 5 vacancies;
- The Trust had recruited 3 international nurses, with a decision to be made in May 2021 if more international recruits were needed.
- The Trust was taking steps to invest in senior clinical leadership with a plan to ensure that each inpatient ward had a Band 6 Nursing Sister on every shift. The aims were to, among others, enhance patient experience, safety outcomes and to provide an in-house career development opportunity for Staff Nurses.

3.3.2 In response to NMc's query around the availability of mentors for the new recruits, NBM stated that applicants for the Band 6 leadership roles would most likely have undergone a development programme and so would need minimal transitional mentoring. NBM added that the Senior Sisters would from March 2021 return to being supernumerary, which would ensure that any new recruits received the level of mentorship required to adapt to the practices and standards of the hospital. It was noted that the Senior

Sisters had come out of being considered supernumerary as they were needed to support the wards during the peak of the COVID-19 pandemic.

The Board **noted** the Nurse Staffing report.

3.4 Responses to the Ockenden Report: Assessment and Assurance Tool

3.4.1 NBM informed the Board that the Trust had submitted its self-assessment and was awaiting the assessment of it from the Regional Team. The Regional Team's assessment would inform the Trust of any follow-up actions which needed to be undertaken.

The Board **noted** the update.

3.5 Safeguarding Children and Young People Update

3.5.1 NBM presented the Safeguarding update and stated that the safeguarding referrals had altered in pattern and complexity since the onset of the COVID-19 pandemic. The pandemic had also altered the access children and young people had to spaces outside of their homes, increasing vulnerability and impacting access to social support and connections. NBM stated that the Trust had worked with partners during the year to address and manage the Safeguarding risks presented by the COVID-19 pandemic. NBM noted that the Safeguarding Team had since December 2020 been asked to support the COVID-19 vaccination programme, which had significantly increased the pressure on them to maintain the service provision.

3.5.2 HS expressed concern that the Safeguarding Team was under pressure to maintain the service provision and enquired if steps were being taken to resolve this. NBM advised that she had had a conversation with the CCG's Chief Nurse about the challenge, and the interaction would continue till a solution was found. In response to HH's query around support tools for the Safeguarding Team, NBM advised that several policies had been completed recently to ensure that they had the necessary support. NBM added that the Safeguarding Team also utilised apps for the young people in their care, to help those young people keep themselves safe.

The Board **noted** the update.

3.6 Freedom to Speak Up (FTSU) Guardian - 2020/21 Annual Report

3.6.1 PB presented the annual report and advised that the FTSU Guardian Team had grown in number over the year from 1 to 7, and added that they had also resolved 6 cases in that period. In response to HH's query around BAME representation on the FTSU Guardian Team, PB stated that there were 2 members from BAME backgrounds, but steps were being taken to recruit more.

3.6.2 DP congratulated PB for taking up the Guardianship role and working to continue raising its profile in the Trust. KJ noted that the growing staff networks and peer to peer support groups would help staff gain the confidence to speak up and that would only help to support the function of the FTSU Guardian. AD on behalf of the Board, thanked PB for the effort he had put into raising the profile of the FTSU Guardian role in the Trust.

The Board **noted** the annual report.

4 Performance and Finance

4.1 Performance Report Month 10

4.1.1 EL presented the report and advised that it had been prepared when COVID-19 infections were at its highest peak in January 2021. EL highlighted the following:

- The percentage of ambulance handovers to the Emergency Department taking more than 30 minutes, which improved to 8.6% in January 2021, had continued to improve;
- Elective activity had been restarted;

- A recovery plan had been developed to increase activity and remove the backlog of patients who had waited longer than 52 weeks without being treated.

The Board **noted** the Month 10 Performance Report.

4.2 Finance Paper Month 10

4.2.1 TW thanked Board members for the welcome that had been afforded him and presented the Month 10 Finance Report. TW noted the noted the following:

- The Trust reported positive variance of £196k against a planned deficit of £762k;
- The negative YTD position of £5,994k included an in-month adjustment to the untaken annual leave accrual of £5,914k;

JH noted that, as a result of the NHS's response to the COVID-19 pandemic, all NHS providers had been financially impacted by their staff's inability take annual leave as required.

The Board **noted** the Month 10 Finance report.

4.3 Workforce Report Month 10

4.3.1 DP presented the Workforce Month 10 report and highlighted the following:

- The vacancy rate has reduced slightly to 12.2% in month but remained higher than expected;
- Recruitment activity in the Trust was progressing as expected;
- In terms of staff sickness, 31 members of staff were off sick with COVID-19 as of 11 March 2021;
- Statutory and mandatory training compliance and appraisals compliance rates were at 95% and 92% respectively;
- The Trust's vaccination programme had provided 20k staff and members of the public with the first doses of the COVID-19 vaccine. The programme had progressed to providing second doses of the COVID-19 vaccine to eligible people.

The Board **noted** the Month 10 Workforce report.

4.4 Staff Health and Wellbeing Report

4.3.1 DP presented the report which provided a summary of the support available to staff throughout the COVID-19 pandemic. DP advised that the Trust had also launched a '12 Weeks of Wellness' programme and other initiatives to support the Trust's workforce as it recovered from the impact of the pandemic. The Trust was also taking steps to develop some initiatives to provide mental health and physical support for the members of staff suffering from the effects of "long" COVID.

4.3.2 JH commended DP and her directorate for epitomising the Trust's response to the COVID-19 pandemic. The HR Directorate had played an excellent part in helping the Trust to progress with the vaccination programme. In response to HT's query around the impact of "long" COVID, DP advised that the support provided included adjustments so recovering staff could return and contribute to the Trust.

The Board **noted** the report.

5 Strategy and Investment

5.1 Revised Estates Strategy: 2020 – 2025

5.1.1 JB presented the Trust Estates Strategy, which had been revised to reflect all the key changes and requirements since it was approved by the Board 2018. The key changes included the development of a BLMK ICS Estates Strategy, a Health Infrastructure Plan, and the requirement to develop an energy strategy which would help the Trust achieve its environmental and net zero carbon targets. The revised strategy was approved at the Private Board meeting in February 2021.

The Board formally **approved** the revised Trust Estates Strategy.

6 Assurance and Statutory Items

6.1 Significant Risk Register

6.1.1 KJ presented the Significant Risk Register and advised the Risk Team was taking steps to comprehensively review it.

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

6.2 Board Assurance Framework (BAF)

6.2.1 KJ presented the BAF and advised that KMB had taken over the monthly reviews of the document. JL suggested that the process for transferring risk entries to the BAF needed to be clarified. KJ advised that Board members would have an opportunity to review the BAF in May 2021.

The Board **noted** the BAF.

6.3 Summary Reports for the Finance and Investment Committee – 11 January 2021, 01 February 2021 and 01 March 2021

6.3.1 The Board **noted** the reports.

6.4 Summary Report for the Charitable Funds Committee – 18 February 2021

6.4.1 The Board **noted** the report.

6.5 Summary Report for the Quality and Clinical Risk Committee – 22 February 2021

6.5.1 The Board **noted** the report.

6.6 Summary Report for the Workforce and Development Assurance Committee – 20 January 2021

6.6.1 The Board **noted** the report.

6.7 Use of Trust Seal

6.7.1 The Board **noted** the report.

7 Administration and Closing

7.1 Questions from Members of the Public

7.1.1 David Tooley, a local reporter asked whether there is any cause for concern over the number of SIs that involved babies and the hospital's maternity services, what the underlying causes of the SIs were.

IR provided the response below:

In all six incidents reported by the maternity and neonatal departments across the last two months, the mothers and babies involved were well and at home. The incidents were unrelated, and there were no apparent links to any individual member of staff or team.

In three of the cases, the challenges of delivering care with reduced face-to-face contact on account of COVID-19 may have partially contributed to a failure to follow to the letter an element of our relevant protocol for dealing with complex cases.

The patients and families involved in these incidents were all aware that they have been reported as serious incidents, and have received copies of investigation reports, have had the opportunity to meet clinicians to discuss what happened, and have received an apology for what went wrong during their care and what we were doing to prevent it happening again.

8 Any Other Business

The meeting closed at 12.10 am.

Midwifery workforce and staffing paper

1 Purpose

This paper outlines the current midwifery workforce establishment staffed to deliver maternity services at Milton Keynes University Hospitals NHS Trust (MKUH). The paper also identifies additional staffing requirements as detailed in the Ockendon Review of Maternity Services 2021.

The review of the maternity workforce formulates part of the reporting requirements of the maternity incentive scheme. The Trust is expected to submit this review to the BLMK Local Maternity and Neonatal System (LMNS) and NHSE/I in May 2021.

2 Background

The maternity staffing model has been managed historically using a flexible approach. Midwives often rotate across maternity services to ensure the midwifery workforce has the required skillset to be agile. This agility allows midwives to be redeployed to work in all areas dependent on increased activity levels or acuity changes.

The nationally recognised safe staffing for maternity services workforce planning system is Birthrate Plus.

This tool includes :

- Total midwifery time required to care for women based on minimal standard of providing one-to-one midwifery care throughout established labour
- A classification for intrapartum care which uses clinical indicators to assess the level of need of both mother and baby.
- Collecting real time data on the length of time a women required care during labour and delivery and an addition of extra midwife time for those with a higher level of need/ intervention or emergency

MKUH completed Birth-Rate plus in April 2018 and this was based on 3760 births and set the blueprint for the maternity services staffing model, providing assurance that our maternity workforce establishment would enable us to deliver safe staffing.

Birth-Rate plus was scheduled to be repeated in 2020 and due to the pandemic this was delayed. We are currently awaiting a timeframe to complete Birthrate Plus which has been funded from BLMK LMNS.

During April 2020 to April 2021 MKUH had 3493 births with 4553 women booked. Whilst the number of births is less than 2018 the complexity of the women has significantly increased, and the implementation continuity of carer model has impacted on the staffing model.

In the light of these changes and in response to the Ockendon Review recommendations each of the maternity services have had their maternity establishment recently reviewed by the interim Head of Midwifery and the Chief Nurse.

3 Current staffing and establishment

The maternity teams are led by a Head of Midwifery, a deputy Head of Midwifery and a team of three matrons who provide leadership for labour ward and ADAU, antenatal / postnatal care, and the community/ continuity of care teams.

3.1 Ward 9

Ward 9 is a 28 bedded ward providing care for women in their antenatal phase and women and babies postnatally. The establishment on ward 9 is detailed below based on current templates including the acuity and dependency of the women and babies.

Ward 9 Staff Numbers	Weekly Average	
	Registered Midwife	Non registered
Day	5	3
Night	4	3

The table below sets out the total number of staff required for Ward 9.

Staff Band	Staff required
Band 7(Supernumerary)	2 WTE
Band 5/6	23.68 WTE
Band 2/3	15.71 WTE
Total	43.4 WTE

3.2 Labour ward

Labour Ward has 11 single rooms with the women on labour ward requiring 1 to 1 care. The following establishment takes into account the continuity of care model, which currently stands at 35% of the maternity case load. The assumption is based on 2 midwives present from the continuity of carer teams each day and each shift having 2 labour ward Coordinators Band 7 (1 supernumerary in charge).

Labour ward staff Numbers	Weekly Average	
	Registered Midwife	Non registered
Day	5	2
Night	5	1

The table below sets out the number of staff required on labour ward.

Staff Band	Staff required
Band 7(Supernumerary)	5.08 WTE
Band 7	5.08 WTE
Band 5/6	23.68 WTE
Band 2/3	7 .97 WTE

3.3 ADAU

The antenatal day assessment unit is open from 08.00am to 20.00 seven days a week.

Staff Numbers	Weekly Average	
	Registered Midwife	Non registered
Long Day	2	1

Staff Grade	Staff required
Band 7	1 WTE
Band 5/6	5.17 WTE
Band 2/3	3.08 WTE

3.5 Total current maternity workforce requirements (including additional workforce detailed in Ockendon Review)

The figures below are dynamic due the flexibility of the service in meeting the demands of the patient group. For this paper, we have removed from the funded establishments the Home Birth team and the Continuity of Care team. There would need to be further reviews of the inpatient services establishments each time we establish another Continuity of Care team.

Staff Band	Staff required for Inpatient	Funded	Difference
Band 7	14.61 WTE	13.2 WTE	-1.41 WTE
Band 5/6	52.53 WTE	43.96 WTE	- 8.57 WTE
Band 2/3/4	26. 76 WTE	26.98 WTE	+ 0.22 WTE

4. Specialist Midwives

There is an allowance in Birthrate plus for specialist midwives We have a 16.6 WTE number of specialist midwives who work across the maternity services totalling Band 7 10.6 WTE and 6 WTE (Band 6).

6. Recommendation from Ockendon Report

There are additional recommendations detailed in the Ockenden report for each Trust to be compliant with the following workforce requirements:

- Each maternity unit to have a Consultant midwife (1 WTE)
- A lead foetal surveillance midwife (1 WTE)
- A lead foetal surveillance Consultant
- A Consultant twice daily ward round review of the whole maternity unit.

As a consequence of the Ockendon Review we anticipate we will require an additional 11 WTE Band 6 midwives (which includes 1 WTE ward leader for the antenatal and postnatal ward (ward 9) within the maternity inpatient services.

In order to meet the requirement to enhance the onsite presence of a consultant obstetrician across the week, and to provide leadership resource in specific areas (for example, foetal surveillance) it is estimated that between 10 and 15 additional consultant programmed activities may be required. This will require additional consultant appointment rather than existing consultants taking on more work: consultant job plans are already full and additional consultants would mitigate the risk of disrupting elective activity (as we recover from the COVID-19 backlog).

7. Conclusion

This paper details the current midwifery workforce establishment levels and outlines the additional staffing requirements identified following the release of the Ockendon Review.

The establishment of 5 continuity of carer teams has driven a review of the maternity workforce establishment due to the changing model of delivery. Currently there is a development of an implementation plan for further continuity of carer teams which will include the impact on core labour ward midwives which will come to board for approval prior to progressing.

MKUH will be working with Bedfordshire, Luton and Milton Keynes LMNS to seek additional national monies to support us to meet these national workforce requirements.

Milton Keynes Hospital NHS
NHS Foundation Trust

Meeting title	Trust Board (public)	6 May 2021
Report title:	**Incident and Learning Report**	Agenda item: 3.3
Lead director **Report author** **Sponsor(s)**	Dr Ian Reckless Kate Jarman Tina Worth	Medical Director Director of Corporate Affairs Head of Risk & Clinical Governance
FoI status:	Public document	

Report summary	This report provides a monthly overview of Risk Management processes/systems in relation to serious incidents in the Trust.			
Purpose *(tick one box only)*	**Information** x	**Approval**	**To note**	**Decision**
Recommendation	The Group 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: 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 & up to £10,000 from a Commissioning contract perspective.
Legal implications including equality and diversity assessment	Contractual and regulatory reporting requirements.

Report history	Serious Incident Review Group
Next steps	Monthly incident/SI overarching issues reporting
Appendices	Trends in graphical format

Introduction and Purpose of the Report

This report is designed to give a summary of Serious Incidents (SIs) to the Board every two months (to each public Board). This report is in addition to a detailed Serious Incident report received at the Quality and Clinical Risk Committee at each of its meetings.

The purpose of this report is to be transparent around the Serious Incidents reported and investigated by the Trust, whilst maintaining the confidentiality of patients and families involved; and to provide assurance to the Board that the Trust has an effective and appropriate framework for the reporting and investigating of incidents, and ensuring actions are undertaken to reduce the likelihood of their recurrence.

The report also summarises programmes to support the continual improvement of the quality of the investigation process and outcomes in relation to learning and clinical care or service improvement.

Serious Incident Report March 2021

There were five new SIs reported on STEIS in March 2021 (table below).

STEIS number	Category	Details
2021/6774	Medication incident	Chemotherapy prescribing error
2021/6906	Unexpected readmission	Baby readmitted following weight loss
2021/6261	New pressure ulcer	Deep tissue injury to heel (Ward 18)
2021/6232	Diagnostic error	Complete miscarriage confirmed without ultrasound (USS) confirmation. Pregnancy later noted to be viable
2021/6762	Unexpected admission to the Neonatal Unit (NNU)	Baby born via emergency caesarean section (EMCS) and admitted to NNU

With regard to Duty of Candour obligations, it is worth noting that whilst there is clear evidence that the Trust continues to be open and transparent with families verbally discussing incidents, there were nine formal Duty of Candour breaches at quarter end as letters were not sent within the timeframe.

The Risk Management Team will add any exemptions - for example maternity bereavements which are managed through the Bereavement Midwife - however the others are the responsibility of the investigating lead. It has been noticed that an increasing number are noted as not applicable (which is an unacceptable exemption) or patient deceased, in which case the written apology would go to the next of kin. On occasions SIRG will agree to an exemption where there are seen to be no care/service delivery concerns, but these are minimal.

Additional support will be provided to ensure lead clinicians and managers are fully aware of the requirement to fulfil the Duty and the steps they must take to do this. Compliance is monitored against every reported moderate harm incident.

Trends and Areas Identified for further investigation to March 2021

1. There has been an increase in incidents of **major obstetric haemorrhage (MOH)/ post-partum haemorrhage (PPH**), with some reported as SIs. A deep dive thematic review has been requested to help identify any thematic contributing factors or issues. Early overview expects this to include:

    - Failure to escalate
    - Documentation of blood loss
    - Identification and planning ahead
    - Medicines management

2. A number of **medication incidents** relating the scanning of patients and medications and the role of the second checker with intravenous medications. A working group is undertaking an analytical review of incidents.

    There is also a working group in the Women's and Children's Division to review medication-related incidents, looking particularly at compliance with the Trust's Medicines Management Policy.

3. **Compliance with clinical guidelines and timeframes for obstetric scans** in relation to capacity and demand. Data analysis of bookings versus routine/urgent scan requirements in addition to Trust standard operating procedures on going

4. A deep-dive report is being undertaken in relation to **patient falls** looking specifically at the time of day the incidents occurred.

5. Collaborative working with the Mental Health Team in relation to increased number of patients presenting with **mental health issues**/conditions and the challenging behaviours they display

Preventing Future Deaths Report

The Trust receiving a Preventing Future Deaths Report on March 28 following a Coronial Inquest into the death of Mr Nicholas Rousseau. The PFD relates to adherence to NICE guidelines and blood lactate levels. The Trust is required to respond to HM Coroner by 24 May and has drafted a detailed response, which the Trust will also share with Mr Rousseau's family. As this is still being prepared and has not yet been disclosed to the family (or HM Coroner) further detailed information will not be shared here.
All staff across the Trust are strongly encouraged to adhere to relevant clinical guidelines so that the safety of the patient is always prioritised.

Covid-19 Outbreak Incidents – Summary of Investigations into Nosocomial (Healthcare Associated) Covid-19 Infections

An outbreak of an infectious disease is defined as two new cases linked in time and place. In relation to COVID-19, this can involve patients and/or staff. A key challenge is that by the time a first (index) case is identified, exposure and infection of others may well have occurred already.

NHS England have introduced defined timeframes in terms of the length of time between admission to a healthcare environment and a first positive COVID test. If this time period is relatively short, the patient likely acquired COVID in the community (and was asymptomatic and incubating the virus at the point of admission). If this time is longer, the likelihood is that

the patient acquired COVID in hospital – whether from the environment, other patients or staff members.

The specific timeframes are as follows: *community acquired* (positive within 48 hours of admission); *indeterminate* healthcare associated (positive screen 3-7 days after admission with no prior hospital admission in the previous 14 days); *probable* healthcare associated (positive specimen 8-14 days after admission, or a specimen date 3-14 days after admission in previous 14 days); and, *definite* healthcare associated (positive specimen date 15 days or more following admission).

In common with most other NHS organisations, we have had several COVID outbreaks over the course of the pandemic. These have been managed according to a standardised process with the involvement of Public Health England and infection prevention and control experts from the NHS Region (independent of MKUH).

Since 01 September 2020, 1,385 specific individuals have been admitted to hospital ('inpatients') and have had a positive Covid-19 swab.

Of these patients, 92 (6.5%) were definite nosocomial and a further 143 (10.3%) were probable nosocomial. We believe that this figure is average for the East of England region.

We are acutely aware of the need to provide the families of patients who have died and who may have acquired Covid-19 in hospital with reports and explanations are working hard to do that as quickly and as thoroughly as possible.

Appreciative Inquiry – Supporting Investigation and Learning from Incidents in Maternity – Programme Update

Summary

The Trust commissioned external support in November 2020 to undertake a 12-month Appreciative Inquiry training with the aim of developing 'a culture that fosters appreciation, curiosity, meaningful engagement, co-creation and innovation that will lead to enhanced relationship-centred practices'.

Appreciative Inquiry builds on what works well, and also asks people to build on their experiences to seek out positive change. It is a well-regarded method to deliver continuous improvement in patient safety and patient and staff experience.

So far (with some delays due to the Covid-19 pandemic) the programme has introduced AI to over 75 people in the organisation which includes presentations to:

- Senior executive team,
- Maternity staff, including maternity support workers, midwives and doctors
- Trust Executive Group
- Governance team
- Quality & transformation team

Maternity Workshops and In-Practice Work

The programme has seen AI specialists work closely with 16 members of the maternity team via face-to-face workshops and in-practice work to support development of leading

appreciative inquiry (Nov/Dec 2020). This cohort has continued to contribute to a community of practice that aims to share, develop and learn about appreciative inquiry.

A follow up workshop with the November maternity team was held in April; with a further workshop involving 12 new members of the multidisciplinary team from maternity, including consultants, nursery nurses, pharmacists, midwives and practice development staff.

The maternity team has piloted new appreciative systems and processes to align with appreciative inquiry principles which include:

- Exploring and reporting on incidents,
- Meetings with complainants,
- Debriefing with staff after incidents,
- Student experience check in sessions,
- Story elicitation to learn about staff, student partner and patient experience,
- Noticing, reporting and discussing positive practices,
- Appreciative meetings
- Reflective sessions on stories gathered

Reflective discussions with staff based on stories drawn from staff and patient experiences using appreciative inquiry principles are now happening once a week on a Wednesday lunchtime for a period of approx. 30 mins. The team have named these ‘Hotwash’.

They are the "after-action" conversations following an event. This is not a debrief session or a traditional case review. Instead, it is a different way of learning and co-creating change, where we use creative methods to explore what is working well, what matters and what we care about in relation to the event to explore what we can take forward to improve care and safety for everyone.

So far, we have had nine Hotwash sessions with midwives, maternity care assistants, student midwives, managers, obstetricians, and anaesthetists attending. The theme for the Hotwash sessions has been mainly influenced by any current ‘hot’ topics however we have also run some ad-hoc topics based on the need of the staff and what’s going on in the unit at the time.

Staff have shared that they truly value the Hotwash sessions as an opportunity to sit and talk to one another, to share their feelings and ideas and be heard.
In addition to the Hotwash sessions we have offered four support sessions to the multi-professional team following recent traumatic events. These have included midwives, student midwives, theatre staff, anaesthetics, paediatricians, medical doctors, emergency department nurses and managers. The overarching response from staff is that this ‘feels different’ – they feel heard, valued, and reassured.

Specific outcomes so far from these sessions include:

- Staff feeling supported
- Valuing the time to talk and share
- More face to face rounding in rooms
- Checking plans of care with staff more by the band 7 leads
- Explain the expectations of ward 9 postnatal care to women and how it is different to labour ward because of the staff/patient ratio.
- How important it is to stay calm and give good care regardless of what else is going on

- Share women's stories alongside other information at meetings such as risk, CSU and SIRG. This would provide a different aspect to the incidents
- Support and training for staff working in theatre and recovery on how to support bereaved parents.
- Triaging phone calls now to be logged on eCare
- Anaesthetic team already in discussions about the appropriate form of anaesthesia in events where babies require full resuscitation
- Put non-urgent requests on the eCare white board to enable doctors to action them from anywhere in the Trust and not being bleeped multiple times for the same thing
- Training and support for junior or staff that need structured support with running a shift and team leader
- Diabetes training for midwives – physiology and managing sliding scales

Emerging learning and outcomes:

As a result of these pilots and the appreciative inquiry development workshops staff and patients have reported the following:

- Feeling heard
- Feeling more positive and calm as a member of staff and as a woman receiving care
- Feeling included and valued
- Feeling able to take forward small cycles of change that involve those who have the experience
- Having more confidence to try new things out
- Have a greater understanding of what is happening in the unit and how they can make small changes and influence change (incident)

Staff perspectives

From a survey carried out six months post initial workshops participants on the programme gave the following feedback (% number of people answering positively):

- Trying to see possibilities rather than joining in negative talk (83%)
- Finding out people's strengths (71%)
- Using respectful language (58%)
- Taking the time to explore why certain things go well (70%)
- Feeling confident to challenge the vision of our unit/organisation (65%)
- Feeling comfortable to discuss differences of opinion in an open way (85%)
- Feeling confident to encourage patients and families to talk about things that are worrying them (42%)

Aspects where there was less of a difference over the last six months since the programme started included:

- Recognizing and seeking support for the emotional demands of my work

In discussion with staff some felt that using appreciative inquiry was an emotionful and emotionally draining experience and that they wondered how they could get support for support emotionally. This – and those areas which remain lower scoring - will be further explored with members of the community of practice and the wider quality teams.

Developments/changes in practice

Specific outcomes and changes in practice that were developed following discovery work about peoples' experiences of giving or receiving care include:

- Emergency response: fewer people rush into woman's room which has been recognised to cause concern. others wait outside until they have been called in
- Handover: used to be in a busy corridor now in a separate room on the ward enabling better focus
- Supporting and caring for staff and patients: exploring how people are feeling after a major incident on the unit as the first step before exploring what happened and what went wrong
- Student, staff and women's experience: exploring how students feel about their experience at regular intervals during their placement to make immediate, small changes
- Exploring how women feel about their experience on a regular basis and using this to develop practice
- Changes to the language used in the maternity unit for example 'breast feeding assessment' to 'breast feeding support discussion' (based on one woman's experience that this term made her feel anxious that she was about to attend a test and was concerned she might fail.

Resources

The Trust intranet improvement site/hub is developing a Quality Improvement Hub with Appreciative Inquiry resources. This Hub will contain over 25 resources that enhance dialogue with staff, patients and families to learn about what is working well and why, and what matters to people to co-create future quality improvement initiatives, however small.

Next Steps

The Appreciative Inquiry programme will continue in maternity and will roll out to patient experience (corporately), the Emergency Department and Theatres (complimenting a programme of Human Factors training currently being undertaken by the multi-disciplinary Theatres team).

Appendix 1: Summary Information on Nosocomial Infection to Families

The following information is sent to families where a relative along with a summary of their admission and concise investigation with input from Medical Examiners and Infection Prevention and Control specialists.

Arrangements for the Management of COVID-19 in Hospital

You are receiving this information sheet as your relative has died at Milton Keynes Hospital and COVID-19 may have been a contributory or causative factor. We wish to extend our sympathies to you at this difficult time. The purpose of the information is to provide you with some context and background for some of the questions that you may have following your relative's death in the hospital. We are also conscious that the restrictions with allowing hospital visiting during the COVID pandemic have been very challenging and difficult for families to understand and accept.

COVID-19

Since COVID-19 (a type of coronavirus) was first seen in the United Kingdom a year ago, we have been building our knowledge about it over time. We know that COVID-19 is highly infectious, that it is spread via a number of routes including through respiratory 'droplets' in the air, and that its presentation can vary from no symptoms whatsoever to a very dangerous and serious situation where the lungs become inflamed to such a degree that they fail. This latter condition occurs sometime after initial infection and is driven in part by the body's own immune system.

For those who do have symptoms, there may well have been a period of incubation (since the infection was first acquired) when there would have been no symptoms and the person may or may not have been infectious. The risk of droplet spread is higher when the patient has a large amount of virus in their system (high viral load) and when certain procedures (known as 'aerosol generating procedures, AGPs') are undertaken: these include the use of non-invasive ventilators to support people to breathe sometimes known as CPAP. COVID-19 can also spread through contaminated surfaces. The elderly are at particular risk of dying with severe COVID lung involvement as they tend to have less 'physiological reserve' and are less able to withstand a deterioration in lung function.

Infection Prevention and Control

The key elements of infection prevention and control in relation to COVID-19 are identical inside and outside the hospital: hands, face and space. Regular hand washing (certainly between all patient contacts) and mask wearing have been in place in the hospital since early in the pandemic. Whilst social distancing is inevitably challenging given the work we do and the nature of direct patient care, staff have been making efforts in their own areas to make appropriate adjustments (for example, smaller ward rounds and use of digital internet solutions for team meetings). Just as adherence to hands, face and space in the community requires continual focus and attention in order to avoid complacency, the same is true in the hospital environment.

Throughout the pandemic, we have been carefully considering where best to look after patients according to the likelihood of them having COVID (with or without symptoms): a green pathway has been in place for patients coming into hospital in a planned way for surgery or a procedure (having had a negative swab a couple of days prior to admission); a red pathway exists for patients who are known to have COVID or who have symptoms highly suggestive of active COVID infection (pending the result of swabs and other tests); and, an amber pathway which is in place for patients coming into hospital without signs or symptoms

of COVID, or a significant history of exposure (again, whilst awaiting the results of an admission swab).

The nature of the red pathway has changed over time according to the levels of COVID in our community and our hospital. In early January 2021, over half of the hospital's admitted inpatients had confirmed COVID-19 and there was only a very small number of ward areas without any patients with COVID. Several wards areas were reserved for COVID positive patients only. The situation was different in the autumn (when the volume of COVID in the community and in the hospital was much lower) and some COVID positive patients were cared for in single rooms on our regular wards. Patients with known COVID undergoing aerosol generating procedures (increasing the risk of droplet spread to others in the vicinity) were cared for in specific areas and zones of the hospital.

Outbreaks

An outbreak of an infectious disease is defined as two new cases linked in time and place. In relation to COVID-19, this can involve patients and/or staff. A key challenge is that by the time a first (index) case is identified, exposure and infection of others may well have occurred already.

NHS England have introduced defined timeframes in terms of the length of time between admission to a healthcare environment and a first positive COVID test. If this time period is relatively short, the patient likely acquired COVID in the community (and was asymptomatic and incubating the virus at the point of admission). If this time is longer, the likelihood is that the patient acquired COVID in hospital – whether from the environment, other patients or staff members.

The specific timeframes are as follows: *community acquired* (positive within 48 hours of admission); *indeterminate* healthcare associated (positive screen 3-7 days after admission with no prior hospital admission in the previous 14 days); *probable* healthcare associated (positive specimen 8-14 days after admission, or a specimen date 3-14 days after admission in previous 14 days); and, *definite* healthcare associated (positive specimen date 15 days or more following admission).

In common with most other NHS organisations, we have had several COVID outbreaks over the course of the pandemic. These have been managed according to a standardised process with the involvement of Public Health England and infection prevention and control experts from the NHS Region (independent of MKUH).

Movement of patients within hospital

In ordinary times, a patient might expect to move wards a couple of times during a hospital stay – for example from the Emergency Department to an Assessment Ward on to an appropriate specialty ward. There is a balance to be struck between providing patients continuity of care (from a single team of healthcare professionals), accessing sub-specialist expertise (for example being looked after by a team which specialises in the cardiac care, the frail elderly or stroke, as opposed to general medicine) and maintaining an environment where the flow of patients through (and discharge from) the hospital can be maintained. When a patient is in an individual ward area they might move bed space for various reasons – usually depending upon the specific needs of the patients in the area (for example, high clinical care needs, psychological distress or palliative care needs), infection control measures, the maintenance of single sex facilities or individual patient preference.

During the pandemic, the factors above have remained relevant. In addition, we have had to adjust the respective footprints of the red and amber pathways. For example, moving from

the management of a total of 4 or 5 COVID patients in single rooms across a small number of ward areas, to cohorting 15 or more COVID positive patients on a specific ward.

Testing

The definitive test for COVID-19 is a Polymerase Chain reaction (PCR) test which involves analysis of a swab from the nose and/or throat. No test is 100% effective in picking up the virus (for several reasons including swabbing technique), and the test can pick up viral remnants that are no longer clinically relevant (many weeks down the line from initial and active infection) and no longer an infection risk. A positive COVID test does not always imply infectivity. Early in the pandemic the PCR tests were all sent to large central laboratories (in the case of MKUH, at the John Radcliffe in Oxford) although in recent months we have acquired local testing machines meaning that approximately half of the MKUH tests are now done here at the hospital. The time taken for the results of the test to be available has varied across the pandemic and now stands at between 2 and 20 hours depending upon the urgency and the testing route. Since mid-December, most of our urgent swabs (for patients being admitted to the hospital in an unplanned way) have been undertaken locally with a shorter turn around time. Other tests called 'lateral flow tests' have been in use at the hospital since Christmas: these tests can be helpful in providing earlier warning of COVID infection but a negative test cannot provide significant assurance and all lateral flow tests need to be sent with a paired laboratory PCR swab.

A small number of patients have persistently negative COVID swabs but a clinical picture and X-ray (CT) changes which are highly suggestive of COVID infection. These patients are also treated as COVID positive.

Spread of COVID within hospital

We aim to minimise the risk of spread of COVID within hospital and recognise that the impact of spread within hospital can be devastating as many inpatients are predictably elderly or frail.

Against this background, it is important to recognise that the hospital will inevitably be the venue within Milton Keynes where the highest number of COVID positive people congregate (as they require care and treatment), and that the nature of healthcare is such that social distancing is a relative rather than absolute concept. Every effort should be made to socially distance but a patient may require the physical help of two or three people to undertake a specific task, or to be turned in bed. Preventing the spread of a virus such as COVID-19 in a busy hospital is extremely challenging, not least because people may be infectious in the absence of any symptoms, tests can be imperfect and can take many hours to provide a result.

We hope that this note is helpful in considering the more specific circumstances which relate to the care your relative received whilst in the hospital.

Meeting title	Board of Directors	**Date:** May 6th 2021
Report title:	Nursing Staffing Report	**Agenda item: 3.4**
Lead director **Report author** **Sponsor(s)**	**Name:** Nicky Burns-Muir **Name:** Matthew Sandham Emma Thorne	**Title:** Director of Patient Care/Chief Nurse **Title:** Associate Chief Nurse Workforce Matron
FoI status:		

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

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

Report history	To every Public Board
Next steps	
Appendices	Appendices 1

Board of Directors Report on Nursing and Midwifery staffing levels Amalgamated report for February and March 2021

1. Purpose

To provide Board with: -

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

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

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

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

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

CHPPD	Total Patient Numbers	Registered Midwives/Nurses	Care Staff	Overall
February	10765	5.1	3.2	8.3
March	11215	5.1	3.4	8.5

Month	RN/RM Day % Fill Rate	HCA/MCA Day % Fill Rate	RN/RM Night % Fill Rate	HCA/MCA Night % Fill Rate
February	72.5%	71.9%	90.7%	98.6%
March	69.3%	73.8%	91.0%	103.0%

- *February and March 2021 data are included in Appendix 1.*

Areas with notable fill rates

During the months of February and March the Trust continued with their staffing surge plan, therefore the data recorded per ward does not entirely reflect the staff allocated on the day. The surge staff could not be allocated to a clinical area as this would require a reallocation of budget. The staffing surge plan came to an end at the end of March with all staff returning to their normal place of work.

Are we safe?

3. Recruitment Overview

The Trust has remained proactive with Nursing and Midwifery recruitment throughout the pandemic. The Senior Nursing Workforce team continue work collaboratively with HR on initiatives to optimise recruitment across the organisation.

Medicine

Band	WTE Vacancy	Percentage	Turn over percentage
Band 2	5.4WTE	4%	6.9%
Band 5&6	45 WTE	11%	6%

Surgery

Band	WTE Vacancy	Percentage	Turn Over percentage
Band 2	6.37 WTE	4%	6%
Band 5&6	18.24 WTE	9%	5%

Women's and Children

Band	WTE Vacancy	Percentage	Turn Over percentage
Band 2	1.17WTE	4%	6 %
Band 5&6	23 WTE	10.7%	2%

Health Care Support Workers Recruitment (HCSW)

As reported in previous reports, Ruth May, the Chief Nursing Officer, for England announced a zero tolerance to HCSW vacancies in NHS Trusts. Milton Keynes University Hospital was therefore set the objective to recruit into all 61wte HCSW vacancies by the end of March/April 2021.

The Trust was commissioned to work with NHSI on the 'Accelerated Healthcare Support Worker Recruitment Scheme'. The aim of the program was to reduce vacancies swiftly, enhance the onboarding process (including mentorship, training, and pastoral support to candidates), and deliver training to optimise safety and enable staff to be competent and safe in practice. A high proportion of the new HCSW's are new to healthcare and have a breadth of previous job roles and experience which will significantly contribute to the clinical teams delivery of care.

During the induction process employees were offered an opportunity to consider undertaking the nursing apprenticeship programme and nursing associate programme .

To date 54.87wte HCSW (a total of 62 individuals) have commenced employment with us. With a further 7.44wte due to commence in May 2021.

This recruitment campaign has been a huge success with individuals starting in the time frame specified and the HCA Trainer from the Practice Education team has facilitated a two-week bespoke induction programme to ensure that all new HCSW's are well educated and fully prepared to undertake their role. The delivery of the programme has received significant interest from the RCN Bulletin and Health Education England to produce articles to share more widely.

Work is now underway related to the retention of this cohort of staff who historically have a higher rate of turnover than registered nursing and midwifery staff .

Registered Nurses Band 5

From a recruitment perspective generic recruitment campaigns have proven successful during the pandemic. As vacancies reduce the Medical and Surgical Divisions plan to return to Divisional recruitment campaigns to tailor their recruitment campaigns going forward led by the Divisional Chief Nurses.

The Workforce Matron continues to work with the Learning Environment Leads to plan and facilitate recruitment education workshops for Student Nurses to ensure that MKUH is their first choice to work. There are 40 MKUH Student Nurses due to qualify in September 2021 and MKUH has committed through BLMK to automatically recruited and offered positions within our organisation, without a formal interview. This process will ensure a supply of nurses three times a year. Therefore, these nurses have undertaken their nurse training with us and have been signed off by the organisation as ready for the professional register and are familiar with our organisational values, standards and policies to facilitate a smooth transition.

International Nurse Recruitment

In the height of the COVID-19 pandemic the trust worked on the national agenda with Health Education England 'Global Learners Programme' to optimise staffing in critical care areas.
As part of this campaign MKUH recruited two nurses from India (1 staff Nurse for Neonatal Unit and 1 staff Nurse for Intensive Care Unit). Our international Nurses arrived in the UK on 6th April and following their isolation period have commenced a comprehensive induction programme in their clinical areas. As an organisation we will support both nurses with their Objective Structured Clinical Examination (OSCE) preparation and assist them in securing their NMC registration.

There are currently no further plans for international recruitment this will be continued to be reviewed on a regular basis by the Senior Workforce and Corporate Nursing team.

Band 6

To optimise patient experience, patient safety and drive standards the Trust has invested in senior clinical leadership that would allow for a Band 6 Junior Sister/ Charge Nurse to be present on every shift.

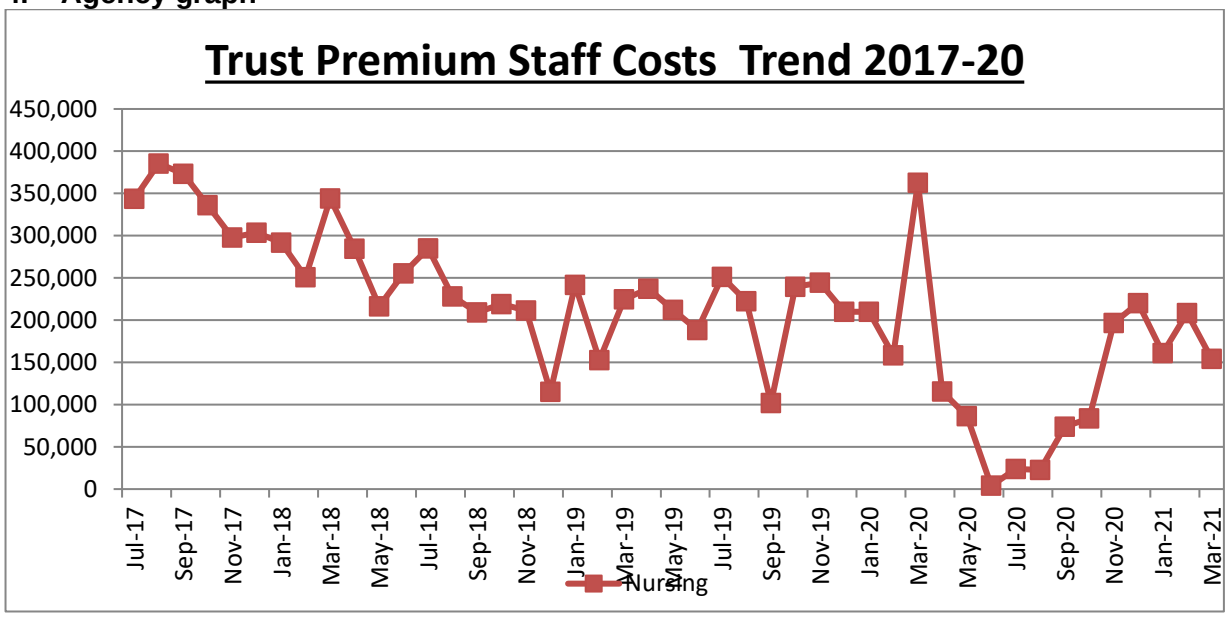
Interviews were held in March and 24.82wte (28 candidates) were successful at interview (3 external candidates). This has been an exciting opportunity for Staff Nurses here at MKUH to progress their career and leadership journey and has created positivity within the nursing teams.

All appointed band 6's will undergo a comprehensive induction with a number of study days over several months irrespective of years of experience to set the expectation of the role

and ensure the impact of investment is realised ie. Improving quality; facilitating discharges and patient flow.

Are we effective?

4. Agency graph



During the period of February and March we saw the agency cost rise and is comparable with same period in 2018 and 2019. This has been driven staff sickness or isolating due mainly COVID 19. The Agency utilisation has been restricted in the month of April and we should see a reduction in spend.

5. SafeCare Update

SafeCare is now 'live' in all wards across the organisation. Wards have been entering the required census data three times a day and Trust wide compliance has reached 90% for data entry.

As an organisation we are now enter the 'validation and professional judgement phase' of SafeCare'. This phase will ensure that data being entered is accurate (in line with the Shelford Safer Nursing Care Tool) and will require senior review from the Matrons to validate the RAG status of all wards to optimise patient safety with safe staffing levels.

SafeCare is now incorporated into the Daily Safety Huddle and Matrons have commenced using SafeCare when reviewing staffing and assessing safety across the organisation.

The data from SafeCare will help inform the establishment reviews planned for May 2021.

We celebrate

Following the conclusion of the Divisional Nursing Leadership consultation there has been a change in the senior structure of nursing with the surgery and medicine divisions with the following appointments:

Liz Winter - Divisional Chief Nurse for Medicine

Emma Codrington - Divisional Chief Nurse for Surgery

Kieran Dunne - Senior Matron for Surgery

Louise Senior – Senior Matron for Medicine

We also welcomed Kirsty Sharp in March who is the Mental Health Practice Educator to MKUH. This post will educate and support staff in managing patients with mental health issues and provide expertise to the organisation on education programmes and operational policies to optimise outcomes for patients with mental health concerns.

The patient and family experience team have appointed a Matron Sharon Robertson who will provide clinical expertise to the complaints and PALS team and engage clinical staff in projects to deliver the patient experience strategy.

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

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
AMU	82.4%	79.5%	98.1%	108.9%	558	5.8	2.4	8.2
MAU 2	54.7%	72.3%	69.5%	114.3%	575	4.1	2.8	6.9
Phoenix Unit	78.6%	71.3%	94.1%	114.9%	476	3.9	3.7	7.6
Ward 15	70.3%	66.3%	90.3%	90.3%	355	9.5	8.9	18.4
Ward 16	62.7%	78.4%	90.2%	96.4%	444	4.9	3.5	8.4
Ward 17	71.6%	77.3%	96.6%	106.3%	619	4.3	2.1	6.5
Ward 18	70.9%	71.1%	85.7%	110.8%	585	3.4	3.8	7.2
Ward 19	72.5%	72.0%	100.0%	108.3%	708	3.1	3.1	6.2
Ward 20	82.3%	61.8%	99.4%	110.7%	582	4.5	3.0	7.5
Ward 21	72.9%	70.8%	88.1%	83.9%	341	6.8	3.3	10.0
Ward 22	69.7%	89.7%	97.6%	97.6%	468	4.5	4.3	8.8
Ward 23	80.9%	82.5%	101.8%	107.1%	1135	3.0	3.0	6.0
Ward 24	30.7%	28.8%	26.2%	28.6%	145	4.3	4.3	8.7
Ward 3	43.1%	61.7%	50.8%	83.5%	468	4.0	4.1	8.1
Ward 5	81.6%	69.5%	149.1%	49.4%	282	14.3	1.6	15.9
Ward 7	69.5%	72.0%	88.1%	103.6%	433	4.6	5.0	9.6
Ward 8	73.7%	85.7%	98.8%	149.9%	615	3.5	3.3	6.8
ICU	110.4%	126.0%	119.8%	-	195	30.6	2.7	33.3
Labour Ward								
Ward 9	77.3%	82.0%	71.4%	93.0%	1029	2.1	1.8	3.9
Ward 10								
NNU	70.0%	54.3%	77.4%	100.0%	220	15.0	2.4	17.4
Ward 25	69.1%	71.2%	98.9%	96.5%	532	4.3	2.8	7.1

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

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
AMU	82.4%	79.5%	98.1%	108.9%	558	5.8	2.4	9.3
ICU	54.7%	72.3%	69.5%	114.3%	575	4.1	2.8	32.1
Ward 2	78.6%	71.3%	94.1%	114.9%	476	3.9	3.7	6.3
NNU	70.3%	66.3%	90.3%	90.3%	355	9.5	8.9	16.0
Ward 14	62.7%	78.4%	90.2%	96.4%	444	4.9	3.5	9.2
Ward 10	71.6%	77.3%	96.6%	106.3%	619	4.3	2.1	-
Ward 15	70.9%	71.1%	85.7%	110.8%	585	3.4	3.8	13.4
Ward 16	72.5%	72.0%	100.0%	108.3%	708	3.1	3.1	8.0
Ward 17	82.3%	61.8%	99.4%	110.7%	582	4.5	3.0	6.5
Ward 18	72.9%	70.8%	88.1%	83.9%	341	6.8	3.3	8.0
Ward 19	69.7%	89.7%	97.6%	97.6%	468	4.5	4.3	8.4
Ward 20	80.9%	82.5%	101.8%	107.1%	1135	3.0	3.0	6.6
Ward 24	30.7%	28.8%	26.2%	28.6%	145	4.3	4.3	9.9
Ward 21	43.1%	61.7%	50.8%	83.5%	468	4.0	4.1	10.2
Ward 22	81.6%	69.5%	149.1%	49.4%	282	14.3	1.6	8.0
Ward 23	69.5%	72.0%	88.1%	103.6%	433	4.6	5.0	13.8
Ward 24	73.7%	85.7%	98.8%	149.9%	615	3.5	3.3	7.6
Ward 3	110.4%	126.0%	119.8%	-	195	30.6	2.7	10.0
Ward 5								8.7
Ward 7	77.3%	82.0%	71.4%	93.0%	1029	2.1	1.8	8.0
Ward 8								4.2
Ward 9	70.0%	54.3%	77.4%	100.0%	220	15.0	2.4	8.0
Ward 25	69.1%	71.2%	98.9%	96.5%	532	4.3	2.8	

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Trust Board**	**Date: 6 May 2021**
Report title:	**Workforce Report**	**Agenda item: 4.1**
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 March 2021 (Month 12) and relevant Workforce and Organisational Development updates to Trust Board			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [x]	**Decision** [ ]
Recommendation	Trust Board is asked to note and receive the Workforce Report for Month 12.			

Strategic objectives links	Objective 8: Investing in our people
Board Assurance Framework links	BAF risks 19-24
CQC outcome/ regulation links	Well Led Outcome 13: Staffing
Identified risks and risk management actions	
Resource implications	
Legal implications including equality and diversity assessment	
Report history	
Next steps	
Appendices	

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators as at 31 March 2021 (Month 12), covering the preceding 13 months.

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

Indicator	Measure	Target	03/2020	04/2020	05/2020	06/2020	07/2020	08/2020	09/2020	10/2020	11/2020	12/2020	01/2021	02/2021	03/2021
Staff in post (as at report date)	WTE		3177.3	3177.0	3238.8	3266.8	3276.7	3227.3	3243.8	3245.1	3256.5	3251.3	3250.0	3284.0	**3311.6**
	Headcount		3666	3656	3723	3761	3766	3707	3727	3728	3738	3729	3730	3765	**3795**
Establishment (as at report date - as per finance data)	WTE		3456.3	3690.8	3698.6	3693.9	3694.0	3693.0	3690.2	3699.9	3702.2	3706.8	3702.6	3701.9	**3701.9**
	%, Vacancy Rate *(for Cost Centres, excludes Reserves)*	10%	8.1%	13.9%	12.4%	11.6%	11.3%	12.6%	12.1%	12.3%	12.0%	12.3%	12.2%	11.3%	**10.5%**
Staff Costs (12 months)	%, Temp Staff Cost		13.8%	13.8%	13.3%	12.9%	12.5%	12.2%	12.1%	11.9%	11.7%	11.7%	11.6%	11.6%	**11.6%**
	%, Temp Staff Usage		14.2%	14.1%	13.6%	13.2%	12.8%	12.5%	12.2%	12.0%	11.9%	11.8%	11.8%	11.8%	**11.8%**
Absence (12 months)	%, 12 month Absence Rate	4%	4.1%	4.4%	4.5%	4.5%	4.4%	4.5%	4.5%	4.6%	4.7%	4.8%	5.0%	5.1%	**4.8%**
	- %, 12 month Absence Rate - Long Term		*2.2%*	*2.3%*	*2.4%*	*2.4%*	*2.3%*	*2.4%*	*2.4%*	*2.6%*	*2.6%*	*2.7%*	*2.7%*	*2.8%*	***2.8%***
	- %, 12 month Absence Rate - Short Term		*1.9%*	*2.1%*	*2.1%*	*2.1%*	*2.1%*	*2.1%*	*2.1%*	*2.1%*	*2.1%*	*2.2%*	*2.4%*	*2.3%*	***2.1%***
	%,In month Absence Rate - Total		6.5%	7.6%	4.7%	3.4%	3.3%	3.6%	4.0%	4.1%	5.0%	6.1%	6.7%	4.7%	**3.4%**
	- %, In month Absence Rate - Long Term		*2.5%*	*3.3%*	*3.0%*	*2.1%*	*2.2%*	*2.5%*	*2.5%*	*2.7%*	*2.6%*	*3.6%*	*2.9%*	*2.9%*	***2.5%***
	- %, In month Absence Rate - Short Term		*4.0%*	*4.3%*	*1.7%*	*1.4%*	*1.1%*	*1.1%*	*1.5%*	*1.4%*	*2.4%*	*2.5%*	*3.8%*	*1.8%*	***0.9%***
	- %, In month Absence Rate - COVID-19 Sickness Absence		1.4%	3.8%	1.3%	0.5%	0.2%	0.2%	0.2%	0.2%	1.1%	2.1%	3.3%	1.3%	**0.5%**
Starters, Leavers and T/O rate (12 months)	WTE, Starters		362.1	369.4	363.3	355.1	355.9	362.0	360.5	336.0	329.9	329.2	313.0	318.0	**311.6**
	Headcount, Starters		414	424	415	406	408	414	413	386	376	373	358	363	**356**
	WTE, Leavers		268.3	270.4	259.9	249.5	251.7	251.5	249.0	241.2	244.7	240.1	233.7	229.3	**203.4**
	Headcount, Leavers		315	318	306	295	298	298	295	286	291	286	278	273	**241**
	%, Leaver Turnover Rate	10%	9.4%	9.6%	9.2%	8.8%	8.8%	8.9%	8.8%	8.5%	8.5%	8.4%	8.2%	8.0%	**7.1%**
	%, Stability Index		85.7%	84.4%	85.6%	86.3%	86.4%	86.3%	86.8%	87.0%	86.9%	87.2%	87.1%	87.0%	**87.8%**
Statutory/Mandatory Training	%, Compliance	90%	94%	94%	93%	94%	94%	95%	95%	94%	95%	95%	95%	96%	**97%**
Appraisals	%, Compliance	90%	94%	90%	90%	92%	93%	92%	92%	93%	91%	90%	92%	93%	**95%**
Medical and Dental Appraisals	%, Compliance	90%	97%	97%	95%	92%	92%	93%	86%	88%	87%	90%	86%	79%	**83%**
Time to Hire (days)	General Recruitment	35	48	66	58	60	49	51	48	47	41	56	49	39	**43**
	Medical Recruitment (excl Deanery)	35	30	36	59	54	40	81	97	71	32	49	34	53	**52**
Employee relations	Number of open disciplinary cases					26	26	26	27	28	25	22	19	23	**14**

2.1. The Trust's **vacancy rate** has reduced to 10.5% further to sustained efforts and investment to drive the vacancy level down towards nationally led targets since the turn of the year.

2.2. Overall **staff absence** remains high at 4.8% which is the 12-month rolling position. As with short term absence, this measure has fallen alongside falling infection rates. Covid related absence has reduced from 1.3% to 0.5% and is expected to fall further in line with national figures. The pre-Covid absence tolerance is 4%. Once Covid absence has reduced to much smaller numbers the Trust absence target is expected to return to within agreed tolerance.

2.3. **The stability index figure** (defined as *proportion of staff in post at end of period who were in post at beginning of period).* The stability index figure has increased slightly in-month to 87.8%. Stability within the organisation is crucial during turbulent times and is helpful to understand the longer-term impact of our various influencing interventions and staff support programmes. The 13-month trend shows an average increase of almost 2%. Similarly, **staff turnover** has improved by almost 2% in this time – now at 7.1% reflecting the Trust's efforts to support wellbeing through engagement, culture and reward initiatives.

2.4. The **time to hire** trend is improving following the impact of targeted interventions to reduce this to acceptable levels in recent months. Medical staffing time to hire has continued to experience delays in issuing visas. UK Border Agency (Visas and Immigration) centres are open but quarantine restrictions remain in place for incoming new entrants in line with national guidance from the Foreign and Commonwealth Office, contributing to the adverse impact on the reported level.

2.5. **Employee Relations cases** have remained fairly static when compared to previous reporting months. As reported previously, case volumes have stabilised as the number of cases resolved at informal level in line with the Trust's Fair and Just Culture principles remains high. A detailed Employee Relations case report is produced on a quarterly basis for Workforce Board and JCNC.

2.6. **Statutory and mandatory training** compliance is at 97% and **appraisals** compliance is at 95%, an increase of 5% since Month 9. The Trust has now completed its temporary extension to appraisal compliance dates during the winter months of the pandemic and the Learning and Development Team has recommenced its reminders and support processes in March to support our drive to 100%, further supported by the Trust's Pay Progression policy.

3. Continuous Improvement, Transformation and Innovation

3.1. In support of organisational recovery and reductions in infection rates, the Covid-19 **staff swabbing process** and **Covid Staff Health helplines** have reduced their staffing levels and amended their processes with effect from 1 April 2021. The helplines remain in operation, providing a valuable service to colleagues but are now being carried out in conjunction with other tasks as demand has reduced significantly

in line with falling infection rates. The swabbing process has also been amended. If colleagues are experiencing symptoms of Covid-19, calls to the Covid Staff Health lines must be made and if a PCR test/swab is required this will now be booked through a local Government testing facility. Results must be notified to the Covid Staff Health helpline and/or CovidStaffHealth@mkuh.nhs.uk

3.2. **Shielding** of Clinically Extremely Vulnerable colleagues came to an end on 31 March 2021; managers of colleagues directly affected by shielding were written to with further guidance to facilitate a gradual and supportive re-entry to the workplace, recognising concerns that colleagues might have in returning to our premises.

3.3. Colleagues were written to in March to offer additional information in support of **staff uptake** of the Trust's Covid-19 vaccination and a guide was produced by the Workforce team to support these conversations. Managers were asked to offer personal conversations to any colleagues who have yet to have the vaccine so that their concerns could be addressed. Where we do not know the vaccination status of colleagues were asked to confirm if they have received it at MKUH/elsewhere, aren't able to receive it or choose not to. Whilst colleagues do not have to have the vaccine it is required that they confirm their status/choice as all colleagues have been offered the vaccination. Approximately 120 colleagues are yet to confirm their status and these are being followed up by the Divisional HR Business Partners.

3.4. The Trust's **Covid-19 vaccination programme** moved out of the MKUH Academic Centre on 30 March having administered close to 35,000 vaccinations in-line with the Government prioritisation criteria. The centre has moved location to the Mass Vaccination site at Saxon Court in MK. Unfortunately, the Pfizer vaccine is not currently being offered from that site. It was originally planned that all Pfizer second doses would be delivered from the MKUH Academic Centre by bringing forward the final few to before their 11th week date. However, vaccine delivery/supply constraints meant this was not possible and so the small number of outstanding Pfizer second doses were handed over to Bedfordshire Hospitals NHS Foundation Trust to deliver with effect from 6 April 2021 as part of their second dose programme.

3.5. Managers have been asked to revisit their **Workplace Covid-19 risk assessments** as the UK moves into its planned lockdown release roadmap, escalating any concerns as required.

4. Culture and Staff Engagement

4.1. The **National NHS Staff Survey 2020** embargo was lifted on 11 March 2021. In w/c 19 April, the Workforce and Development Assurance Committee received a presentation on the key themes, questions and areas of improvement compared to our own results in 2019 and our comparators in 2020. Further to that which was presented to Trust Board Seminar in March, detail was included in respect of the prevalence and aggravating factors of patient on staff violence and the context of increased levels of additional paid hours work. Two distinct working groups have been commissioned to understand these issues further and to make recommendations for their improvement.

4.2. Divisional Staff Survey data and heatmaps are expected by 7 May for the HRBPs to engage with colleagues to report local outcomes and understand how best to drive further improvement through the *Staff Survey Goes Large* listening events established in 2019. Following this a full improvement plan for each area, based on survey results, will be drafted.

4.3. The Trust's **Living our Values** programme has commenced, with external partners *A Kind Life*. The programme complements Appreciative Inquiry approaches to Quality Improvement and aligns to the timescales outlined in the Trust's NHS People Plan delivery plan. Alignment pre-workshops took place in w/c 12 April, with co-design workshops scheduled for 5 to 10 May. A comprehensive communications plan has been drafted to support launch, engagement and delivery. Staff and patient culture surveys have also been drafted to provide local level data in support of upcoming workshops with the Trust.

5. Current Affairs & Hot Topics

5.1. The Agenda for Change Pay Progression came into effect from 1 April 2021; colleagues need to be 100% compliant with their Statutory and Mandatory Training and must have had an appraisal within the previous 12 months to qualify for their next pay increment. Appraisals must be recorded on Electronic Staff Record to enable this process to run smoothly and so as not to disadvantage colleagues unfairly. A series of training sessions have been run via MS Teams since January 2021 and these are now available to watch on Workspace.

6. Recommendations

6.1. Trust Board is asked to note and receive the Workforce Report for Month 12, in particular the outstanding Trustwide collaboration involved in delivery of the Trust's vaccination programme.

Meeting title	Trust Board	Date: 06 May 2021
Report title:	Clinical Excellence Awards (CEA) 2020 Awards Process	Agenda item: 4.3
Lead director Report author Sponsor(s)	Name: Dr Ian Reckless Name: Rosie Sampson Name: Alison Davis	Title: Medical Director Title: Business Manager Title: Chairwoman
FOI status:		

Report summary				
Purpose *(tick one box only)*	Information [x]	Approval [ ]	To note [ ]	Decision [ ]
Recommendation	This report is supplied to Trust Board for information only to demonstrate compliance with current terms and conditions of medical staff and the Trust Policy on CEAs for consultants (and discretionary points for Associate Specialists)			

Strategic objectives links	Improving clinical effectiveness Improving patient safety Improving patient experience Investing in our people Being well governed and financially viable
Board Assurance Framework links	
CQC regulations	Regulations 17: Good Governance
Identified risks and risk management actions	
Resource implications	Implementation of Schedule 30, National Terms and Conditions of Consultants (NHS Employers)
Legal implications including equality and diversity assessment	

Report history	A previous year's report was submitted to Board in January 2020
Next steps	
Appendices	

1. Purpose of the Report

This report is for information only, to inform the Board of the process surrounding the execution of the local clinical excellence awards in respect of consultant performance in 2019/20.

2. Background

Clinical Excellence Awards (CEAs) are made available to eligible consultants on a competitive basis each year by application. We are currently in the midst of a three year 'transitionary period' from old style CEAs to a revised version. The revised version of the scheme (to which we are transitioning) has not yet been agreed and articulated through national negotiation.

Old style CEAs were awarded on a consolidated (recurrent) basis, were pensionable and were paid via monthly payroll. In the transitionary period, CEAs are non-recurrent and non-pensionable one-off payments.

For 2017/18 and 2018/19, competitive application rounds were operated, with a Local Awards Committee (LAC) in place. The outputs of the 2018/19 LAC were reported to Board in January 2020.

For 2019/20, a national decision was made that local CEA rounds could not be operated in their usual format on account of the pressures of the COVID-19 pandemic. Instead, available funds were to be distributed *pro rata* to eligible consultants.

It has subsequently been announced that 2020/21 will now be treated as a further (fourth) year of the transitionary period. It is highly likely that a similar approach (available funds to be distributed *pro rata* to eligible consultants) will be used again.

Each year, the CEA process is run in accordance with Schedule 30, Terms and Conditions – Consultants (England) 2003 (NHS Employers, April 2018) and/or (in the case of this round) subsequent national instruction from NHS Employers.

3. Context

The Clinical Excellence Awards (CEA) scheme is intended to recognise and reward those consultants who contribute above and beyond in the delivery of safe and high-quality care to patients and to the continuous improvement of NHS services (including those who do so through their contribution to academic medicine).

As part of the framework for these awards, an annual report is required to ensure the process is transparent, fair and based on clear evidence.

Ordinarily, the annual report would describe the composition of the panel, the number / characteristics of applicants, and the number / characteristics of successful and unsuccessful applications. A key purpose of the report is to provide assurance as to the fairness and transparency of the process – both in general and from the perspective of protected characteristics.

4. Body of the Report

a) Members of the LAC

In the absence of a competitive process, a local awards committee was not convened in respect of 2019/20.

b) Number of consultants eligible

A list of the Trust's Consultant staff was derived from payroll and cross-checked with Medical Staffing. Eligibility was defined on the following basis (all five must apply):

1. Consultant working at MKUH (and not in another organisation) as a substantive consultant at the beginning of the relevant year (on 01 April 2019).
2. Consultant still working at MKUH as a substantive consultant when round launched (10 February 2021).
3. Doctor in post as a substantive Consultant at MKUH or in another NHS Trust for at least twelve months prior to the start of the relevant year (a substantive NHS consultant – at MKUH or elsewhere – since 01 April 2018). In other words, the doctor cannot have been in the first year of his/her substantive consultant appointment at the start of the reference year.
4. Consultant not in receipt of a Level 9 old style local CEA or a national award.

5. Consultant not in receipt during 2019/20 of the equivalent cash value of a Level 9 old style local CEA (for example, an old-style Level 7 award plus a transitionary CEA payment of £12,000).

Category	Number
Consultant List	226
Consultants removed from list based on criterion 4 or 5 above	- 9
Consultants removed from list on basis of: • duplicates within the list; • criterion 1 or 2 above; • a non-substantive (fixed term / locum) appointment; or, • resignation / retirement effective prior to 10 February 2021	- 78
Consultants eligible for *pro rata* award	**139**

These 139 eligible Consultants were given an opportunity to opt out of the receipt of the *pro rata* award if they so wished.

139 consultants received an award of £1,626 (gross) through March payroll representing a total calculated CEA resource for the Trust of £226K in respect of 2019/20 – this amount is fixed (calculated based on the number of eligible consultants and nationally determined investment ratios).

In addition, it was agreed that in recognition of the extension of the transitionary CEA period (secondary to the impact of COVID 19) to a fourth year, those in receipt of an award in respect of 2017/18 would receive a fourth and final payment. This round had been undertaken at MKUH before delayed national negotiations on the transitionary period had reached a conclusion – it had been agreed that 2017/18 awards would be non-consolidated and non-pensionable but that they would be paid annually for each of the three transitionary years.

c) The names of people recommended for an award in respect of 19/20

Given the extraordinary circumstances this year and the absence of an application and scoring process, it is not felt appropriate or necessary to name those given a

Clinical Excellence Award in this paper.[1] In ordinary years, the paper would draw attention to the protected characteristics of those who had / had not been successful in the awards process. This year, the eligibility criteria are clear (above).

d) The number of appeals that have been:

No concerns have been raised about the application of the eligibility criteria for this CEA awards year.

e) Compliance statement

The process adopted by the Milton Keynes University Hospital was completed fairly and in accordance with the guidance (standing or exceptional) issued by ACCEA.

Recommendations/ Actions

No action is required by the Board.

[1] Note: The Medical Director (lead director in relation to this paper) is one of the 139 consultants in receipt of an award as described in this paper. The Medical Director is also the recipient of two old style clinical excellence awards made by a prior employer and therefore recognised at MKUH.

NHS Milton Keynes University Hospital NHS Foundation Trust

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	2020/21 M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
3.1	Overnight bed occupancy rate		93%	93%	78.4%	84.1%	✓	▼	✓		54.1%	59.8%	67.3%	75.0%	71.6%	79.3%	87.8%	84.2%	88.6%	88.5%	84.0%	84.1%
3.4	30 day readmissions				8.5%	7.7%		▲			6.5%	10.0%	11.4%	9.8%	9.3%	8.7%	6.8%	7.7%	8.6%	8.7%	8.9%	7.7%
3.5	Follow Up Ratio		1.50	1.50	1.68	1.46	✓	▲	✗		2.49	2.16	1.82	1.86	1.74	1.66	1.62	1.48	1.65	1.55	1.49	1.46
3.6.1	Number of Stranded Patients (LOS>=7 Days)		198	198		184	✓	▼			71	99	122	112	115	149	176	144	172	196	172	184
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		53	53		77	✗	▼			20	23	24	30	38	42	71	58	58	76	75	77
3.7	Delayed Transfers of Care		25	25		12	✓	▼			6	9	7	8	12	11	19	11	16	10	9	12
3.9	Ambulance Handovers >30 mins (%)		5%	5%	4.7%	5.0%	✓	▼	✓		1.8%	2.7%	1.7%	3.4%	2.6%	2.4%	4.9%	5.7%	11.6%	8.6%	4.5%	5.0%

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	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
4.1	ED 4 hour target (includes UCS)		90.0%	90.0%	93.1%	90.3%	✓	▲	✓		95.6%	99.1%	98.8%	97.6%	97.6%	96.0%	94.3%	92.2%	84.4%	83.4%	86.7%	90.3%
4.2	RTT Incomplete Pathways <18 weeks		79.0%	79.0%		57.8%	✗	▲			64.1%	56.9%	46.7%	42.0%	49.0%	53.0%	55.8%	58.0%	56.1%	53.2%	54.7%	57.8%
4.4	RTT Total Open Pathways		18,878	18,878		23,271	✗	▲			21,810	23,244	22,679	24,109	24,930	23,610	24,867	24,752	24,577	25,013	24,185	23,271
4.5	RTT Patients waiting over 52 weeks			0		1073	✗	▼			10	58	93	175	249	393	404	343	311	450	773	1,073
4.6	Diagnostic Waits <6 weeks		99%	99%		83.2%	✗	▲			53.57%	70.06%	80.60%	83.34%	80.65%	79.34%	79.15%	81.98%	81.49%	74.92%	82.29%	83.16%

ID	Indicator	DQ Assurance	Target 20-21	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data	Q1 - 2020-21	Q2 - 2020-21	Q3- 2020-21	Q4 - 2020-21
4.7	All 2 week wait all cancers (Quarterly)		93.0%	93.0%		82.7%	✗	▲			86.35%	81.81%	82.74%	
4.8	31 days Diagnosis to Treatment (Quarterly)		96.2%	96.2%		95.1%	✗	▲			94.74%	94.81%	95.10%	
4.9	62 day standard (Quarterly)		85.5%	85.5%		77.4%	✗	▼			74.37%	84.75%	77.38%	

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	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
5.1	GP Referrals Received		Not Available		66,504	7,922	Not Available	▼	Not Available		1,777	3,596	4,846	5,765	5,053	6,450	6,782	6,664	5,883	5,469	6,297	7,922
5.2	A&E Attendances				73,397	6,981		▼			3,615	5,645	6,005	6,601	6,826	6,958	6,897	6,391	6,515	5,683	5,280	6,981
5.3	Elective Spells (PBR)				16,255	2,208		▼			496	485	885	1,230	1,293	1,583	1,759	1,879	1,615	1,350	1,472	2,208
5.4	Non-Elective Spells (PBR)				22,208	2,273		▼			1,603	1,750	1,729	1,960	1,951	2,003	1,997	1,931	1,842	1,500	1,669	2,273
5.5	OP Attendances / Procs (Total)				313,363	33,870		▼			12,686	15,174	22,935	26,687	23,877	29,282	30,193	31,641	28,496	27,617	30,905	33,870
5.6	Outpatient DNA Rate				6.1%	5.3%		▬			5.2%	3.9%	5.0%	5.8%	7.3%	6.9%	6.6%	6.7%	7.2%	6.4%	5.3%	5.3%

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	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
7.1	Income £'000		Not Available		309,993	46,026	Not Available	▲	Not Available		23,333	23,077	23,581	24,159	23,388	23,071	24,418	24,542	24,858	24,750	24,790	46,026
7.2	Pay £'000				(208,970)	(26,239)		▼			(16,069)	(15,949)	(15,229)	(15,694)	(15,431)	(15,355)	(15,318)	(16,483)	(22,269)	(17,484)	(17,451)	(26,239)
7.3	Non-pay £'000				(86,928)	(10,444)		▼			(6,104)	(5,960)	(7,186)	(6,584)	(6,612)	(6,659)	(7,982)	(7,421)	(8,432)	(7,117)	(6,427)	(10,444)
7.4	Non-operating costs £'000				(13,829)	(446)		▲			(1,229)	(1,235)	(1,234)	(1,950)	(1,400)	(1,124)	(1,334)	(1,286)	(1,338)	(749)	(504)	(446)
7.5	I&E Total £'000				266	8,897		▲			(69)	(67)	(68)	(69)	(55)	(67)	(216)	(647)	(7,181)	(600)	408	8,897
7.6	Cash Balance £'000					48,765		▼			34,189	43,330	44,850	46,777	48,263	49,456	45,507	50,228	51,933	53,312	57,262	48,765
7.7	Savings Delivered £'000				2,266	178		▼			0	0	0	0	0	0	1,097	150	476	172	193	178
7.8	Capital Expenditure £'000				45,216	17,271		▼			398	1,549	359	368	387	454	536	1,316	1,489	9,052	12,037	17,271

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	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
8.1	Staff Vacancies % of establishment		10%	10%		9.6%	✓	▬			13.1%	11.5%	10.9%	10.4%	9.3%	10.6%	10.9%	10.9%	10.8%	10.8%	9.6%	9.6%
8.2	Agency Expenditure %		4.1%	4.1%	2.6%	1.1%	✓	▲	✓		3.5%	3.0%	2.0%	1.8%	2.4%	2.4%	2.6%	3.6%	3.6%	2.8%	3.5%	1.1%
8.3	Staff Sickness % - Days Lost (Rolling 12 months)		4%	4%		5.1%	✗	▼			4.1%	4.4%	4.5%	4.5%	4.4%	4.5%	4.5%	4.6%	4.7%	4.8%	5.0%	5.1%
8.6	Substantive Staff Turnover		10%	10%		7.1%	✓	▲			9.5%	9.2%	8.8%	8.8%	8.9%	8.8%	8.5%	8.5%	8.4%	8.2%	8.0%	7.1%

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	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
O.2	Rebooked cancelled OPs - 28 day rule		95%	95%	48.4%	NULL	✓	▲	✗		88.9%	75.0%	100.0%	NULL	NULL	NULL	100.0%	0.0%	0.0%	10.0%	100.0%	NULL

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: 29/04/2021

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Meeting title	Public Board Meeting	Date: May 2021
Report title:	**Finance Paper Month 12 2020-21**	**Agenda item: 5.3**
Lead director **Report authors**	Terry Whittle Chris Panes	Director of Finance Head of Management Accounts
FoI status:	Private document	

Report summary	**An update on the financial position of the Trust at Month 12 (March 2021)**			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** X	**Decision** ☐
Recommendation	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 MARCH 2021

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.
   - Provide assurance that the Trust is adequately responding to change in funding regime and additional financial impacts of the COVID-19 pandemic.

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. For M1-6, the block payment was made up of three components; a fixed amount based on run rate from last year, a top up amount to address a deficit from the block and a covid top up by return for additional covid related costs (allowing the Trust to report a breakeven position). For M7-12 the block payment has been revised with the top up amount being restricted to a fixed envelope and the implementation of an "elective incentive scheme" to encourage Trusts to meet its activity targets. For the second half of the year the Trust plannned to report a deficit of £3.6m.

3. *Income and expenditure* –Against the revised plan and funding arrangement the Trust has reported a positive variance of £8,418k against (£3,615k positive FY) a planned deficit of £444k (£3,615k FY) for March 2021. Within this position the Trust has claimed an additional £1.2m (£11m YTD) of income directly related to the COVID-19 outbreak (against which the Trust is able to evidence an additional £10m of direct costs relating to covid).

4. Cash and capital position – the cash balance as at the end of March 2021 was £48.8m, which was £38.8m above the revised plan.

   The Trust has spent £44.1m on capital up to month 12 after accounting for donations and derecognition of assets, against a budget allocation (CDEL) of £44.7m. The spend for 20/21 relates to £10.1m on various IT projects including replacement of the Pathology IT system (LIMS), £8.9m HIP2, £3.9m on Adapt and Adopt schemes supporting endoscopy and imaging, £3.6 additional backlog infrastructure including replacement of flat roofs and installation of solar panels, £2.3m Covid including Diagnostic equipment, £2.7m MRI equipment, £1.6m on ICS, £1.7m Pathway Unit, £1.6m UEC, £0.2m Radiotherapy and £7.6m 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* –As of at M12 £2.2m of schemes had been identified and added to the trust tracker with a delivery of £2.3m for the year.

INCOME AND EXPENDITURE

7. The Trust is required to report externally against a revised plan based on the national block funding arrangement. However, in order for the Trust to get a better understanding of the Trust's cost base and how this has been impacted by covid, the Trust is also monitoring performance against a planned position that would meet the original financial control total (excluding the regional 0.5% additional efficiency requirement). The tables below summarise performance against the revised plan and the Trust's original plan. For the purposes of the report, the narrative discusses performance against the Trust's original plan and the revised forecast plan.

Revised Forecast Plan:

All Figures in £'000	Month 12 Plan	Month 12 Actual	Month 12 Var	Month 12 FY Plan	Month 12 FY Actual	Month 12 FY Var
Clinical Revenue	18,547	24,475	5,928	220,494	227,282	6,788
Other Revenue	1,355	16,027	14,672	15,762	31,167	15,405
Total Income	19,902	40,502	20,600	236,256	258,449	22,193
Pay	(16,281)	(26,239)	(9,958)	(192,395)	(208,971)	(16,576)
Non Pay	(7,225)	(10,439)	(3,214)	(82,197)	(86,921)	(4,724)
Total Operational Expend	(23,506)	(36,678)	(13,172)	(274,592)	(295,892)	(21,300)
EBITDA	(3,604)	3,824	7,428	(38,336)	(37,444)	892
Financing & Non-Op. Costs	(1,178)	(489)	689	(14,931)	(13,092)	1,839
Control Total Deficit (excl. top up)	**(4,782)**	**3,334**	**8,116**	**(53,267)**	**(50,536)**	**2,731**
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	3,413	3,413	0	39,523	39,523	0
COVID Top up	925	1,227	302	10,150	11,034	884
Control Total Deficit (incl. top up)	**(444)**	**7,974**	**8,418**	**(3,594)**	**21**	**3,615**
Donated income	0	1,012	1,012	14	1,115	1,101
Donated asset depreciation	(68)	36	104	(815)	(732)	83
Impairments & Rounding	0	(11)	(11)	0	(11)	(11)
Reported deficit/surplus	**(512)**	**9,011**	**9,523**	**(4,395)**	**393**	**4,788**

Performance against original internal plan:

All Figures in £'000	Month 12 Plan	Month 12 Actual	Month 12 Var	Month 12 FY Plan	Month 12 FY Actual	Month 12 FY Var
Clinical Revenue	21,125	19,027	(2,098)	233,455	186,750	(46,705)
Other Revenue	1,584	16,027	14,443	19,309	31,169	11,860
Total Income	22,708	35,054	12,345	252,763	217,919	(34,845)
Pay	(15,083)	(26,239)	(11,156)	(180,692)	(208,971)	(28,279)
Non Pay	(6,840)	(10,439)	(3,599)	(82,026)	(86,921)	(4,895)
Total Operational Expend	(21,923)	(36,678)	(14,755)	(262,718)	(295,892)	(33,174)
EBITDA	785	(1,624)	(2,410)	(9,955)	(77,974)	(68,019)
Financing & Non-Op. Costs	(1,192)	(478)	714	(14,299)	(13,092)	1,206
Control Total Deficit (excl. PSF)	**(407)**	**(2,103)**	**(1,696)**	**(24,254)**	**(91,066)**	**(66,812)**
Adjustments excl. from control total:						
FRF	4,946	0	(4,946)	19,784	0	(19,784)
MRET	269	0	(269)	3,228	0	(3,228)
National/Other Block	0	5,448	5,448	0	40,532	40,532
National Top up	0	3,413	3,413	0	39,523	39,523
COVID Top up	0	1,227	1,227	0	11,032	11,032
Control Total Deficit (incl. PSF)	**4,808**	**7,985**	**3,177**	**(1,242)**	**21**	**1,263**
Donated income	300	1,012	712	1,000	1,115	115
Donated asset depreciation	(68)	36	104	(816)	(732)	84
Impairments & Rounding	0	(11)	(11)	0	(11)	(11)
Reported deficit/surplus	**5,040**	**9,022**	**3,982**	**(1,058)**	**393**	**1,451**

Monthly and year to date review

8. The **deficit excluding central funding (top up) and donated income** in month 12 is £2,103k which is £1,696k 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 on the Trust's cost base.

    However, on a control total basis after the block payment and top up income the Trust has reported a £7,985k surplus position for the month and £21k surplus for the year which is £8,418k favourable to the revised plan position in month and favourable by £3,615k for the year.

    Included within the YTD position is £2,000k additional funding from the CCG, £3,911k annual leave accrual funding and £9,978k of direct covid costs (excluding loss of non-clinical income which is outside the scope of provider claims) against which the Trust expects to receive an additional £11,393k top-up.

    The impact of the elective incentive scheme has not been reported in month due to the number of COVID beds being above 15% of the total bed base.

9. **On a payment by results basis, income (excluding block, top up and donations effect)** against the original plan is £12,345k favourable in March and £34,845k adverse for the year with significant reductions in non-elective activity and low levels of activity following suspension of non-urgent elective activity earlier in the year and the occurrence of the second wave (clinical income is £2,098k adverse to plan in month and £46,705k full year).

    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.

    Against the revised trust plan/forecast income is 20,600k favourable in month and £22,193k for the year.

10. **Operational costs** in March are adverse to the original plan by £14,755k in month and £28,279k for the year. Against the revised plan/forecast operational costs are adverse by £13,172k in month and £21,300k full year.

11. **Pay costs** are £11,156k adverse to budget in Month 12 and £28,279k for the full year against the original plan. Against the revised plan pay costs are £9,958k adverse in month and £16,576k adverse for the year. The full year position includes a increase of £5,914k against untaken the annual leave accrual, £7,214k of pension costs and a further provision against 2021-22 backfill of additional annual leave. High costs against substantive, bank and agency include direct covid related costs due to changes in rotas, additional hours and cover of sickness/self-isolation.

12. **Non-pay** costs were £3,599k adverse to the original plan in month and £4,895k adverse full year. Against the revised plan non pay reported a £3,214k adverse variance in month and £4,724k adverse for the year. The in month and full year position includes £3,646k of expenditure related to PPE stock offset with income.

13. **Non-operational costs** are £1,279k favourable in month and £807k favourable for the year, this is a result of increase in PDC costs offset by timing differences in depreciation.

COST SAVINGS

14. Work on tracking and delivering schemes has resumed following a temporary suspension due to COVID. The Trust submitted its financial plan which included a target of £5m for CIP delivery by year end, however progress was restricted by the emergence of the second wave of COVID-19.

15. For the year £2.2m of schemes have been identified and added to the trust tracker with a delivery of £2.3m.

CASH AND CAPITAL

16. The cash balance at the end of March 2021 was £48.8m, which was £38.8m above the revised plan.

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 £130.8m as at 31 March 2020) was repaid in September 2020 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 above plan by £17.8m; this is driven by additional capital projects.
- Current assets are above plan by £29.1m, this is due to cash £38.8m and inventory £0.2m above plan offset by receivables £9.9m below plan.
- Current liabilities are above plan by £35.1m. This is being driven by Trade and Other Creditors £17.2m (of which £7.0m relates to untaken annual leave and £10.0m relates to capital), deferred income £12.2m, Provisions £0.2m and borrowings £0.1m above plan.
- Non-Current Liabilities are on plan.

19. The trust ended the financial year with a capital spend of £44.1m, after accounting for donations and derecognition of assets, against a budget allocation (CDEL) of £44.7m. This resulted in a variance of £0.6m which relates to CT equipment that the Trust was allocated PDC funding during late February but was unable to procure and get delivered before the end of the financial year.

RISK REGISTER

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

a) There is a risk that if the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.

To mitigate the risk the Trust has had cost and volume contracts replaced with block contracts (set nationally) for clinical income combined with top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until September 2021). Budgets are to be reset for FY22 based on financial regime with financial controls and oversight to be reintroduced to manage financial performance. Cost efficiency programme to be also reset to target focus on areas of greatest opportunity to deliver.

b) There is a risk that the Trust is unable to achieve the required efficiency improvements through the transformation programme leading to an overspend.

The Trusts Transformation programme has governance to ensure that savings are robust and measured aprropriately. Oversight of the programme is delivered through the Transformation programme board and Trust Executive Group.

c) There is a risk that if the Trust is unable to successfully tender for external audit services in 2021 then financial audits and other required annual assurance exercises will not take place LEADING TO the Trust failing in its statutory obligations.

Trust's current external audit contract ends August 21. The trust is looking to place a direct award for 1 years contract with its current external audit firm.

d) There is a risk that if the expenditure position cannot be appropriately controlled given the Trust's historic deficits then the cash available to meet its financial obligations will be insufficient

It should be noted that the Trust currently has sufficient cash balances to manage its obligations. Monthly cash flow forecasting is undertaken to establish at which point the Trust balances become close to £1m (historically the value advised by NHSEI to be held)

RECOMMENDATIONS TO BOARD

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

Appendix 1

Milton Keynes Hospital NHS Foundation Trust
Statement of Comprehensive Income
For the period ending 31st March 2021

	March 2021			Year to Date			Full year
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME							
Outpatients	4,833	4,012	(822)	51,328	37,060	(14,267)	51,328
Elective admissions	2,787	2,149	(638)	29,148	17,302	(11,846)	29,148
Emergency admissions	6,300	6,200	(101)	73,776	61,356	(12,420)	73,776
Emergency adm's marginal rate (MRET)	(277)	(270)	6	(3,238)	(3,162)	76	(3,238)
Readmissions Penalty	0	0	0	0	0	0	0
A&E	1,357	1,169	(187)	15,489	12,522	(2,968)	15,489
Other Admissions	266	164	(102)	3,114	2,107	(1,007)	3,114
Maternity	1,897	1,901	5	21,186	21,046	(140)	21,186
Critical Care & Neonatal	561	498	(64)	6,572	6,146	(426)	6,572
Excess bed days	0	0	0	0	0	0	0
Imaging	554	703	149	5,799	4,237	(1,561)	5,799
Direct access Pathology	477	409	(68)	4,987	3,726	(1,261)	4,987
Non Tariff Drugs (high cost/individual drugs)	1,850	2,024	174	19,348	18,854	(494)	19,348
Other	518	1,441	923	5,946	6,927	13	5,946
National Block Top Up	0	4,076	4,076	0	39,160	39,160	0
Clinical Income	**21,125**	**24,475**	**3,350**	**233,455**	**227,282**	**(6,173)**	**233,455**
Non-Patient Income	**7,099**	**21,679**	**14,580**	**43,321**	**82,839**	**39,518**	**43,321**
TOTAL INCOME	**28,223**	**46,154**	**17,930**	**276,775**	**310,121**	**33,345**	**276,775**
EXPENDITURE							
Total Pay	**(15,083)**	**(26,239)**	**(11,156)**	**(180,692)**	**(208,971)**	**(28,279)**	**(180,692)**
Non Pay	(4,990)	(8,415)	(3,425)	(62,678)	(68,067)	(5,389)	(62,678)
Non Tariff Drugs (high cost/individual drugs)	(1,850)	(2,024)	(174)	(19,348)	(18,854)	494	(19,348)
Non Pay	**(6,840)**	**(10,439)**	**(3,599)**	**(82,026)**	**(86,921)**	**(4,895)**	**(82,026)**
TOTAL EXPENDITURE	**(21,923)**	**(36,678)**	**(14,755)**	**(262,718)**	**(295,892)**	**(33,174)**	**(262,718)**
EBITDA*	**6,300**	**9,476**	**3,175**	**14,057**	**14,228**	**171**	**14,057**
Depreciation and non-operating costs	(1,000)	(255)	745	(11,995)	(10,234)	1,760	(11,995)
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**5,300**	**9,220**	**3,920**	**2,062**	**3,993**	**1,932**	**2,063**
Public Dividends Payable	(260)	(198)	62	(3,120)	(3,601)	(481)	(3,120)
OPERATING DEFICIT AFTER DIVIDENDS	**5,040**	**9,022**	**3,982**	**(1,058)**	**393**	**1,452**	**(1,058)**
Adjustments to reach control total							
Donated Income	(300)	(737)	(437)	(1,000)	(840)	160	(1,000)
Donated Assets Depreciation	68	(36)	(104)	816	732	(84)	816
PPE stock (excl.CT)	0	(275)	(275)	0	(275)	(275)	0
Impairments	0	11	11	0	11	11	0
PSF/FRF/MRET	(5,217)	0	5,217	(23,016)	0	23,016	(23,026)
CONTROL TOTAL DEFICIT	**(409)**	**7,985**	**8,394**	**(24,258)**	**22**	**24,280**	**(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 March 2021

	Unaudited Mth12 2020-21 £000	Mth 11 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	4,274	(4,972)	9,246
Operating surplus/(deficit) of discontinued operations			
Operating (deficit)	**4,274**	**(4,972)**	**9,246**
Non-cash income and expense:			
Depreciation and amortisation	9,947	9,726	221
Non-cash donations/grants credited to income	(600)	0	(600)
(Increase)/Decrease in Trade and Other Receivables	5,098	8,567	(3,469)
(Increase)/Decrease in Inventories	(285)	(7)	(278)
Increase/(Decrease) in Trade and Other Payables	18,846	18,131	715
Increase/(Decrease) in Other Liabilities	11,970	20,336	(8,366)
Increase/(Decrease) in Provisions	1,949	(14)	1,963
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	(113)	(103)	(10)
Other movements in operating cash flows	(3)	(3)	0
NET CASH GENERATED FROM OPERATIONS	**51,083**	**51,661**	**(578)**
Cash flows from investing activities			
Interest received	4	4	0
Purchase of intangible assets	(7,753)	(2,898)	(4,855)
Purchase of Property, Plant and Equipment, Intangibles	(31,164)	(9,028)	(22,136)
Net cash generated (used in) investing activities	**(38,913)**	**(11,922)**	**(26,991)**
Cash flows from financing activities			
Public dividend capital received	154,600	134,814	19,786
Loans repaid to Department of Health	(130,852)	(130,852)	0
Capital element of finance lease rental payments	(221)	(202)	(19)
Interest paid	(273)	(273)	0
Interest element of finance lease	(280)	(257)	(23)
PDC Dividend paid	(3,378)	(2,096)	(1,282)
Receipt of cash donations to purchase capital assets	713	103	610
Net cash generated from/(used in) financing activities	**20,309**	**1,237**	**19,072**
Increase/(decrease) in cash and cash equivalents	**32,479**	**40,976**	(8,497)
Opening Cash and Cash equivalents	**16,286**	**16,286**	
Closing Cash and Cash equivalents	**48,765**	**57,262**	**(8,497)**

Appendix 3

Milton Keynes Hospital NHS Foundation Trust
Statement of Financial Position as at 31st March 2021

	Audited Mar-20	Mar-21 YTD Plan	Mar-21 YTD Actual	In Mth Mvmt	YTD Mvmt	% Variance
Assets Non-Current						
Tangible Assets	143.2	163.4	174.0	10.6	30.8	21.5%
Intangible Assets	16.1	14.6	22.0	7.4	5.9	36.6%
Other Assets	0.9	0.9	0.7	(0.2)	(0.2)	(22.2%)
Total Non Current Assets	**160.2**	**178.9**	**196.7**	**17.8**	**36.5**	**22.8%**
Assets Current						
Inventory	3.4	3.4	3.6	0.2	0.2	5.9%
NHS Receivables	18.7	20.2	7.3	(12.9)	(11.4)	(61.0%)
Other Receivables	6.9	10.7	13.7	3.0	6.8	98.6%
Cash	16.3	10.0	48.8	38.8	32.5	199.4%
Total Current Assets	**45.3**	**44.3**	**73.4**	**29.1**	**28.1**	**62.0%**
Liabilities Current						
Interest -bearing borrowings	(131.3)	(0.1)	(0.2)	(0.1)	131.1	-99.8%
Deferred Income	(2.3)	(2.0)	(14.2)	(12.2)	(11.9)	517.4%
Provisions	(1.5)	(1.3)	(3.3)	(2.0)	(1.8)	120.0%
Trade & other Creditors (incl NHS)	(38.9)	(46.9)	(64.1)	(17.2)	(25.2)	64.8%
Total Current Liabilities	**(174.0)**	**(50.3)**	**(81.8)**	**(31.5)**	**92.2**	(53.0%)
Net current assets	**(128.7)**	**(6.0)**	**(8.4)**	**(2.4)**	**120.3**	**(93.5%)**
Liabilities Non-Current						
Long-term Interest bearing borrowings	(5.8)	(5.7)	(5.6)	0.1	0.2	(3.4%)
Provisions for liabilities and charges	(1.6)	(1.6)	(1.7)	(0.1)	(0.1)	6.2%
Total non-current liabilities	**(7.4)**	**(7.3)**	**(7.3)**	**0.0**	**0.1**	(1.4%)
Total Assets Employed	**24.1**	**165.6**	**181.0**	**15.0**	**156.9**	**651.7%**
Taxpayers Equity						
Public Dividend Capital (PDC)	105.3	251.2	259.9	8.7	154.6	146.8%
Revaluation Reserve	48.4	48.4	50.1	1.7	1.7	3.5%
Financial assets at FV through OCI reserve	0.0	0.0	0.2	0.2	0.2	#DIV/0!
I&E Reserve	(129.6)	(134.0)	(129.2)	4.8	0.4	(0.3%)
Total Taxpayers Equity	**24.1**	**165.6**	**181.0**	**15.4**	**156.9**	**651.0%**

Meeting title	MKUH Board meeting	Date: 6 May 2021
Report title:	BLMK Strategic Priorities	Agenda item:
SRO:	Name: Rima Makarem	Title: Chair Bedfordshire, Luton and Milton Keynes ICS
Report Author:	Name: Nicola Kay	Title: BLMK Programme Director

Document summary	To provide an update on the development of the strategic priorities for the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System (ICS).			
Potential Risks and Issues				
Purpose *(tick one box only)*	Information ☐	Approval ☐	To note x	Decision ☐
Recommendation	The Board is recommended to note the contents of this report and provide steers on how the work can best consider the challenges and opportunities for the people of Milton Keynes which CNWL serves.			
Document history	The outcome of the workshops is being reported to each partner organisation Board or Health and Wellbeing Board.			
Appendices	None			

Purpose

1. This paper provides an update on the development of the strategic priorities for the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System (ICS). The purpose of this work is to create a common strategic direction for the ICS in terms of what it will deliver for population health over the medium and long term.

Background

2. In 2019, BLMK produced a Long Term Plan[1], following extensive engagement with partner organisations, residents, community groups and stakeholders. It is now the appropriate time to build on the basis outlined in the long term plan, ensure that BLMK strategic priorities align with the strategic objectives of partner organisations, identify any changes due to the pandemic and focus on population health outcomes. In addition, the Covid pandemic has further exposed inequalities in our society which we need to address collectively for the wellbeing of individuals and our communities.

[1] https://www.blmkpartnership.co.uk/wp-content/uploads/2020/10/10137-BLMK-LTP-SUMMARY-Living-longer-in-good-health-05.03.2020-1.pdf

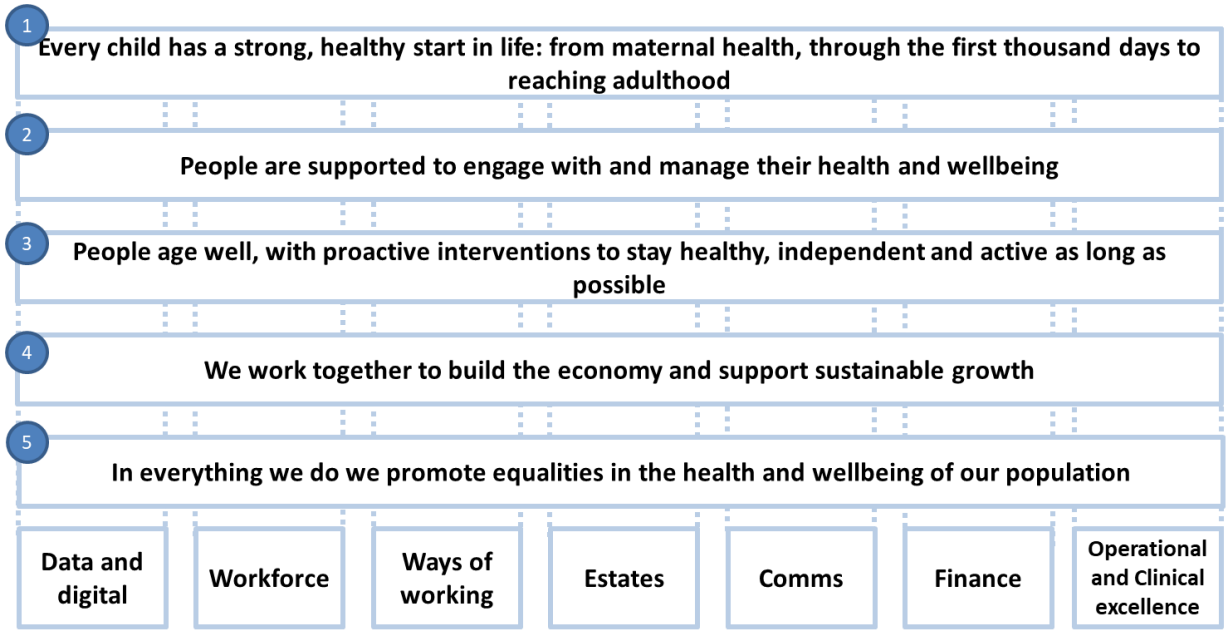
3. The intention of this work is to take a single system approach, with flexibility at place and care alliance level to meet local population needs. We will need to put in place appropriate governance to enable successful delivery of these priorities.

4. BLMK Chair and Executive Lead have met with all the CEOs and Leaders/Chair of the partner organisations to ascertain their views on the priorities for BLMK and the place they represent. The organisational priorities for each partner organisation and the impacts of Covid have been taken into account in the consideration of the BLMK priorities.

5. A set of draft priorities were discussed at a workshop of BLMK Partnership Board members on 3rd March 2021 and those attending were asked to identify the medium and long-term outcomes to address population health. In addition, the impacts of the Covid pandemic on local people, the workforce and the provision of services were also considered. For example the changes in demand for ambulance services and the impact of the pandemic on our workforce. The outputs from this workshop were considered at a second workshop on 24th March, to further develop the priorities and unpack the activity needed at each level of the system to deliver on these.

Emerging priorities

6. These are the emerging priorities for the ICS:



7. We have also identified a set of cross-cutting enablers, which will support the successful delivery of the priorities above, and where some activity will need to take place at ICS level. These include data and digital, workforce, ways of working, estates, communications, finance and operational & clinical excellence.

8. We want to ensure that we are threading a reduction in inequalities throughout all the priorities set out above, as well as looking at reducing systemic inequality as part of priority 5. This means that the way delivery is designed is not entrenching inequalities and more vulnerable groups are explicitly supported. The full emerging strategy priority framework is in Annex A.

9. At the workshop on the 24th March, we discussed the priorities in more detail for each place. MKUH representatives, with partners in Milton Keynes, focussed on priority 1

around supporting children and their families to make a healthy start in life which will continue into adulthood.

10. As part of this development work, we are taking into account wider changes that will affect our population and services in BLMK. For example:

- Making the most of the Oxford-Cambridge Arc
- Additional investment in rail infrastructure as part of East West Rail, connecting Oxford and Cambridge via Bedford and taking in Milton Keynes on a branch will also open up opportunities for growth
- Following on from the above, we may be able to identify greater research and investment opportunities, potentially working more closely with the universities in BLMK
- Embedding technological advances in our system, including broadband access for all, and new advances which will enable better delivery of health and care
- Shifting generational expectations about receiving services that we need to be mindful of and aligned with

11. Principles for how we work together

Across our system, we want to develop effective ways of working which mirror the more formal governance approaches. In the conversations with system leaders, we heard a range of perspectives about what is important around how we work. From these conversations, we developed a proposed set of principles which were agreed at the Partnership Board on 7 April 2021.

- We learn from good practice both from within and outside our system and we embed it, adapting to local circumstances as needed but not reinventing
- We take a subsidiarity approach, with activity taking place at the lowest possible level, with activity taking place at a higher level only where that is more efficient and effective
- We are mutually accountable for delivering our priorities, with everyone taking responsibility for delivering their contribution as well as supporting others in delivery of theirs
- We keep the needs of the population at the centre of everything we do, taking a co-production approach with system partners across all sectors, the VCSE and with people with lived experience
- We build from where we are now, taking into account different starting points and reflect and adapt as we go along, embedding the principles of a learning system
- We take into account others' perspectives and are open with each other about our challenges, supporting each other in resolving any difficulties to better deliver continuous improvement

The Board are requested to adopt these principles of working in partnership with statutory, voluntary and community organisations in BLMK.

Next steps

12. The next stage will be to:

(i) Support the places in BLMK to develop activities across all of the 5 priorities – the main focus so far has been deep dives into priorities 1 and 4; so we need to develop the thinking in partnership on priorities 2, 3 and 5

(ii) Work with places to deliver place-based plans against all of the priorities, accelerating and building on existing activity and supporting development of appropriate resource and governance structures to enable successful delivery

(iii) Develop the plans at ICS level for the cross-cutting enablers and governance for this work, and ensuring that all this work comes together in a single plan for 'year 1' for delivery of the priorities across BLMK for 2021/22

Recommendation

13. The Board is recommended to note the contents of this report and provide steers on how the work can best consider the challenges and opportunities for the people of Milton Keynes.

14. The Board is asked to adopt the principles of how we work together in partnership.

Annex A: Priorities Summary Framework

	Priority 1: Every child has a strong, healthy start in life: from maternal health, through the first thousand days to reaching adulthood	Priority 2: People are supported to engage with and manage their health and wellbeing	Priority 3: People age well, with proactive interventions to stay healthy, independent and active as long as possible	Priority 4: We work together to build the economy and support sustainable growth	Priority 5: In everything we do we aim to embed the principles of population health and reduce inequalities
Evidence	• Our earliest experiences in life, starting in the womb, through birth, early years and into childhood and adolescence are vital in laying the foundations for future good health and wellbeing. • Children with adverse experiences growing up, such as living in a household with substance misuse or domestic violence, are less likely to be healthily and achieve in life • Fragmentation in the children's system leads to poorer outcomes for our most vulnerable children	• Supporting people to stay well for longer and making the most of the expertise, capacity and potential of people, families and communities in delivering better health and wellbeing outcomes and experiences will reduce pressures on health and care services • Earlier identification of health conditions can help to improve outcomes and reduce premature mortality	• Tackling issues such as social isolation, alongside reducing risk factors such as physical activity, poor hydration and nutrition and sensory impairment improves quality of life and reduces health service pressures and demands • Supporting independence, using an asset based approach, is a priority in maximising quality of life	• People's economic circumstances – the security and safety of their jobs and their level of income – are key to their health. Good employment is closely linked to good health and wellbeing and protects against social exclusion • High quality economic infrastructure enhances quality of life • The quality and availability of affordable homes is a key contributor to wellbeing of individuals and families	• Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Inequalities arise because of the conditions in which we are born, grow, live, work and age • Evidence says that people living in our most deprived areas face the worse inequalities in relation to health access, experiences and outcomes.
BLMK context	• 39% of 15-16 year olds achieve grades 9-5 in English and Maths, compared to an England average of 43% • One third of children in year 6 are overweight or obese. One third of 5 year olds in Luton have tooth decay • 24% of children living in Central Bedfordshire, 31% of children in MK and Bedford Borough and 46% of children in Luton live in poverty • Infant mortality is higher in Luton compared with similar areas • Covid has caused a rise in mental health needs and eating disorders	• Compared to England, the smoking prevalence in Luton and in routine/manual occupations in Milton Keynes are significantly higher • Milton Keynes and Bedford Borough residents are less likely than average to visit the natural environment for health or exercise purposes • A baby girl born in Central Bedfordshire can expect to live for almost six years longer than a baby boy born in Luton; this gap mainly reflects higher deaths from circulatory diseases, cancer and respiratory diseases in deprived areas	• 44% of social care service users in BLMK feel they have as much social contact as they would like • Over 150,000 over-65s live in BLMK and this is expected to increase to 210,000 over the next 20 years. The number of over-90s is expected to more than double in that period • Emergency hospital admissions due to falls for people 65 and over are 11% higher in Milton Keynes than the England average	• There are 1.15 jobs per person of working age in Milton Keynes and 0.75 jobs per person elsewhere in BLMK; England has 0.87 jobs per person • The employment rate gap in BLMK is 11 percentage points worse for people with a long term condition, 67 for people with a learning disability and 68 for people in contact with secondary mental health services • Overall, close to 1/5 jobs pay less than the living wage	• In the most healthy wards of BLMK, women enjoy 20 years longer in good health than in the least healthy small areas. For men the gap is 17 years • Babies born in the most affluent parts of BLMK will live longer than those born in the most deprived areas. The biggest gap for men is in Bedford Borough (10 years) and the smallest is for women in Luton (6 years). • Two thirds of children are living in poverty in Biscot and Dallow wards in Luton and Queens Park ward in Bedford

Goals	• All children, regardless of where they live or their background, will be supported to have the best possible health and emotional wellbeing
	• Improved outcomes for pregnant women and infants; eliminating inequalities for Black and Asian women and those in deprived areas
	• Children can grow up in a safe and healthy home environment
	• There is an increase in educational attainment and employment levels for young people leaving education
		• Levels of wellbeing in the population increase, with people able to manage their own health and wellbeing
		• An increase in the number of years of healthy life expectancy
		• A reduction in the gap between highest and lowest decile healthy life expectancy
		• A reduction in premature mortality in BLMK
			• Fewer older people feel lonely or socially isolated
			• Older adults stay healthier, happier and independent for longer
			• There is a reduction in the number of older people having falls
			• People receive good quality end of life care and have good deaths
				• Increased economic growth rates
				• Increased levels of employment and the proportion of people earning the living wage
				• Closing the employment gap for people with long term conditions and learning disabilities and mental health issues
				• Increasing the quality and availability of our housing stock across BLMK
					• Achieve reductions in inequalities through the work of priorities 1-4
					• Reduce the gap between outcomes for our wider communities and
					  • Gypsy and traveller communities
					  • BAME communities
					  • For people with specific conditions including people with learning disabilities, autism or both

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Public Board	May 2021
Report title:	Significant Risk Summary Report	**Agenda item: 7.1**
Lead director **Report author** **Sponsor(s)**	**Paul Ewers** **Kate Jarman**	**Risk & Systems Manager** **Director of Corporate Affairs**
FoI status:	**Disclosable**	

Report summary	The report includes all significant risks across all Risk Registers, where the Current Risk Rating is graded as 15 or above, as at 27th April 2021			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [ ]	**Decision** [ ]
Recommendation	The Public Board is asked to note and discuss the contents within the report, in to ensure risks are being robustly and actively managed across the Trust.			

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

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

Executive Summary:

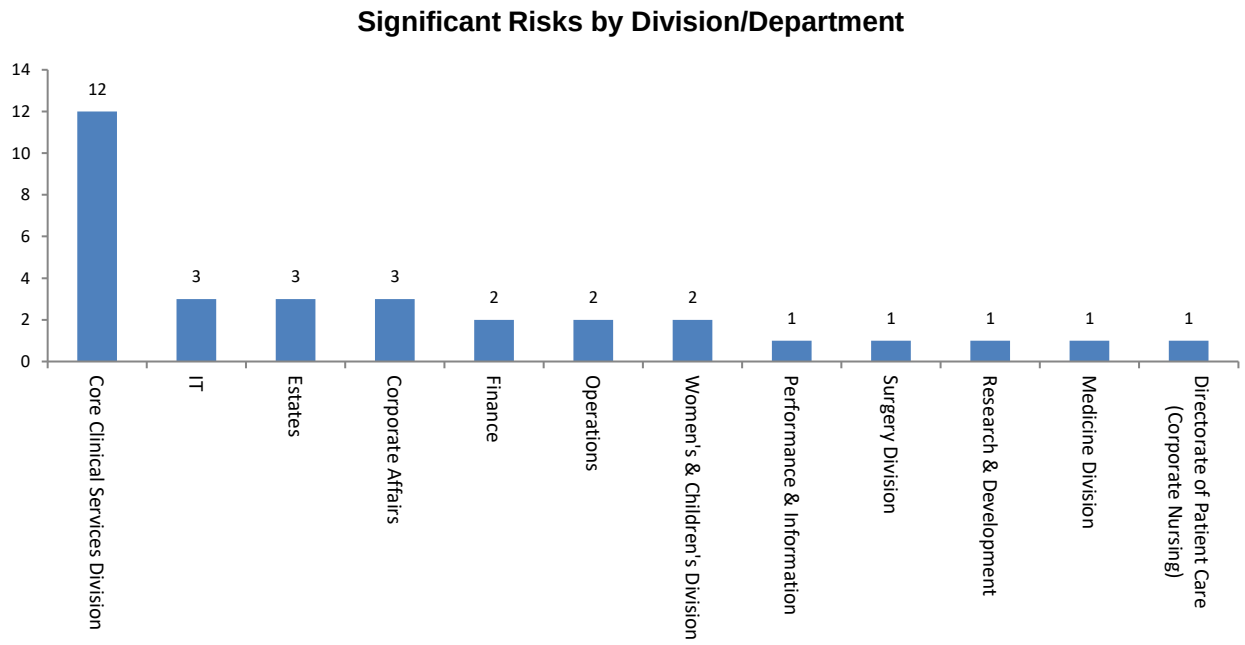
This report shows the profile of significant risks across the Trust by type and area.

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

The Board is asked to note the content of this report

Risk Profile

- There is a total of 32 significant risks identified on Risk Registers across the Trust:



- Of these risks 10 are overdue their review date and have been escalated for corporate review.

- There was one new significant risk added during April 2021:

  ID3066 - *The neurology department runs a botox injection clinic for patient staffed by a single consultant, increasing the risk of longer waiting times due to consultant capacity.*

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

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

- One of the risks are categorised as being tolerated even though their Current Risk Rating is higher than the target (i.e. the level of risk identified as tolerable) – this has been escalated for corporate review.

- There are no Actions identified for 12 of the risks. It should be noted that, for many of these risks, actions have been and are being undertaken, however the risks have not been updated on Datix. A process has commenced for all risks to have an additional formal annual review (see below). One of the aims of this new process is to ensure that all actions are added to the risk register for completeness and to support the ongoing management of the risk.

Corporate Risk Register

A proposal is going to the next Trust Executive Group (TEG) to introduce a Corporate Risk Register. This to enhance the ability to manage risks that impact more than one area of the Trust. It will also enable the Divisions to escalate significant risks that they do not have the capacity/ability to manage. Risks will not automatically move between Divisional to Corporate Risk Registers purely based on Current Risk Rating (which is currently the case), but by discussion and agreement by the Risk Board and/or TEG. This risk register will be used to ensure robust operational management of risk.

It is recognised that TEG need to have oversight of all significant risks. Therefore the Significant Risk Register will be used as a mechanism for reporting all significant risks to TEG on a regular basis.

Annual Review of Risks

A new process has commenced where all risks will have an annual review and refresh. A new 'Annual Review Date' column has been included onto Datix and the Risk Register templates. This annual review and refresh work will ensure the quality and completeness of the data on the risk register will be improved. It will also ensure that risks that have been on the risk register for some time, are still relevant. The annual review will be in addition to the necessary regular risk reviews currently undertaken by the Divisions/Departments.

As part of this work, the Risk & Systems Manager is undertaking a review of all Division's/Corporate Department's risk registers and providing feedback to the relevant managers for inclusion in their annual risk register review.

Significant Risk Register Summary

Division	Description	Controls in place	Current Risk Level
Operations	The risk of capabilities in responding to a Novel Coronavirus (COVID-19) impacting on patient care within clinical and non-clinical services, with the inability to maintain safety for staff and patients due to national pressures on supplies and infrastructure.	COVID-19 operational and contingency plans in place reviewed through Silver and Gold command structure, with meeting recorded through action logs PPE logged daily covering delivery and current stock	HIGH
Women's & Children's Health - Children's Health	Overcrowding and insufficient space in the Neonatal Unit, exacerbated by need for social distancing due to COVID-19	1. Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards 2. Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID 3. Added to capital plan 4. Feasibility study completed	HIGH
Women's & Children's Health - Women's Health	Inability of Trust to provide maternity care locally for some women (during times of peak demand on service, delays in clinical care) and potential increased readmission rate due to reduced length of stay	Daily huddle & bed state reviews Escalation process Review of obstetric clinical pathways Three times a day Maternity specific safety huddle (March 2021) Regular reviews with Exec Team	HIGH
Finance	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.	1. Cost and volume contracts replaced with block contracts (set nationally) for clinical income;2. Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until September 2021); 3. Budgets to be reset for FY22 based on financial regime; financial controls and oversight to be reintroduced to manage financial performance.4. Cost efficiency programme to be reset to target focus on areas of greatest opportunity to deliver	HIGH
Core Clinical & Support Services - Pharmacy	The risk is there will be insufficient staff in pharmacy to meet demands of the organisation and ensure patient safety in the use of medicines.	Actively recruiting, listening events with staff, identifying quick wins from staff to reduce turnover, implementing 1-1 system to support staff, reviewing work activities of 8a's and above	HIGH

Division	Description	Controls in place	Current Risk Level
Corporate Affairs	There is a risk that not all known incidents, accidents and near misses are reported onto Trust Incident Reporting System (Datix) and that they will not be robustly investigated within the required timescales	1. Incident Reporting Policy 2. Incident Reporting Mandatory/Induction Training 3. Incident Reporting Training Guide and adhoc training as required 4. Datix Incident Investigation Training sessions 5. Daily review of incidents by Risk Management Team to identify potential Serious Incidents and appropriate escalation 6. Serious Incident Review Group (SIRG) ensure quality of Serious Incident Investigations 7. SIRG ensure appropriate reporting of Serious Incidents to Commissioners 8. Staff able to have automatic feedback following investigation approval 9. Incident Reporting Awareness Campaign - September 2017 10. Standard Operating Procedure re Risk & Governance Team supporting the closure of incident investigations during unprecedented demand on service (e.g. Covid-19 Pandemic) approved - February 2021 11. Patient Safety Framework introduced	HIGH
Operations	Risk that patient discharges will significantly be delayed, especially those requiring complex coordination of the discharge process	Covering a small number of shifts with former Discharge Coordinator carrying out bank shifts, when available. Offered bank shift to train an Agency Nurse who has shown an interest in the role. Recruited in to one vacancy and interviewing in to Bucks Coordinator role on 2/8/19. Reviewed role and delegated minor responsibilities to Rotational Operations Liaison Officers. Support requested from key nursing areas who have the skills to support a number of aspects relating to the role & discharge process- awaiting confirmation	HIGH

Division	Description	Controls in place	Current Risk Level
Finance	There is a risk that the Trust is unable to achieve the required efficiency improvements through the transformation programme leading to an overspend against plan	1. Tracker in place to identify and track savings and ensure they are delivering against plan 2. Savings measured against Trust finance ledger to ensure they are robust and consistent with overall financial reporting 3. All savings RAG rated to ensure objectivity 4. Oversight of the transformation programme through the Transformation Programme Board and Trust Executive Group.	HIGH
Core Clinical & Support Services - Clinical Support Services	The risk is that the trust is failing in its statutory legal duty under the Health & Safety at Work etc. Act 1974, Management of Health & Safety at Work Regulations 1999, Workplace (Health, Safety & Welfare) Regulations 1992 and Display Screen Equipment Regulations 1992 to provide a safe and well maintained place of work including welfare facilities for staff	Due to the number of staff within the area, some staff have to work from home (rota basis) Mobile air conditioning units distributed. Plumbed in water cooler in situ. .	HIGH
IT	IF the internal Trust telephone systems are not upgraded, THEN they will fall into a state where they cannot be supported by the Trust's IT Department or any third-party suppliers, LEADING TO potential loss of telephone systems either in small areas or across the Trust. This would have a significant impact upon operational procedures, especially during critical or busy periods.	Support in place, upgrade ETA Pending Capital funding	HIGH
Core Clinical & Support Services - Diagnostic & Screening	The 10yr old mammography machine in BS2 could fail due to its age. The increased amount of unplanned downtime this year is consistent with aging equipment. With the introduction of new technologies the availability of replacement parts is a worry. A replacement part needed to be shipped from Chicago.	Comprehensive service contract All faults reported immediately to external contractor / physicist for support. Robust QA systemin process to monitor system performance. This is reviewed weekly by medical physics.	HIGH

Division	Description	Controls in place	Current Risk Level
Surgical - Musculoskeletal	There is a risk to head injury patients not being appropriately cared for as they are not being treated in accordance with NICE guidance (CG176: Head injury: assessment and early management, updated September 2019)	1, 2 & 3. Preventive controls - On going discussions with Senior Medical Team - CSU Lead to escalate via trauma network - Alert process is in place for escalation within T&O & externally. - Resources available at tertiary site for advice/support 1, 2 c& 3. mitigating controls - Policy for management of head injuries has been developed - Awaiting appointment of head injury liaison Nurse	HIGH
Corporate Affairs	Clinical Governance and Imaging staff are unable to meet statutory and mandatory Good Governance requirements and accreditations if IT systems do not support their remit.	System in place but requires updating and Q pulse which manages Trust documentation is no longer able to archive since the shared drive was moved. Updates made to Q-Pulse and SharePoint	HIGH
Performance & Information	The Trust Information data warehouse could fail or be subjected to a security attack.	There are reactive controls in to support the data warehouse using the in-house teams, including daily check of the servers, deleting redundant information stored on the server is conserve space. Additionally, A business case to migrate the information platform to Microsoft Azure platform has been submitted to the Executive directors for consideration and awaiting a decision.	HIGH
Estates	IF the estates infrastructure contingency plans are not adequately tested THEN in the event of a infrastructure failure plans may not succeed LEADING TO contingency plans not being effective and to potential loss of services, poor patient experience, financial loss and loss of reputation	1. Partially tested Contingency Plans. 2. Review of Business Continuity Plan review process completed in conjunction with Gordon Austin assisting with reviewing process and plans. 3. Continuity plans reviewed and shared with team. 4. Noted that plans partially tested during the recent flooding incident. 5. Emergency Planning Officer has been sent the plan for review and comment. 6. Met EPO and reived document, awaiting publication.	HIGH
IT	The current bleep system (main system A and back-up system B) is obsolete and no maintenance support contract is available from the company. The risk is that the equipment may not be able to be repaired if failed.	-DISCUSSED WITH LINE MANAGER AND ESCALATED -TEMPORARY RADIO COMMUNICATION SYSTEM 3. User group formed with IT & EBME to identify options	HIGH
Core Clinical & Support Services - Diagnostic & Screening	Delayed detection of breast screening cancers due to COVID 19	Restart proposal approved by the Trust, SQAS and PHE. Guidance issued as to the management of the women to ensure that no-one is missed has been issued by Hitachi/PHE and has been implemented by the programme.	HIGH

Division	Description	Controls in place	Current Risk Level
Core Clinical & Support Services - Diagnostic & Screening	Lack of space for appropriate management of CT and MRI with additional issues of lack of scanners to manage the increasing demand.	Extended working hours and days, some scans sent off site to manage demand. Reduced appointment times to optimise service. 1.12.20 no change to risk rating services remain challenged due to lack of basic capacity made worse by Covid social distancing and cleaning issues. IS provider approached to provide more MRI capacity	HIGH
IT	IF the IT Department does not have a stock of replacement network switches, THEN if a switch fails a replacement will need to be sourced, procured, delivered, and installed, LEADING TO a delay in bringing up to 48 devices back online, potentially losing IT devices for a whole area/department for up to two weeks.	There is no stock left.	HIGH
Core Clinical & Support Services - Clinical Support Services	Unable to meet the demand for existing patients leading to increased waiting times Unable to develop existing outpatient services Unable to optimise student placements	1. Extended working hours 2. Introduction of shift pattern 3. Introduction of telephone triage clinics 4. Group treatment sessions	HIGH
Core Clinical & Support Services - Clinical Support Services	There is a risk that the Women & Men's Health Physiotherapy Service is unable to meet its referral demand	Non clinical time including training, development and audit are being minimised to increase the number of available patient appointments Job plans are being completed by all staff to show impact on workload Patients are being booked into group where possible instead of individual appointment slots Recruited to all vacant posts To explore options for supporting dictation of letters to free up clinical capacity.	HIGH
Core Clinical & Support Services - Clinical Support Services	There is a risk that Children's Physiotherapists are not able to run to their full capacity in order to treat all children on their caseload/waiting list	Physiotherapy staff timetables designed to avoid clusters of staff all working in the CDC at the same time. Room booking system in place. All have been in place for years; the problem is worsening as the building is shared with other teams which are growing.	HIGH

Division	Description	Controls in place	Current Risk Level
Directorate of Patient Care	The MUST conformance criteria were set out in the NHS accessible information specification for compliance by the 31st July 2016	Some of the meeting individual needs resources identified i.e.BSL sign language interpreters, braille, easy read Ongoing EPR agile preparation events E Care launch plan in progress	HIGH
Core Clinical & Support Services - Diagnostic & Screening	There is a risk that the available space within Cellular Pathology will not be enough to meet the demands of the service as workload continues to expand	Storage of specimens minimised. No unnecessary specimens stored Storage period reduced from 6 weeks to 4 weeks with the approval of Pathologists and Clinical Lead	HIGH
Medical Director	R&D department has yearly running staff contracts, not permanent contracts and we are not able to provide longer term contracts for the team	1. Requested support from the network CRN 2. Discussed with other Trusts Partners regarding their existing contracts	HIGH
Core Clinical & Support Services - Clinical Support Services	Increasing numbers of patients being added to the physiotherapy outpatient waiting list, in addition to those on hold due to the COVID-19 pandemic, resulting in waiting times of well over 18 weeks for any type of intervention. A further increase in referrals may result from patients with post-COVID symptoms	- Virtual management of patients - Video and telephone clinics - Additional IT sourced to support virtual management - Reconfiguration of department to support virtual working and enable social distancing along with staff working from home - recovery plans are being written/in place to enable essential patients to be seen in the department of a face to face basis - Educational material including exercise programmes and access to YouTube clips are made available to patients	HIGH
Core Clinical & Support Services - Clinical Support Services	Poor outcomes for children and young people referred to the children's physiotherapy service	Coding and prioritizing of referrals 1:1s and caseload supervision	HIGH
Medicine - Specialty Medicine	The neurology department runs a botox injection clinic for patient staffed by a single consultant; this consultant is now on long term sick leave. There are 50 patients awaiting review and treatment in clinic.	There is no substantial control in place	HIGH

Division	Description	Controls in place	Current Risk Level
Corporate Affairs	There is a risk that changes required to practice are not implemented and we are not meeting best practice criteria	Audit report templates available to identify audit action plans. However these are not always being utilised and actions are not Always evidenced and monitored Monitoring via Clinical Audit & Effectiveness Committee (CAEB) TOR CAEB revised to include quality improvement, GIRFT etc Escalation/exception reporting to Management Board Refresh of Sharepoint data base to assist with data capture, with Level 1 audit a priority Transformation Team audit	HIGH
Estates	There is a risk of roof failure in relation to flat roofs across the Trust	1. Inspections and repairs as needed. 2. Updated annual 6 facet survey by Oakleaf 3. Large patch repairs undertaken as emergency business cases 4. 1 x Post Grad roof fully replaced 19/20. 5. Ward 10 - 50% of roof patch repairs completed 19/20 6. Phase 1, Phase 2 and Community Hospital survey completed.(52 roof leaks noted in 12 months Jan 19 -Aug 20) 16 leaks in 1st week of October 2020 7. Pharmacy small roof replaced September 20. 8. Business Case approved for 4 to 5 year rolling programme. 9. Work underway March 2021	HIGH
Core Clinical & Support Services - Clinical Support Services	The risk is that the paediatric team can not provide a full dietetic service to children and young people in the Milton Keynes area	Existing staff are working some additional hours but this remains insufficient to meet the needs of the service.	HIGH
Estates	The current risk is that there is not enough space in the Medical Equipment Library(MEL) to carry out the required cleaning process to comply with the appropriate guidelines set by CQC and MHRA.	Staff members are taking processed equipment straight to the shelving areas as soon as it is cleaned to avoid cross contamination. This ensure equipment is kept separate, but this is not a productive method of working.	HIGH

Recommendations:

The Board are asked to review and discuss this paper.

Definitions:

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

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

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

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

Significant Risk Register

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2920		05/05/2021	Director of Clinical Services	Biggs, Adam	Operations	Emergency Planning	The risk of capabilities in responding to a Novel Coronavirus (COVID-19) impacting on patient care within clinical and non-clinical services, with the inability to maintain safety for staff and patients due to national pressures on supplies and infrastructure.	Surge of COVID-19 patients impacting on Trust ability to maintain patient care and clinical services. Loss of staff to support clinical and non-clinical services due to high levels of absence. Loss of national stockpile in PPE or medical devices (ventilators) resulting in the Trust not receiving deliveries to preserve the safety of patients and staff.	Loss of clinical and non-clinical services Financial impacts Risk to patient care Risk to staff wellbeing	5	5	25	HIGH	COVID-19 operational and contingency plans in place reviewed through Silver and Gold command structure, with meeting recorded through action logs PPE logged daily covering delivery and current stock		5	4	20	HIGH	Trust has no control over national stockpile of PPE and medical devices required for response. This is monitored and reported daily.	5	3	15	HIGH	TREAT - above tolerable level - appropriate cost-effective control required		21/10/2020	No Change	National oversight	09/11/2020
2570	9-1	30/03/2021	Director of Clinical Services	Gawlowski, Dr Zuzanna	Women's & Children's Health - Children's Health	Neonatal	Overcrowding and insufficient space in the Neonatal Unit, exacerbated by need for social distancing due to COVID-19	Cot spacing does not comply with BAPM guidance or the latest PHE guidance for COVID-19. The Unit is seeking to increase both total cot spacing and cot numbers by 4 HDU/ITU cots in line with Network 5 year projections of acuity and demand, and spacing in line with National Recommendations.	Without the increase in cot numbers and corresponding cot spacing we will be unable to meet patient needs or network requirements. We will now also be unable to meet PHE recommendations for social distancing This may result in a removal of Level 2 status if we continue to have insufficient space to adequately fulfil our Network responsibilities and deliver care in line with national requirements. This may also impact on our ability to protect babies and their families during COVID	5	5	25	HIGH	1. Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards 2. Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID 3. Added to capital plan 4. Feasibility study completed	1. NNU Feasibility study in progress awaiting decision of the Board as to whether to proceed with major reconfiguaration and increased cots to meet TVN demand. 2.Planning for a specific W&C build is being discussed	5	4	20	HIGH	1. Outline business case for NNU rebuild has been developed by Trust and estates department and submitted to CCG/STP partners for consideration. Awaiting final decisions	3	3	9	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Approval of business case - Complete Business Case for Refurnishing Milk Kitchen and Sluice	30/03/2021	No Change	No change	30/06/2021
2955	N/A	30/03/2021	Director of Patient Care / Chief Nurse	Styles, Janice	Women's & Children's Health - Women's Health	Obstetrics & Maternity	Inability of Trust to provide maternity care locally for some women (during times of peak demand on service, delays in clinical care) and potential increased readmission rate due to reduced length of stay	Location of Gynaecology patients on Ward 10 resulting in the loss of 13 obstetric beds	Delays in clinical care (inductions, pain relief etc) at times of heavy demand while beds sourced & potential need to divert to neighbouring maternity units when unable to accommodate women. Poor patient experience.	5	5	25	HIGH	Daily huddle & bed state reviews Escalation process Review of obstetric clinical pathways Three times a day Maternity specific safety huddle (March 2021) Regular reviews with Exec Team	LOS data Incident reporting rate on readmissions - deep dive analysis currently ongoing	5	4	20	HIGH	Requirement for EPAU to be away from ante and postnatal ward areas. Bed space needs to be increased	3	3	9	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Review of potential plan to move EPAU away from ante and postnatal ward areas and increase bed space	30/03/2021	No Change	ongoing risk	30/06/2021
940	7-3		Director of Finance	Aldridge, Sophia	Finance	Financial Management	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.	Unknown funding regime beyond September 2021 due to disruption caused by COVID-19	1.Increase in operational expenditure in order to manage COVID-19. 2.Reductions in non-NHS income streams as a direct result of COVID-19.3.Impaired operating productivity leading to costs for extended working days and/or outsourcing. 4.Potential for material increase in efficiency requirement from NHS funding regime to support DHSC budget affordability.	4	5	20	HIGH	1. Cost and volume contracts replaced with block contracts (set nationally) for clinical income;2. Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until September 2021); 3. Budgets to be reset for FY22 based on financial regime; financial controls and oversight to be reintroduced to manage financial performance.4. Cost efficiency programme to be reset to target focus on areas of greatest opportunity to deliver	Monthly financial performance monitoring information by the F&I Committee and the Trust Board Cost efficiency reporting BLMK ICS finance performance reporting	4	5	20	HIGH	Financial regime for FY22 only valid for first half of the year. Trust has minimal ability to influence	5	2	10	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Maintain dialogue with CCG re Contract Raise risk of dispute over interpretation of Contract with Monitor	19/04/2021	Increased	Increased	19/05/2021

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2796			Director of Clinical Services	Chadwick, Ms Helen	Core Clinical & Support Services - Pharmacy	Pharmacy	The risk is there will be insuffient staff in pharmacy to meet demands of the organisation and ensure patient safety in the use of medicines.	High turnover of staff due to work pressure and not having the opportunity to work at the top of their licence. Also difficulty in recruiting particularly to 8a posts.	1. increased length of stay due to TTO delay 2. increase in prescribing errors not corrected 3. increase in dispensing errors 4. increase in missed doses 5. failure to meet legal requirements for safe and secure use of medicines Breach of CQC regulations	4	5	20	HIGH	Actively recruiting, listening events with staff, identifying quick wins from staff to reduce turnover, implementing 1-1 system to support staff, reviewing work activities of 8a's and above to identify what could stop for a period of time.	Morale remains low, turn over remains high.	4	5	20	HIGH	Use of senior staff to support not viable long term.	2	3	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Bc to execes	26/02/2021	No Change	turnover remains Reduced pressure c19	26/03/2021
1472	1-4	24/03/2021	Director of Corporate Affairs	Ewers, Mr Paul	Corporate Affairs	Risk Management	There is a risk that not all known incidents, accidents and near misses are reported onto Trust Incident Reporting System (Datix) and that they will not be robustly investigated within the required timescales	Failure to comply with the Incident Reporting Policy; Poor incident reporting culture; Lack of understanding of the necessity and importance of reporting incidents; Lack of incentives to report incidents due to lack of feedback or poor quality investigation outcomes; Lack of consequences for failing to report; Lack of consequences for poor quality investigations; Lack of computer access to report incidents; Conflicting priorities and lack of time to report; Perceived difficulty in completing the online incident reporting form	The Trust will not have a complete list of incidents occurring in the Trust; Inability to learn from incidents, accidents and near-misses; Inability to stop potentially preventable incidents occurring; Potential failure to comply with Duty of Candour legislation requiring the Trust to report all known incidents where the severity was moderate or higher; Potential under reporting to the National Reporting & Learning System (NRLS); Potential failure to meet Trust Key Performance	4	5	20	HIGH	1. Incident Reporting Policy 2. Incident Reporting Mandatory/Induction Training 3. Incident Reporting Training Guide and adhoc training as required 4. Datix Incident Investigation Training sessions 5. Daily review of incidents by Risk Management Team to identify potential Serious Incidents and appropriate escalation 6. Serious Incident Review Group (SIRG) ensure quality of Serious Incident Investigations 7. SIRG ensure appropriate reporting of Serious Incidents to Commissioners 8. Staff able to have automatic feedback following investigation approval 9. Incident Reporting Awareness Campaign - September 2017 10. Standard Operating Procedure re Risk & Governance Team supporting the closure of incident investigations during unprecedented demand on service (e.g. Covid-19 Pandemic) approved - February 2021 11. Patient Safety Framework introduced	1. Risk Management Dashboard monitoring trends 2. Weekly overdue incident reporting 3. Routine and exception reports to Risk & Compliance Board 4. Weekly Compliance Report to Executive Team 5. Incident reporting rate and overdue incidents monitored through Trust KPIs 6. Regular reporting to Divisions through Clinical Governance reports 7. Divisional Dashboards to monitor trends 8. Bi-monthly National Reporting	4	4	16	HIGH	1. Lack of a high incident reporting culture 2. Lack of robust investigations for non-Serious Incidents 3. Lack of feedback to reporters/staff following incident investigations 4. Staff lack access to a computer to report incidents 5. Staff lack time during shift to report incidents 6. More intuitive incident reporting system - procurement scoping exercise on going for Datix Cloud/new system	4	3	12	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Comms Initiative being developed to coincide with launch of simpler incident reporting form and enhanced Incident reporting training at Induction/Mandatory Training - Complete Quality Improvement Project to be undertaken - Ongoing through Learning From Incidents Focus Group Recruitment of two new band 7 facilitators - complete Launch the 'SHARE' Incident Reporting Campaign with Comms Team - Complete Letter re-iterating the importance of incident reporting to be sent from CEO via wage slips - Decision made not to undertake - Complete Incident Reporting Handbook for staff to coincide with 'SHARE' launch to be developed - Decision made not to undertake - Complete Consider the increase of accessibility to computers in order to report incidents at Risk & Compliance Board - Complete Datix Manager to speak to higher reporting Trusts to see how they have developed an effective reporting culture - Complete Develop Risk Systems Business Case -	26/02/2021	No Change	No change since last review	30/04/2021
2791			Director of Clinical Services	Orr, Mrs Julie	Operations	Patient Discharge	Risk that patient discharges will significantly be delayed, especially those requiring complex coordination of the discharge process	The Discharge Coordinators (Registered Nurses B6 level) are currently severely short staffed due to vacancies and sudden long term sickness, with an additional Discharge Coordinator due to have major surgery leading to additional long term sickness. The Discharge Team currently consists of 5 wte B6 Registered Nurses. At present there are 3wte in post however 2wte are on long term sick leave.	Increased length of stay (LOS) for complex discharges, leading to a potential for an increase in hospital acquired infections, de-conditioning Potential to affect the stranded and super stranded patient numbers and a failure achieve National target set for 2019-20, with associated impact on ED performance Increased delayed transfers of care (DToC) Poor patient experience due to the delays in discharge/discharge planning and referrals Other services capacity not being fully utilised due to delays in internal assessments Need for the Head of Clinical Services & Trust Lead for Discharge to take on some of the functions impacting on	4	5	20	HIGH	Covering a small number of shifts with former Discharge Coordinator carrying out bank shifts, when available. Offered bank shift to train an Agency Nurse who has shown an interest in the role. Recruited in to one vacancy and interviewing in to Bucks Coordinator role on 2/8/19. Reviewed role and delegated minor responsibilities to Rotational Operations Liaison Officers. Support requested from key nursing areas who have the skills to support a number of aspects relating to the role & discharge process- awaiting confirmation	Review of Datix incidents figures Superstranded patirnt data	4	4	16	HIGH	Additional funding to over recruit 1 WTE to for a 6 month period to cover the long term sickness	3	3	9	MOD	TREAT - above tolerable level - appropriate cost-effective control required		28/08/2019	No Change	New Risk	30/11/2019

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1519	7-2		Director of Finance	Aldridge, Sophia	Finance	Financial Management	There is a risk that the Trust is unable to achieve the required efficiency improvements through the transformation programme leading to an overspend against plan	Transformation delivery is not adequately resourced and prioritised and/or schemes are unrealistic and not well planned.	The Trust may not deliver its financial targets leading to TO potential cash shortfall and non-delivery of its key targets	4	4	20	HIGH	1. Tracker in place to identify and track savings and ensure they are delivering against plan 2. Savings measured against Trust finance ledger to ensure they are robust and consistent with overall financial reporting 3. All savings RAG rated to ensure objectivity 4. Oversight of the transformation programme through the Transformation Programme Board and Trust Executive Group.	1. Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partners. 2. Cross-cutting transformation schemes being worked up. 3. Savings plan for 21/22 financial year not yet fully identified."	4	4	16	HIGH	Saving schemes to be identified to deliver maximum savings in 2021/22	3	3	9	MOD	TREAT - above tolerable level - appropriate cost-effective control required		19/04/2021	Increased	Schemes still need to be worked up	19/05/2021
2055			Director of Corporate Affairs	Stamp, Mr Jamie	Core Clinical & Support Services - Clinical Support Services	Dietetics	The risk is that the trust is failing in its statutory legal duty under the Health & Safety at Work etc. Act 1974, Management of Health & Safety at Work Regulations 1999, Workplace (Health, Safety & Welfare) Regulations 1992 and Display Screen Equipment Regulations 1992 to provide a safe and well maintained place of work including welfare facilities for staff	Health and Safety lead for the Trust has confirmed that the maximum number of staff by law would be 11 staff, this is exceeeded on a regular basis as staff are unable to write their notes on the wards due to a lack of WOWs.	1. Physical and mental wellbeing concerns in relation to staff welfare with potential for sickness absence and potential litigation claims 2. Multiple breaches of statutory and regulatory duties leading to interest from the Health & Safety Executive 3.Enforcement action including formal notices; potential criminal prosecution resulting in fines and/or imprisonment dependent upon the action pursued; loss of Trust reputation; adverse publicity	4	4	16	HIGH	Due to the number of staff within the area, some staff have to work from home (rota basis) Mobile air conditioning units distributed. Plumbed in water cooler in situ. .		4	4	16	HIGH	The portacabins continues to provide insufficient space for the staff using this base, this has been further compromised by the social distancing requirements for COVID-19.	2	3	6	LOW	TOLERATE - at lowest practicable/cost-effective level	Risk to be reviewed by the Trust when office staff move to into MK Centre resolve short term issues - drinking water / flooring / window latches / changing facilities / secure path Upkeep of the portacabin including drinking water facilities, flooring and windown seals	06/04/2021	No Change	No change	01/07/2021
2735			Deputy CEO	York, Craig	IT	Information Technology	IF the internal Trust telephone systems are not upgraded, THEN they will fall into a state where they cannot be supported by the Trust's IT Department or any third-party suppliers, LEADING TO potential loss of telephone systems either in small areas or across the Trust. This would have a significant impact upon operational procedures, especially during critical or busy periods.	Failure of the telephone system, communications being lost across critical areas.	As system versions get older, the likelihood of there being reliability issues increases, the cyber security threat increases, and the risk that telephone system suppliers stop supporting the system increases.	4	4	16	HIGH	Support in place, upgrade ETA Pending Capital funding		4	4	16	HIGH	An upgrade is required, that currently is not funded; network business case required.	4	1	4	LOW	TREAT - above tolerable level - appropriate cost-effective control required		13/01/2021	Increased	Technical issues	13/04/2021
2892			CEO	Noble, Deborah	Core Clinical & Support Services - Diagnostic & Screening	Screening Services	The 10yr old mammography machine in BS2 could fail due to its age. The increased amount of unplanned downtime this year is consistent with aging equipment. With the introduction of new technologies the availability of replacement parts is a worry. A replacement part needed to be shipped from Chicago.	Failure of the machine and unavailability of parts.	Failure of the machine would lead to a loss of service capacity for the 2ww clinics and NHSBSP programme which give have a detrimental effect on Trust metrics.	4	4	16	HIGH	Comprehensive service contract All faults reported immediately to external contractor / physicist for support. Robust QA systemin process to monitor system performance. This is reviewed weekly by medical physics.	QA monitored weekly by physicists.	4	4	16	HIGH	Availability of replacement parts.	3	1	3	VLOW	TREAT - above tolerable level - appropriate cost-effective control required		22/01/2021	Increased	Aging equipment	26/03/2021

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767	3-2	30/03/2021	Medical Director	James, Mr Andrew	Surgical - Musculoskeletal	Trauma & Orthopaedics	There is a risk to head injury patients not being appropriately cared for as they are not being treated in accordance with NICE guidance (CG176: Head injury: assessment and early management, updated September 2019)	1. NICE guidance sets out very specific recommendations for where and how patients should be managed and treated 2. Clinicians may have to wait for an opinion from the Tertiary Centre at Oxford 3. Head injuries frequently fall under the remit of the T&O Team or be nursed on a surgical ward(patients should be under neurological team).	- Potential reduction in patient safety - T&O surgeons and nursing teams may be unaware of how to care for patients with moderate to severe head injuries especially patient who are anticoagulated. - Clinicians may have to wait for an opinion from the Tertiary Centre. - Staff training, competency and experience - Serious incidents. - Reduced patient experience	4	3	12	MOD	1, 2 & 3. Preventive controls - On going discussions with Senior Medical Team - CSU Lead to escalate via trauma network - Alert process is in place for escalation within T&O & externally. - Resources available at tertiary site for advice/support 1, 2 c& 3. mitigating controls - Policy for management of head injuries has been developed - Awaiting appointment of head injury liaison Nurse	25/03/2021 Team continue to express concerns around the allocation of head injury patients to T&O. - Monitoring of Datix reported incidents by CGL for Surgery and CSU Lead - Team discussion of incidents/mortalities at CIG and M&M meetings.	4	4	16	HIGH	- 29/03/2021 T&O continues to received referral for complex head injury patients. - 23/09/2020 T&O continues to receive referrals for complex head injury patients under their speciality. - 28/01/2020 despite agreed pathway for admitting head injury patients under T&O team - non complex/ significant co-morbidities/ or anticoagulated the team are still having to care for these patient. - Trust is not in line with other trauma units - Regional trauma centre advises head injury should not be managed by trauma and orthopaedics and after 24 hours the patient should be referred to neurosurgery. - Potential delay in opinion from Tertiary Centre	4	2	8	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Monitoring of incidents where tertiary advice/support was not available Monitor incidents where delay in tertiary opinion has occurred	31/03/2021	No Change	Ongoing risk	30/04/2021
2640		24/03/2021	Director of Corporate Affairs	Worth, Mrs Tina	Corporate Affairs	Clinical Governance	Clinical Governance and Imaging staff are unable to meet statutory and mandatory Good Governance requirements and accreditations if IT systems do not support their remit.	Existing governance systems do not support meeting Trust /legal/stakeholder requirements and are unsupported by the Trust IT department or an external IT provider	Unable to meet statutory and mandatory Good Governance requirements and accreditations if IT systems do not support their remit.	5	5	25	HIGH	System in place but requires updating and Q pulse which manages Trust documentation is no longer able to archive since the shared drive was moved. Updates made to Q-Pulse and SharePoint	The controls are ineffective to manage documentation on such a scale to support accreditation. No response from Datix regarding system capabilities. IT support staff no longer able to support - new member of staff commences July 2018 for project to be handed over. Scoping exercise with other IT systems to Datix that may include a document management service. QPulse move to Microsoft Teams pending - further	5	3	15	HIGH	Systems require updating Purchase of additional modules on Datix (business case fo Datix cloud/other system progressing)	2	1	2	VLOW	TREAT - above tolerable level - appropriate cost-effective control required	Risk Systems Business Case with potential for Document Management system	26/02/2021	No Change	New risk	30/04/2021

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2894			Deputy CEO	Dwarakanath, Aniruddha	Performance & Information	Information	The Trust Information data warehouse could fail or be subjected to a security attack.	The Trust Data warehouse is currently hosted on two SQL Server 2008 R2 servers (MKG-Arden-05 & MKG-BI-01) on site. Microsoft have ended extended support for SQL Server 2008 R2 on 09 July 2019**, which means the above server do not receive any security and technical updates from Microsoft, making it vulnerable to security attacks and technical failures. Furthermore, due to the outdated technology there have been intermittent outages of the server which are being managed by the Trust. Additionally, the free storage space on the server is less than 10% (as of Feb 2020), which will be consumed within the next couple of months. **	If this risk were to materialise, the impact will vary depending on the failure. If there is a security attack on the servers there will be a data breach under GDPR leading to reputational damage and financial consequences. If the data warehouse were to fail, the Trust will not be able to fulfil any internal and national reporting requirements including RTT and financial reporting, submission of CDS, ECDS (to SUS), etc. This will have operational and financial impact leading to compromised patient safety and patient experience.	4	5	20	HIGH	There are reactive controls in to support the data warehouse using the in-house teams, including daily check of the servers, deleting redundant information stored on the server is conserve space. Additionally, A business case to migrate the information platform to Microsoft Azure platform has been submitted to the Executive directors for consideration and awaiting a decision.		3	5	15	HIGH	None	2	3	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required		11/09/2020	No Change	No Change	04/03/2021
824			Deputy CEO	Eagles, Phil	Estates	Estates	IF the estates infrastructure contingency plans are not adequately tested THEN in the event of a infrastructure failure plans may not succeed LEADING TO contingency plans not being effective and to potential loss of services, poor patient experience, financial loss and loss of reputation	untested contingency plans, in the event of a infrastructure failure plans may not succeed	an increased safety and service disruption risk to patients and staff.	5	4	20	HIGH	1. Partially tested Contingency Plans. 2. Review of Business Continuity Plan review process completed in conjunction with Gordon Austin assisting with reviewing process and plans. 3. Continuity plans reviewed and shared with team. 4. Noted that plans partially tested during the recent flooding incident. 5. Emergency Planning Officer has been sent the plan for review and comment. 6. Met EPO and reived document, awaiting publication.		5	3	15	HIGH	Waiting publication of agreed document.	5	1	5	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Testing regimes to be further developed with Gordon Austin	09/03/2021	No Change	see comments	30/06/2021
2740			Deputy CEO	York, Craig	IT	Information Technology	The current bleep system (main system A and back-up system B) is obsolete and no maintenance support contract is available from the company. The risk is that the equipment may not be able to be repaired if failed.	the equipment failure	failure of the current bleep system will have impact on patient care due to clinicians not being contacted via the bleep system	5	4	20	HIGH	-DISCUSSED WITH LINE MANAGER AND ESCALATED -TEMPORARY RADIO COMMUNICATION SYSTEM 3. User group formed with IT & EBME to identify options		5	3	15	HIGH	Identify costs of possible solutions and draft business case. Estates to own crash bleep solution; IT will own the clinical messaging and task-orientated communication functions. Digital Information Manager for Strategic estates will be driving the project to replace the emergency/urgent bleep replacement.	5	1	5	LOW	TREAT - above tolerable level - appropriate cost-effective control required		29/09/2020	No Change	new risk	13/04/2021
2968			Director of Corporate Affairs	Noble, Deborah	Core Clinical & Support Services - Diagnostic & Screening	Screening Services	Delayed detection of breast screening cancers due to COVID 19	The cessation of the programme has meant that women have been delayed an invite for screening. The programme has restarted but with reduced capacity to enable social distancing in both the mobile and static sites.	Women of screening age may receive a positive diagnosis that has been delayed due to the cessation of the programme. Treatment regimes will be delayed as a result.	5	4	20	HIGH	Restart proposal approved by the Trust, SQAS and PHE. Guidance issued as to the management of the women to ensure that no-one is missed has been issued by Hitachi/PHE and has been implemented by the programme.	KPI's monitored buy NHSBSP Regular communication with QA team and commissioners.	5	3	15	HIGH	No Gaps	2	2	4	LOW	TREAT - above tolerable level - appropriate cost-effective control required		24/04/2020	Decreased	No change	25/06/2021
2928			Director of Corporate Affairs	Evans, Ms Joanne	Core Clinical & Support Services - Diagnostic & Screening	Imaging	Lack of space for appropriate management of CT and MRI with additional issues of lack of scanners to manage the increasing demand.	The issue is increasing demand at upto 14% annually with a requirement to reduce turnaround times.	Financial due to missed targets Reputation due to long waiting times Reputation and financial due to increased infection rates Staff leaving due to poor working conditions. This is delaying patient management and causing issues with meeting the diagnostic waiting times. Inability to manage patients privacy and dignity also increased risk of infection due to overcrowding of faciliities.	4	5	20	HIGH	Extended working hours and days, some scans sent off site to manage demand. Reduced appointment times to optimise service. 1.12.20 no change to risk rating services remain challenged due to lack of basic capacity made worse by Covid social distancing and cleaning issues. IS provider approached to provide more MRI capacity	patients are managed through the service safely although space is compromised and capacity limited Adoption of the MRI service from the IS and the installation of a second MRI scanner will help (expected late 2020)	3	5	15	HIGH	no current gaps, just shortage of capacity. Should be addressed by the development of the scanner centre	2	2	4	LOW	TOLERATE - at lowest practicable/cost-effective level		01/12/2020	No Change	No Change	30/06/2021

Significant Risk Register

ID	Ref	Triumvirate Annual Review Date	Executive Responsible	Risk Owner	Division	Specialty	Description	Cause	Impact	C	L	Inherent Risk Rating	Inherent Risk Level	Controls in place	Assurance on Controls	C	L	Current Risk Rating	Current Risk Level	Gaps in Controls	C	L	Target Risk Rating	Target Risk Level	Treatment Category	Action Plan Summary	Date Risk Last Reviewed	Trend	Trend Rationale	Review Due?
2546			Deputy CEO	Chandler, Ollie	IT	Information Technology	IF the IT Department does not have a stock of replacement network switches, THEN if a switch fails a replacement will need to be sourced, procured, delivered, and installed, LEADING TO a delay in bringing up to 48 devices back online, potentially losing IT devices for a whole area/department for up to two weeks.			4	4	16	HIGH	There is no stock left.	to have stock will mean that there are no outages within key functional areas. This is an entirely appropriate measure to assure the current control.	3	5	15	HIGH	No stock available, discussions regarding replacement network are in flight.	2	3	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Write business case for additional switches	13/01/2021	Increased	Increase - no stock	13/04/2021
1970			Director of Clinical Services	Hyem-Smith, Ms Celia	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	Unable to meet the demand for existing patients leading to increased waiting times Unable to develop exisitng outpatient services Unable to optimse student placements	The cause is the lack of clinical space available for patient treatment	The impact is failure to meet contracts, lost revenue, poor patient experience and poor staff morale	3	5	15	HIGH	1. Extended working hours 2. Introduction of shift pattern 3. Introduction of telephone triage clinics 4. Group treatment sessions		3	5	15	HIGH	Amalgamation and integration of department space and teams to utilise current space more efficiently. Potential to increase clinical space but this would require significant investment.	3	5	15	HIGH	TREAT - above tolerable level - appropriate cost-effective control required	Review of space in Therapies	17/02/2021	No Change	No change	31/05/2021
2983			Director of Clinical Services	Hyem-Smith, Ms Celia	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	There is a risk that the Women & Men's Health Physiotherapy Service is unable to meet its referral demand	Insufficient staffingleading to increased waiting times Referral number into service via multiple routes	Potential for poor clinical outcome, poor patient experience, complaints and staff stress Potential delay to patient treatment Potential for patients with new diagnosis of cancer and pregnant women are not seen in a timely fashion further	3	5	15	HIGH	Non clinical time including training,development and audit are being minimised to increase the number of available patient appointments Job plans are being completed by all staff to show impact on workload Patients are ebing booked into group where possible instead of individual appointment slots Recruited to all vacant posts To explore options for supporting dictationn of letters to free up clinical capacity.	Patients requiring an individual slot are often not being treated in a timely manner to meet the needds of their clinical repsentation. Team is fully established and Band 4 assistant is being used to support	3	5	15	HIGH	Staff capacity to meet current referral demand	2	4	8	MOD	TREAT - above tolerable level - appropriate cost-effective control required	Establish increasing referral rate trends, map against capacity and establish increase income vs uplift in staff to meet demand Budget reallocation and VCP for Band 6 post Therapy Strategy is being finalised to support investment for business case, to present strategy at management once shared with senior members of the Trust To discuss interim plans to manage staffing and impact on Women's division	19/06/2020	Increased	No changes to staffing	31/05/2021
1695			Director of Clinical Services	Chappell, Faye	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	There is a risk that Children's Physiotherapists are not able to run to their full capacity in order to treat all children on their caseload/waiting list	Insufficient rooms within the Child Development Centre for Children's Physiotherapy	1. Poor use of NHS funds as therapists are not treating patients 2. Inabiliity to treat all children on caseload leading to increased waiting list 3. Loss of income as the Trust are only paid when physios are with a patient and reduced treatment for children with physical needs 4. Poor patient experience and potential impact on clinical	3	5	15	HIGH	Physiotherapy staff timetables designed to avoid clusters of staff all working in the CDC at the same time. Room booking system in place. All have been in place for years; the problem is worsening as the building is shared with other teams which are growing.		3	5	15	HIGH	Insufficient space for treating therapists	2	3	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Action required Contact and attend meetings with CNWL•Find out who owns the building.•Review the feasibility of moving to SSHC Review of space in Therapies additional OP space required - looking to use current SLT office (when they move offices) Negotiating additional space at Stony Stratford Health Centre, awaiting update from NHS Property Services	15/04/2021	Increased	Access to rooms has reduced	17/05/2021
1874			Director of Patient Care / Chief Nurse	Tait, Mrs Michaela	Directorate of Patient Care	PPI	The MUST conformance criteria were set out in the NHS accessible information specification for compliance by the 31st July 2016	The Trust currently cannot meet all of requirements set out in this specification which is driven by the NHS England, the Equality Act 2010 and Care Act 2014 to ensure patients with a disability are not discriminated against.	1. The CCG as part of the Quality Schedule 2. The CQC recognise the role of this standard as an indicator of high quality care for people with particular information and communication support needs and will be included as part of their inspections of a service. 3. A workstream to the patient led assessment of the care environment (PLACE). Identiication of non compliance could lead to an enforcement action from any of the above performance monitoring stakeholders.	3	5	15	HIGH	Some of the meeting individual needs resources identified i.e.BSL sign language interpreters, braille, easy read Ongoing EPR agile preparation events E Care launch plan in progress	Patient Experience team are working with external providers and will be picked up as part of the Quality Account	3	5	15	HIGH	Go live date agreement for EPR - Cerner have confirmed that the system will allow the required alert flags etc. Equality and Diversity Trust legal requirements to be identified, documented in policy and staff advised. This impacts on all policies and guidelines. Interpreting and translation policy - contract now agreed Gap analysis of patient information (sits with Patient Experience) - what is available?	3	2	6	LOW	TOLERATE - at lowest practicable/cost-effective level	Steering Group to monitor progress Review of proces for patient information publication & availability	28/02/2019	No Change	First review	28/08/2019

Significant Risk Register

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2297			Director of Clinical Services	Thwaites, Elizabeth	Core Clinical & Support Services - Diagnostic & Screening	Pathology	There is a risk that the available space within Cellular Pathology will not be enough to meet the demands of the service as workload continues to expand	Increasing workload requiring additional specimen storage, workspace additional equipment and additional staff	The department will be unable provide the storage space required to accommodate the increasing workload leading to 1. An inability to retain specimens for the period of time required to meet RCPath guidance 2. An increased risk of formalin spillage / increased levels of formalin vapour 3. Increasing risk to staff and to specimens because of cramped workspace e.g. Specimen reception area encroaches on cut-up area 4. Inability to safely operate and / or validate equipment 5. Insufficient space for	3	5	15	HIGH	Storage of specimens minimised. No uneccessary specimens stored Storage period reduced from 6 weeks to 4 weeks with the approval of Pathologists and Clinical Lead	Controls are currently not effective due to increased workload and pressure of social distancing.	3	5	15	HIGH	Additional storage space now identified - move to business case Staff continue to work within confined space and these working conditions were a contributing factor to SI Web65568 2019/3478	3	2	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required	Identify additional storage space Review space and workflow and identify activities that can be relocated Develop business case for space expansion into courtyard area	13/04/2021	No Change	Plans under review	17/05/2021
2438			Medical Director	Colda, Antoanela	Medical Director	Research & Development	R&D department has yearly running staff contracts, not permanent contracts and we are not able to provide longer term contracts for the team	the positions will be not attractive to new applicants and not secure posts for the existing staff members	potential reduce number/quality applications for the existing vacancies	3	5	15	HIGH	1. Requested support from the network CRN 2. Discussed with other Trusts Partners regarding their existing contracts	1. Able to maintain existing staff 2. Increase staff level	3	5	15	HIGH	Longer term contracts	2	3	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required	set up meeting with finance director to review contracts	03/10/2018	No Change	no change	31/12/2020
2936			Director of Clinical Services	Hyem-Smith, Ms Celia	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	Increasing numbers of patients being added to the physiotherapy outpatient waiting list, in addition to those on hold due to the COVID-19 pandemic, resulting in waiting times of well over 18 weeks for any type of intervention. A further increase in referrals may result from patients with post-COVID symptoms	The COVID-19 pandemic has led to outpatients only reviewing urgent patients virtually by telephone or video call, pre-COVID waiting lists could be managed effectively by groups, this is no longer possible due to social distancing and patients shielding.	Litigation and/or complaints due to lack of timely treatment intervention, potentially resulting in permanent and unecessary disability.	3	5	15	HIGH	- Virtual management of patients - Video and telephone clinics - Additional IT sourced to support virtual management - Reconfiguration of department to support virtual working and enable social distancing along with staff working from home - recovery plans are being written/in place to enable essential patients to be seen in the department of a face to face basis - Educational material including exercise programmes and access to youtube clips are made available to patients		3	5	15	HIGH	To identify process for validate routine patient lists to ensure that clinical priorities are seen the correct order	2	3	6	LOW	TREAT - above tolerable level - appropriate cost-effective control required	To develop strategy for validating routine patient waiting list	17/02/2021	No Change	new risk	31/05/2021
3055			Director of Clinical Services	Chappell, Faye	Core Clinical & Support Services - Clinical Support Services	Physiotherapy	Poor outcomes for children and young people referred to the children's physiotherapy service	Staffing level and staffing structure that do not meet the needs of the service. This is compounded by insufficient space to deliver.	Delayed treatment, insufficient treatment, less effective treatment resulting in poorer outcomes and experiences for children and young people referred to the service. Increased complaints and incidents. Difficulties with staff recruitment and retention due to low morale and low work satisfaction.	3	5	15	HIGH	Coding and prioritizing of referrals 1:1s and caseload supervision		3	5	15	HIGH	Insufficient staffing to manage workload	2	2	4	LOW	TREAT - above tolerable level - appropriate cost-effective control required		15/04/2021	No Change	n/a	17/05/2021
3066		20/04/2021	Director of Clinical Services	Ohadekwe, Ms Edith	Medicine - Specialty Medicine	Neurology	The neurology department runs a botox injection clinic for patient staffed by a single consultant; this consultant is now on long term sick leave. There are 50 patients awaiting review and treatment in clinic.	Department is unable to deliver a botox service due to lack of availability of consultant	50 patients awaiting clinic appointments	3	5	15	HIGH	There is no substantial control in place		3	5	15	HIGH	There is no clinical staff to treat patient in this category	2	2	4	LOW	TOLERATE - at lowest practicable/cost-effective level		31/03/2021	No Change	New Risk	31/05/2021

Significant Risk Register

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1740		24/03/2021	Director of Corporate Affairs	Worth, Mrs Tina	Corporate Affairs	Clinical Governance	There is a risk that changes required to practice are not implemented and we are not meeting best practice criteria	If recommendations and actions from audit are not evidenced, monitored and completed in the Trust	Potential impact on the top 3 Trust objectives (patient Safety, Clinical Effectiveness, Patient Experience) Potential poor quality of service and associated impact on resources CQC concerns re audit activitu & learning from national audits	3	5	15	HIGH	Audit report templates available to identify audit action plans. However these are not always being utilised and actions are not Always evidenced and monitored Monitoring via Clinical Audit & Effectivess Committee (CAEB) TOR CAEB revised to include quality improvement, GIRFT etc Escalation/exception reporting to Management Board Refresh of Sharepoint data base to assist with data capture, with Level 1 audit a priority Transformation Team audit	Limited assurances from RSM audit review Sharepoint has ability for audit action plans to be attached with evidence of completion but audit cycle not completed to this level Jan - Feb 2020 repeat RSMUK reveiw due Limited assurances from RCB?CAEB - pals to move to integrated governance & divisional meetings approach	3	5	15	HIGH	Capturing audit evidence at specialty CIG meetings including actions to improve practice or examples of good practice. Divisional audit reports at CAEB detailing compliance on Level a audits Sharepoint evidence to support action plan from audits - review & overhaul of system scheduled for November at Risk Management Team Divisional accountability at Performance Management Board Implementation of new integrated governance agenda National audits on hold & local audits & audit meetings limited due to Covid pandemic	1	3	3	VLOW	TREAT - above tolerable level - appropriate cost-effective control required	Implementation of KPMG action plan, to be monitored by Audit Committee Meeting with CGLs to review Sharepoint format for capturing audit completion/complinace to best ensure this helps give accurate data & evidence Risk Systems Business Case with potential for Document Management system	22/12/2020	Increased	KPMG Audit / CQC	30/04/2021
1964			Deputy CEO	Eagles, Phil	Estates	Estates	There is a risk of roof failure in relation to flat roofs across the Trust	If the flat roofs identified in the Langley Roof report and 6 facet survey as requiring replacement or upgrading, are not replaced.	Water ingress - Potential damage to equipment, disruption to service, damage to reputation.	3	5	15	HIGH	1. Inspections and repairs as needed. 2. Updated annual 6 facet survey by Oakleaf 3. Large patch repairs undertaken as emergency business cases 4. 1 x Post Grad roof fully replaced 19/20. 5. Ward 10 - 50% of roof patch repairs completed 19/20 6. Phase 1, Phase 2 and Community Hospital survey completed.(52 roof leaks noted in 12 months Jan 19 -Aug 20) 16 leaks in 1st week of October 2020 7. Pharmacy small roof replaced September 20. 8. Business Case approved for 4 to 5 year rolling programme. 9. Work underway March 2021		3	5	15	HIGH	NIL	3	1	3	VLOW	TREAT - above tolerable level - appropriate cost-effective control required	Replacement/upgrade of flat roofs identified in the 6 facet survey	09/03/2021	No Change	ONGOING RISK and works	30/06/2021
2341			Director of Clinical Services	Stamp, Mr Jamie	Core Clinical & Support Services - Clinical Support Services	Dietetics	The risk is that the paediatric team can not provide a full dietetic service to children and young people in the Milton Keynes area	Insuffient capacity and on-going unsustainable demand for dietetic input for Paediatric patients (both inpatient and outpatient) Home Enterally Fed Paediatrics patients should be seen as part of community contract, currently this group of patients is being seen through our outpatient structure which is not adequate to meet their demands and needs. As a results of this staff are be stretched to cover a service that has not been resourced correctly which in turn impacts on the wider outpatient and inpatient work load. The current dietetic workforce is not able to meet the Increasing referral for children with diabetes, this means that	1. Patient care and patient safety will be at risk 2. Vulnerable children becoming nutritionally compromised. 3. Unable to assess and advise new patients and review existing patients in a timely manner. 4. Impacting on patients nutritional status and longer term dietary management on what is a very vulnerable group of patients. The majority of our caseload is infants or tube fed infants and children where there nutrition and growth is a priority.	3	5	15	HIGH	Existing staff are working some additional hours but this remains insufficient to meet the needs of the service.		3	5	15	HIGH	There is insufficient to paediatric dietetics to manage the demand for outpatients, inpatients specifically the paediatric dietetic service is unable to deliver the national standards for Home Enterally Fed and Diabetic patients on the caseload.	1	3	3	VLOW	TREAT - above tolerable level - appropriate cost-effective control required	The need for a paediatric community dietetic service for patients on HEF being raised with CCG Current staffing provision is not sustainable and is not adequate for delivery the Home Entral feeding serivce which is not commissioned	06/04/2021	No Change	No change	01/07/2021
2958			Deputy CEO	Ahmed, Ayca	Estates	Capital Planning	The current risk is that there is not enough space in the Medical Equipment Library(MEL) to carry out the required cleaning process to comply with the appropriate guidelines set by CQC and MHRA.	Space pressure increasing due to growth of the MEL and additional tasks	Lack of cleaning and processing space due to the growth of the MEL over the years means not keeping unprocessed and processed equipment separately, not complying with CQC Regulation 15: Premises and equipment and MHRA Documentation: Managing Medical Devices April 2015	3	5	15	HIGH	Staff members are taking processed equipment straight to the shelving areas as soon as it is cleaned to avoid cross contamination. This ensure equipment is kept separate, but this is not a productive method of working.		3	5	15	HIGH	Nil	3	1	3	VLOW	TREAT - above tolerable level - appropriate cost-effective control required		09/03/2021	No Change	New Risk	30/06/2021

Meeting Title	Trust Board	**Date:** May 2021
Report Title:	Board Assurance Framework	**Agenda item:**
Lead Director	**Name:** Kate Jarman	**Title:** Director of Corporate Affairs
FoI Status:	**Public**	
Report Summary	Board Assurance Framework containing the principal risks against the Trust's objectives. 1. The risk scores for the following risk entries have been revised downwards: a. Risk Entry 10 – From 15 to 12 (page 27); b. Risk Entry 13 – From 15 to 10 (page 33); c. Risk Entry 19 – From 12 to 8 (page 46); d. Risk Entry 23 – From 12 to 8 (page 57); e. Risk Entry 24 – From 20 to 15 (page 59). 2. The risk score for the following risk entry has been revised upwards: a. Risk Entry 16 – From 15 to 20 (page 39); b. Risk Entry 21 – From 8 to 12 (page 52)	

Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [ ]	**Decision** [ ]
Recommendation	The Group is asked to review the content of the Board Assurance Framework			
Strategic objectives links	All			
Board Assurance Framework links	All			
CQC outcome/ regulation links	Governance/ Well Led (Regulation 17)			
Identified risks and risk management actions				
Resource implications				
Legal implications including equality and diversity assessment				
Report history	New			
Next steps				
Appendices				

The Board Assurance Framework – Summary of Activity April 2021

COVID-19 Risks

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

Strategic Risks to be Reviewed to the BAF at the June 2021 Trust Board Seminar

1. HIP2 programme and estate development – given the scale and timeframe of this programme it is recommended that the Board consider the risks against the Trust's strategic aim of making best use of the estate
2. Use of health information – the Trust has recently launched access to health data with Apple, enabling patients using MyCare to access
3. Use of health information –It is recommended that the Board consider whether it should consider further opportunistic risk around the use of health information for clinical research purposes against the Trust's strategic aims of developing teaching and research and being innovative and sustainable.

The Board Assurance Framework

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

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

Strategic Objectives

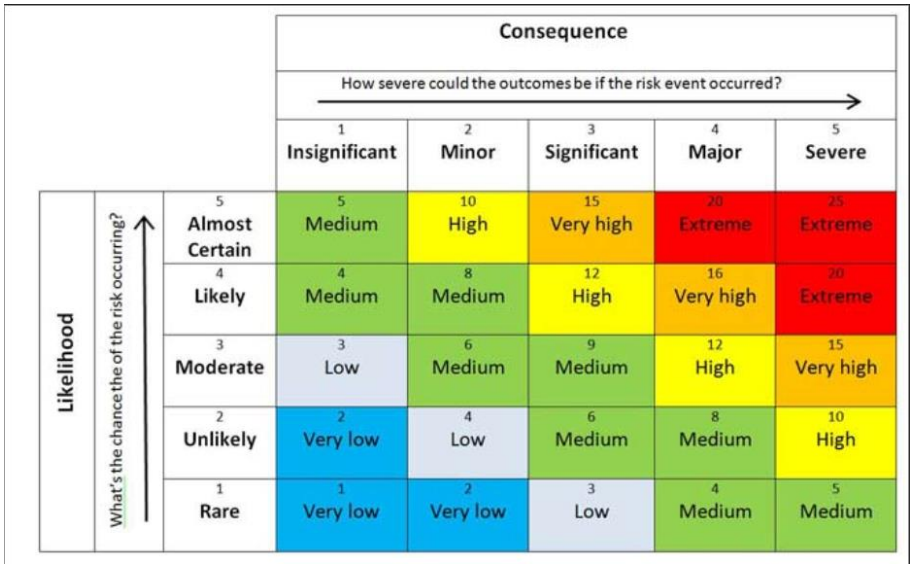
1. Improving patient safety
2. Improving patient experience
3. Improving clinical effectiveness
4. Delivering key performance targets
5. Developing MK at place
6. Developing teaching and research
7. Being well governed and financially viable
8. Investing in our people
9. Developing our estate
10. Being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

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

Assurance ratings:

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

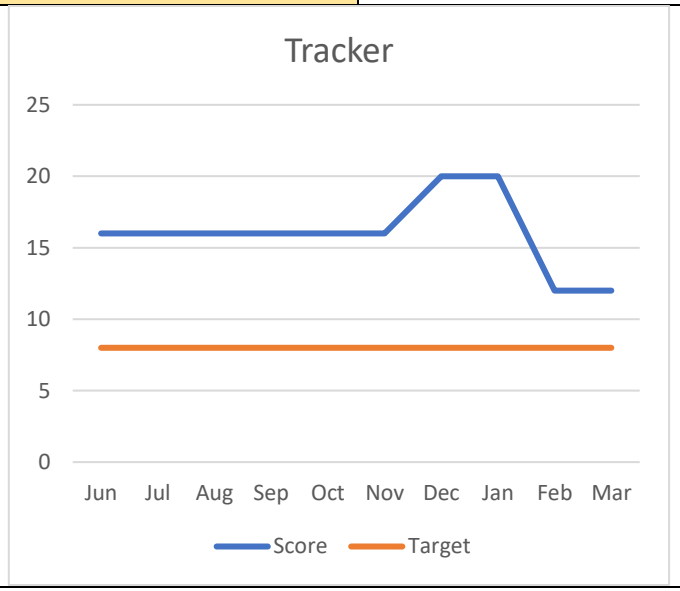
5X5 Risk Matrix:



Likelihood	What's the chance the of the risk occurring?		Consequence: How severe could the outcomes be if the risk event occurred? →				
			1 Insignificant	2 Minor	3 Significant	4 Major	5 Severe
	↑	5 Almost Certain	5 Medium	10 High	15 Very high	20 Extreme	25 Extreme
		4 Likely	4 Medium	8 Medium	12 High	16 Very high	20 Extreme
		3 Moderate	3 Low	6 Medium	9 Medium	12 High	15 Very high
		2 Unlikely	2 Very low	4 Low	6 Medium	8 Medium	10 High
		1 Rare	1 Very low	2 Very low	3 Low	4 Medium	5 Medium

RISK 1: Ability to maintain patient safety during periods of overwhelming demand

Strategic Objective 1: Improving Patient Safety

Strategic Risk	Ability to maintain patient safety during periods of overwhelming demand						**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm		
Executive Lead	Director of Operations	**Consequence**	4	4	**Risk Appetite**	Avoid		
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat		
Date of Review	30/03/21	**Risk Rating**	12	8				

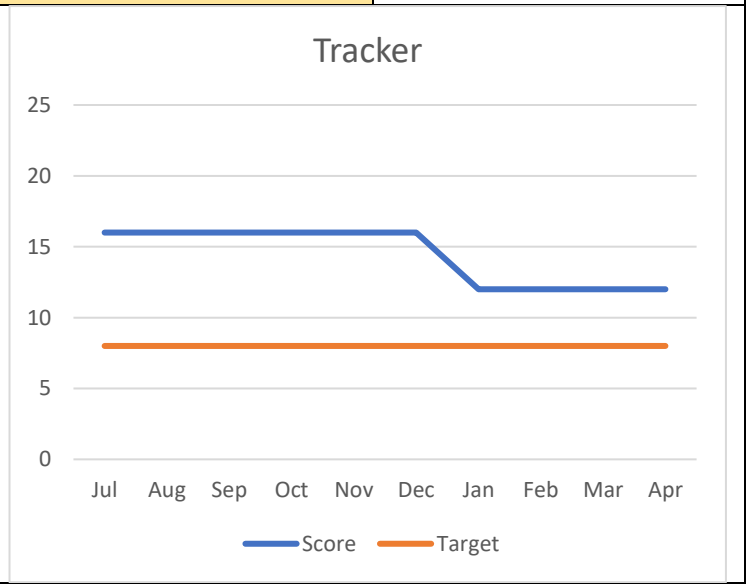
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Significantly higher than usual numbers of patients through the ED Significantly higher acuity of	Clinically and operationally agreed escalation plan Adherence to national OPEL escalation	Vacancies in nurse staffing Higher than normal staff absences and sickness	Ongoing recruitment drive Redeployment of staff from other areas at times of need.	Daily huddle / silver command meetings System-wide (MK/BLMK/ICS) Partnership Board, Alliance	Short term sickness or unexpected staffing levels / surges	Escalation By CSM and Silver OCM on shift	

patients through the ED Major incident/ pandemic – constraints on space and adherence to IPC measures	management system Clinically risk assessed escalation areas available. Surge plans, COVID-specific SOPs and protocols have been developed		Additional senior nursing presence on 24/7 rota to manage staff deployment & patient safety through the pandemic. Services reorganised to manage pandemic	& Weekly Health Cell Regional and National - NHSI reporting requirements - Daily COVID sitrep			

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If an effective reporting, investigation and learning loop is not established and maintained, the Trust will fail to embed learning and preventative measures following serious incidents/ Never Events.				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	19/04/21	**Risk Rating**	12	8		



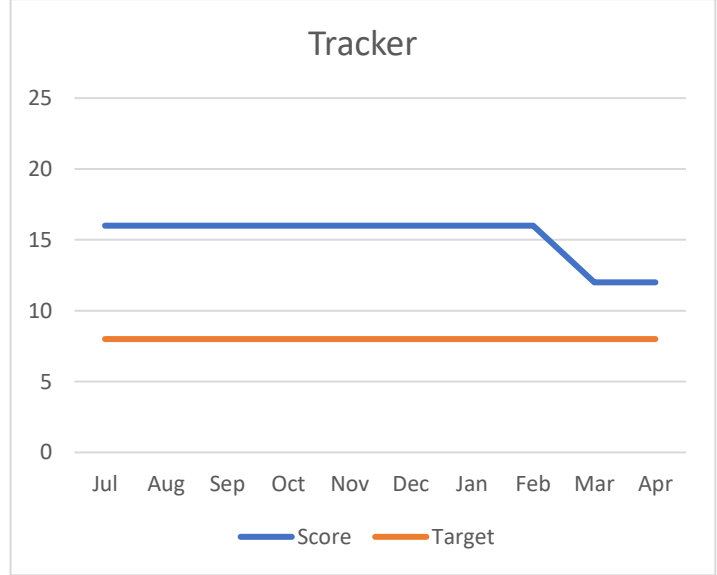
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Not appropriately reporting, investigating or learning from incidents.	Improvement in incident reporting rates	Establishing Learning and Improvement Board	October 2020 - ongoing	NRLS data SIRG	Intuitive Reporting Rates	Appraisals	

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

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust is unable to accurately predict demand (for example, relating to the COVID-19 pandemic) and re-purpose its resources (physical, human and financial) with agility, the Trust will fail to manage clinical risk during periods of sustained or rapid change in the level or type of demand.				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	19/04/21	**Risk Rating**	12	8		



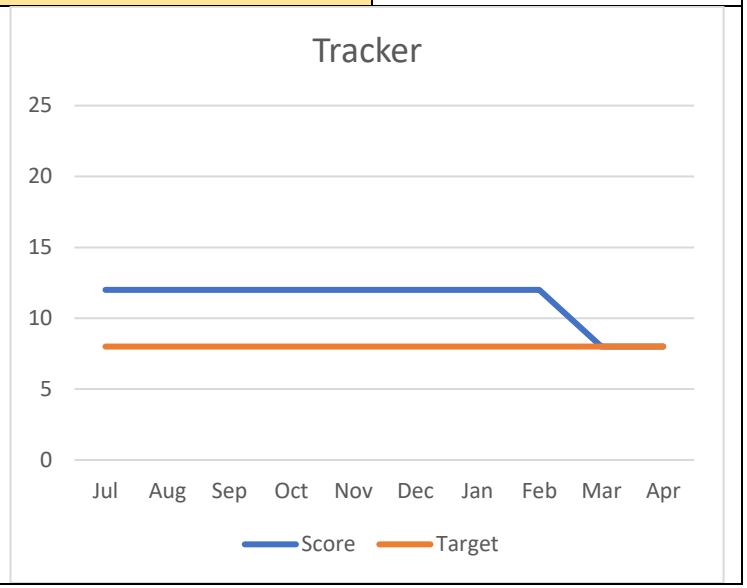
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Rapid or sustained period of upheaval and change	Board approved major incident plan and procedures	Inability to accurately predict or	None Currently	MK place-based and ICS-based planning	Incomplete oversight of OP delays	Enhanced visibility of OPD	

caused by the Covid-19 pandemic and need to respond and maintain clinical safety and quality	Rigorous monitoring of capacity, performance and quality indicators Established command and control governance mechanisms Gold (Daily) Level 3/4 Incident management	forecast levels of activity and risk		and resilience fora Regional and national data and forecasting COVID MARC Meeting (Data, Intelligence, Collaboration with partners)		PTL and non RTT pathways	

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust does not carefully manage its significant digital change programme, then the delivery of clinical services will be impaired				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Deputy CEO	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	19/04/21	**Risk Rating**	8	8		



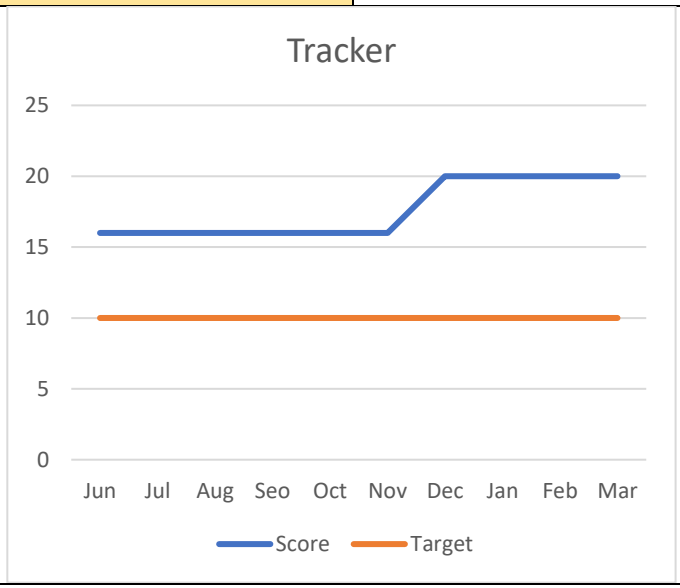
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Inadequate assessment of clinical risk/ impact on clinical	Robust governance structures in place with programme management at all levels	None currently	Continue to maintain programme governance and keep	Established governance and external/ independent	None currently	Continued iterative testing of products	

services or practices Inadequate resourcing Inadequate training	Clinical oversight through CAG Thorough planning and risk assessment Regular review of resourcing Regular review of progress Risks and issues reported Track record of successful delivery of IT projects		resourcing under review	escalation and review process		post-roll out	

RISK 5: Failure to provide capacity to match demand for elective care, including cancer and screening programmes

Strategic Objective 1: Improving Patient Safety

Strategic Risk	Failure to provide capacity to match demand for elective care, including cancer and screening programmes				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Operations	**Consequence**	5	5	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	30/03/21	**Risk Rating**	20	10		



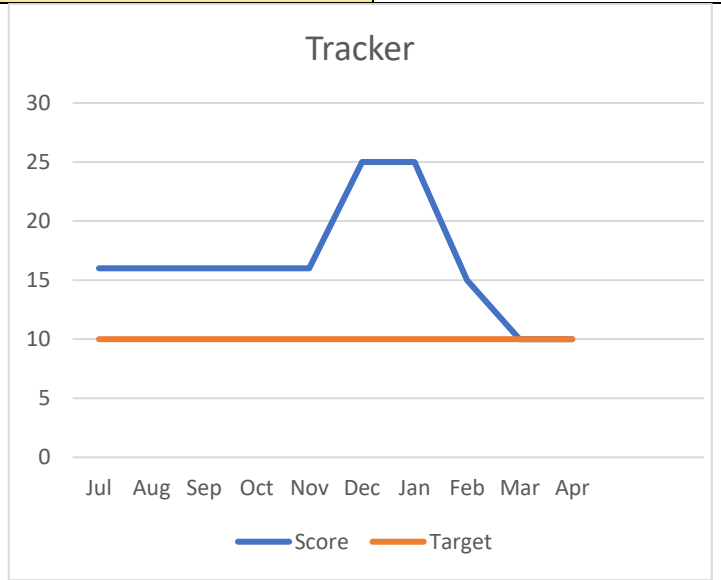
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Cessation of all routine elective care, including cancer screening and other pathways, during the peaks of the Covid-19 pandemic	Compliance with national guidance Granular understanding of demand and capacity requirements with use of national tools.		Continue to maintain programme governance and keep resourcing under review	Established governance and external/ independent escalation and review process			

Inability to match capacity with demand	Robust oversight at Board, and sub committees. Divisional and CSU management of WL. Agreement of local standards and criteria for alternative pathway management – clinical prioritisation and validation Long-wait harm reviews Use of Independent Sector. Extension of working hours and additional WLI to compensate capacity deficits through distancing and IPC requirements. Additional capacity being sourced and services reconfigured.	Historic issue with ASI & capacity Limitations to what ISP can take. Resilience and well being of staff and need for A/L and rest. Set up time for services off site.	Dedicated project resource commissioned Trust-wide and local Recovery Plans in place Reconfiguration of MKUH capacity	Regional and national monitoring. Project reports & training programme Mutual aid options. BLMK System working.			

			services to best use ISP				

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust does not establish and maintain effective capacity management processes it will be unable to cope with high demand for ITU and inpatient care during a public health crisis (or due to the Covid-19 pandemic)				**Strategic Objective**	Improving Patient Safety	
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	
Executive Lead	Medical Director	**Consequence**	5	5	**Risk Appetite**	Avoid	
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat	
Date of Review	19/04/21	**Risk Rating**	10	10			

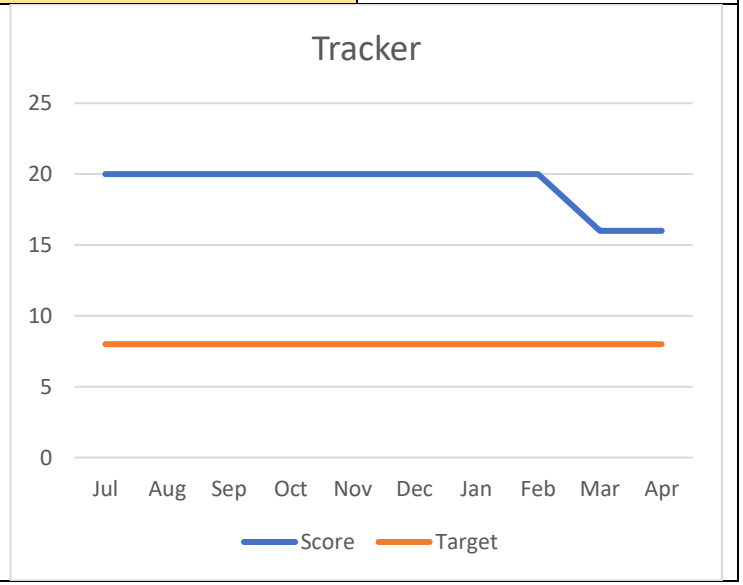
Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Demand for ITU and inpatient beds exceeds capacity,	Increased capacity across the hospital	Inability to accurately forecast demand	None currently	Tested escalation plans	None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

including escalation capacity within the hospital and regionally	Increased capacity for ITU Clear escalation plans Real time visibility of regional demand/ capacity			Active part of regional networks Clear view of CPAP support for COVID-19 patients Medical Director and Chief Nurse liaising with			

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

Strategic Objective 2: Improving Patient Experience

Strategic Risk	If the radiotherapy pathway provided until 2019/20 in Milton Keynes by Genesis Care (under contract with OUH) is not replaced, the access and experience of patients on clinical oncology (radiotherapy) pathways will continue to be negatively impacted.				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	19/04/21	**Risk Rating**	16	8		



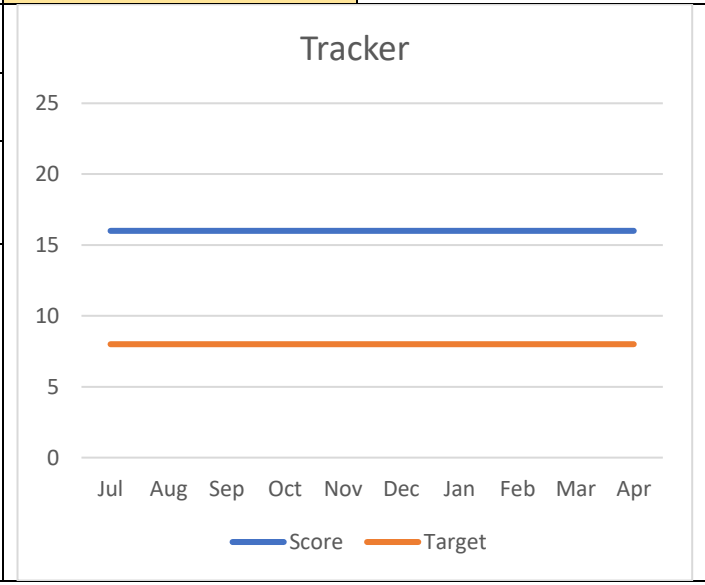
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Break down in the established relationship (sub contract) between Oxford University Hospitals and the	Contingency for the provision of treatment to patients in Oxford and the ongoing provision of palliative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

private Genesis Care facility (Linford Wood, Milton Keynes) which has provided local radiotherapy to MK residents for the last six years. This breakdown results in less choice and longer travel distances for patients requiring radiotherapy. Patients tend not to differentiate between the different NHS provider organisations. This risk materialised 16.12.2019 when the contract expired and no extension was agreed.	radiotherapy at Linford Wood or in Northampton Promotion of agreement between OUH and Northampton General Hospital to facilitate access to facilities at Northampton for those who prefer treatment in this location. Promotion of rapid options appraisal and decision making at OUH and MKUH in relation to a medium to long term solution for radiotherapy provision on site at Milton Keynes University Hospital (build, operation, governance etc.) and route to capital funding. Proactive communications strategy in relation to current service delivery issues.				Impact of ICS capital control limits		

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

Strategic Objective 2: Improving Patient Experience

Strategic Risk	If the Trust does not effectively work with patients and families in delivering care and positive patient experience the national patient surveys may not demonstrate improvement.				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Chief Nurse	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	21/04//21	**Risk Rating**	16	8		



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

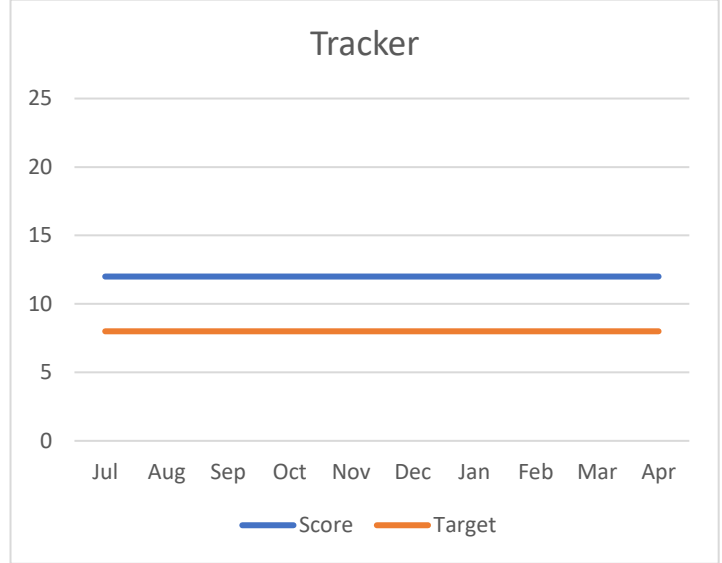
(measured through the national surveys). Children and Young People Survey Adult Inpatient Survey Urgent and Emergency Care Survey Maternity Survey Cancer Patient Experience Survey	governance arrangements in place at Trust, division and department levels, including but not limited to: • Patent Experience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

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

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

Strategic Objective 2: Improving Patient Experience

Strategic Risk	If the Trust does not effectively work to use feedback from complaints and PALS contacts to inform learning and embed related changes patient experience will not be improved.				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Chief Nurse	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	21/04/21	**Risk Rating**	12	8		



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

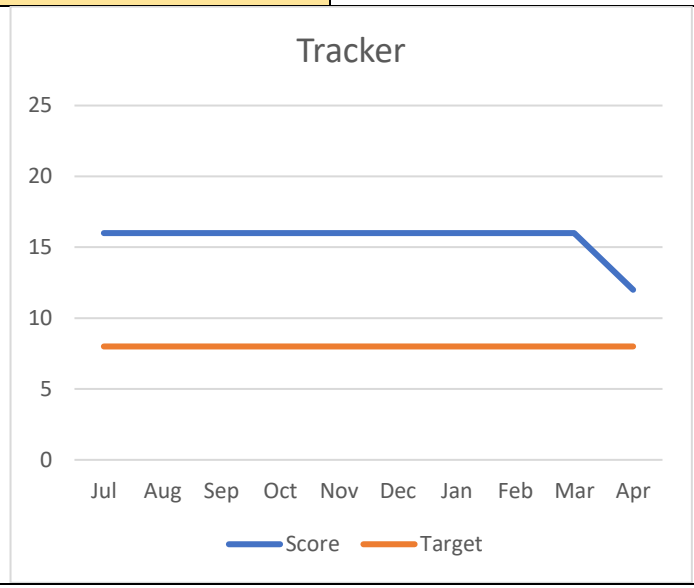
of complaints and PALS contacts.	department levels, including but not limited to: • Patent Experience Strategy • Learning Disabilities Strategy • Dementia Strategy • Nutrition steering group • Catering steering group • Domestic planning group • Discharge steering group • Induction training Customer service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

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

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

Strategic Objective 3: Improving Clinical Effectiveness

Strategic Risk	If clinical audit requirements are not completed the Trust will fail to meet the requirements of clinical compliance regimes including NICE				**Strategic Objective**	Improving Clinical Effectiveness
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Corporate Affairs	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	20/04/21	**Risk Rating**	12	8		



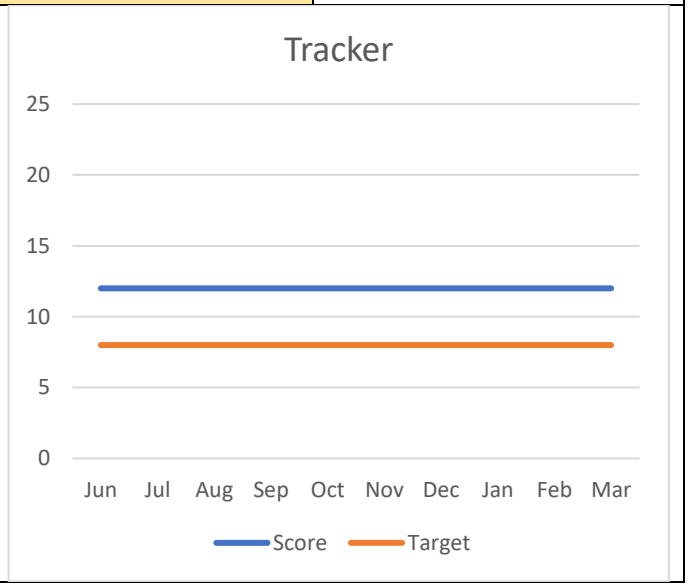
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
1. Lack of understanding/ awareness of audit requirements by clinical audit leads	1. Designated audit leads in CSUs/ divisions 2. Clinical governance and administrative	1. Resource to complete audits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

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

RISK 11: Failure to ensure adequate data quality leading to patient harm, reputational damage and regulatory failure

Strategic Objective 3: Improving Clinical Effectiveness

Strategic Risk	Failure to ensure adequate data quality leading to patient harm, reputational damage and regulatory failure				**Strategic Objective**	Improving Clinical Effectiveness
Lead Committee	Audit	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Operations	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	30/03/21	**Risk Rating**	12	8		



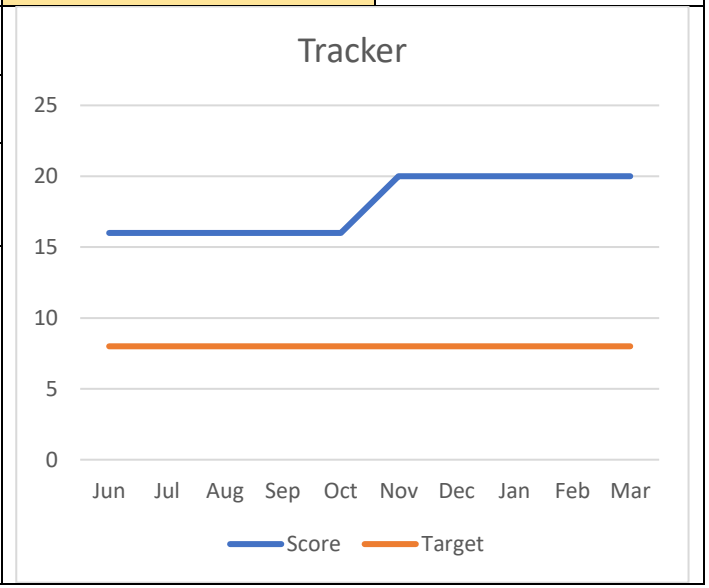
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure because data quality	Robust governance around data quality processes including executive ownership Audit work by data quality team	RPAS will reduce the numbers of manual input errors Better training of the	RPAS scheduled in for implementation in 2022 Director of Transformation	Data Quality Board External benchmarking			

processes are not robust	More robust data input rules leading to fewer errors	administration teams leading to more consistent recording of data	working with OP areas to improve training				

RISK 12: Failure to meet elective waiting time targets due to seasonal emergency pressure or further Covid-19 surges

Strategic Objective 4: Meeting Key Targets

Strategic Risk	Failure to meet elective waiting time targets due to seasonal emergency pressure or further Covid-19 surges				**Strategic Objective**	Meeting Key Targets
Lead Committee	TEG	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Operations	**Consequence**	5	5	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	30/03/21	**Risk Rating**	20	10		



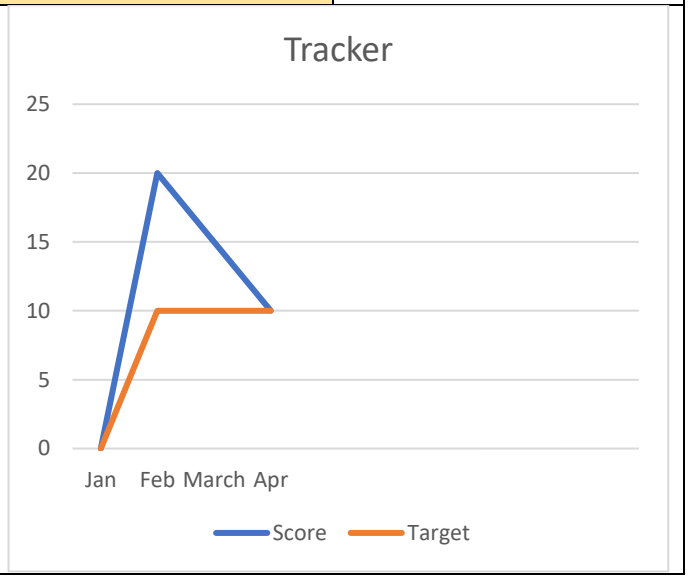
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Elective activity is suspended (locally or by national directive) to enable the Trust to cope with emergency demand or further Covid-19 surges,	Winter escalation plans to flex demand and capacity Plans to maintain urgent elective work and cancer services through periods of peak demand	Unpredictable nature of both emergency demand and the surge nature of Covid-19 Workforce and space (in	Continued planning and daily reviews (depending on Opel and incident levels)	Emergency Care Board (external partners) Regional and national tiers of reporting and planning			

resulting in increasing waits for patients needing elective treatment – including cancer care	Agreed plans with local system National lead if level 4 incident, with established and tested plans Significant national focus on planning to maintain elective care	pandemic) rate limiting factors					

RISK 13: If the Trust does not successfully appoint an external audit services provider in 2021 then the Trust will not be able to meet its statutory obligations

Strategic Objective 7: Being Well Governed and Financially Viable

Strategic Risk	If the Trust does not successfully appoint an external audit services provider in 2021 then the Trust will not be able to meet its statutory obligations				**Strategic Objective**	Being Well Governed and Financially Viable
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	DoF	**Consequence**	5	5	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	22/04/21	**Risk Rating**	10	10		



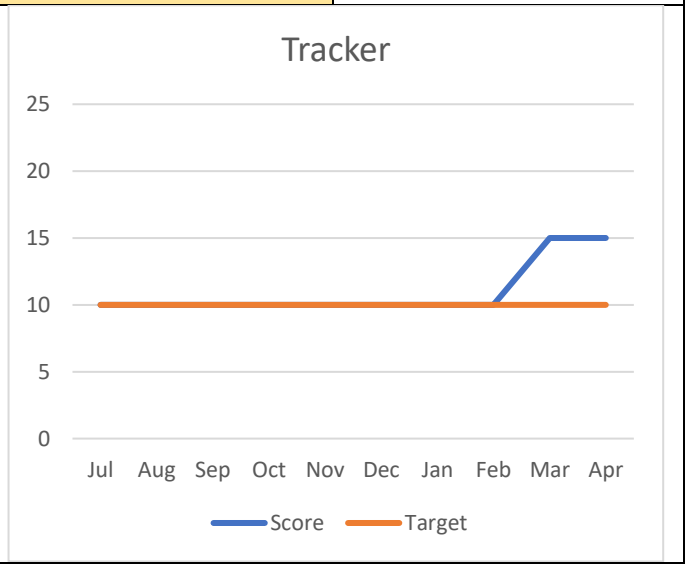
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
A number of audit firms are not bidding for audits currently due to Pricing – there have been recent	The Trust is looking to extend its current External Audit Contract by a year through a direct award for its current external auditors	The Trust has limited control over which audit firms will take-up offers to tender	The Trust will consider and implement as appropriate advice from	External review and reporting	Intelligence of intent to tender from framework listed suppliers	The Trust will undertake a timely retender exercise for	

changes in regulatory requirements increasing costs, in addition framework contracts were tendered a number of years ago and the rates are no longer at a level that audit firms would consider acceptable Capacity- due to Covid many audit clients in other sectors have moved their audit timetables which has caused capacity issues	Timely tender exercise for appointment beyond FY22		professional associations to mitigate risk to successful external audit appointment (e.g. HFMA). The position will be reviewed with updates provided to the Audit Committee			services beyond FY22 and will identify potential suppliers early in this process	

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

Strategic Objective 7: Being Well Governed and Financially Viable

Strategic Risk	If the Trust does not maintain investment in its IT infrastructure and systems then all operational systems will be severely affected by IT failures such infiltration by cyber criminals.				**Strategic Objective**	Being Well Governed and Financially Viable
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	Deputy CEO	**Consequence**	5	5	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	19/04/21	**Risk Rating**	15	10		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Hardware failure due aged equipment Cyber attack	2 dedicated cyber security posts Good network protection from cyber security breaches such as Advanced	None identified	Continued review	External review and reporting Purchases new equipment to install in 9 months	None currently	None currently	

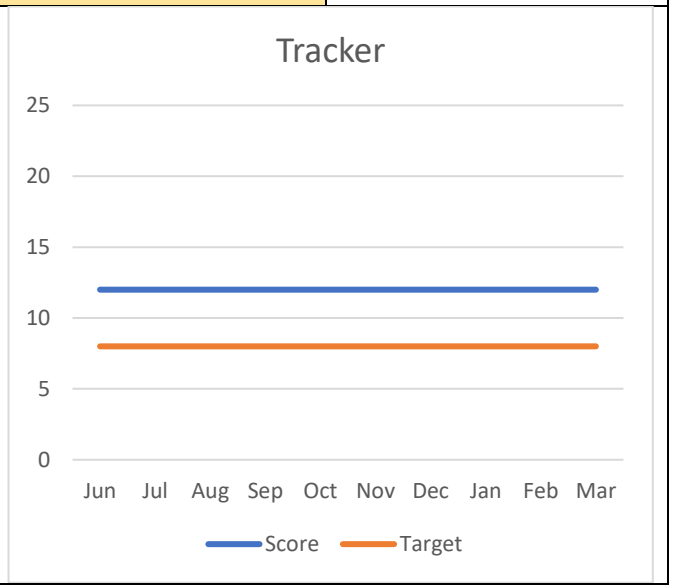
	Threat Protection (ATP) – A part of the national programmes to protect the cyber security of the hospital All Trust PCs less than 4 years old Purchase new hardware – not implemented yet EPR investment						

RISK 15: There is a risk that delays in the business case approvals process (including regulatory approvals), and/or delays in capital funds being made available (through PDC financing or other sources) prevent the Trust from being able to progress its entire capital programme in 2020/21 leading to a missed opportunity in the event funds cannot be carried forward to future years.

Superseded by the risk associated with the HIP2 Programme – to be reviewed at the June 2021 Board Seminar Meeting

Strategic Objective 7: Being Well Governed and Financially Viable

Strategic Risk	There is a risk that delays in the business case approvals process (including regulatory approvals), and/or delays in capital funds being made available (through PDC financing or other sources) prevent the Trust from being able to progress its entire capital programme in 2020/21 leading to a missed opportunity in the event funds cannot be carried forward to future years.				**Strategic Objective**	Being Well Governed and Financially Viable
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	DoF	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	22/04//21	**Risk Rating**	12	8		

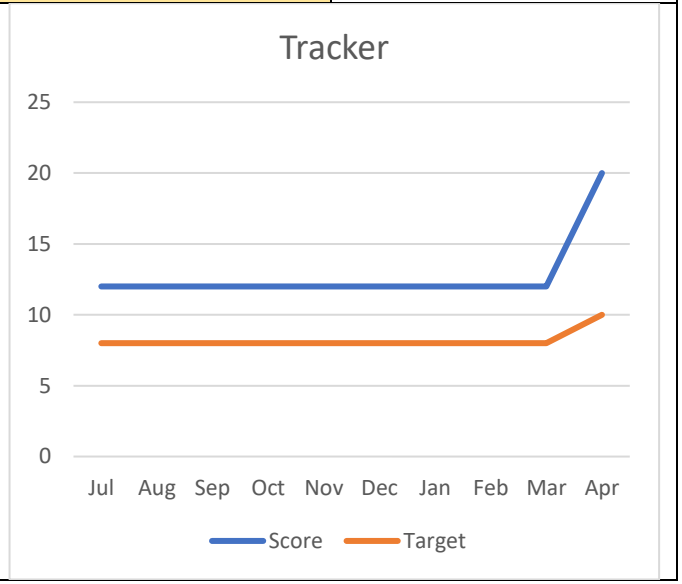


Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Despite increased investment being made available to respond to covid-19, the national NHS capital financing regime remains under significant pressure. Capital expenditure limits have been implemented for NHS provider organisations and whilst the Trust's capital plan is within this envelope there have, in the past, been delays in funds being received to support capital investment.	1. Capital prioritisation process in place (through the Trust's Capital Control Group (CCG) and Clinical Board Investment Group (CBIG) to ensure the Trust prioritises its capital schemes its resources effectively. 2. Alternative funding sources identified to support continued investment in the Trust's estate and physical infrastructure in line with requirements in the event that funding is not made available. 3. Close working with regulator partners to ensure the Trust is supported through the approvals process and any delays can be escalated through the NHS regional finance/capital teams.	The Trust has only limited influence on the national policy regarding the capital funding regime and the constraints on the national CDEL.	Continued review	External review and reporting			

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

Strategic Objective 7: Being Well Governed and Financially Viable

Strategic Risk	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.				**Strategic Objective**	Being Well Governed and Financially Viable	
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial	
Executive Lead	DoF	**Consequence**	5	5	**Risk Appetite**	Cautious	
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat	
Date of Review	22/04//21	**Risk Rating**	20	10			



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

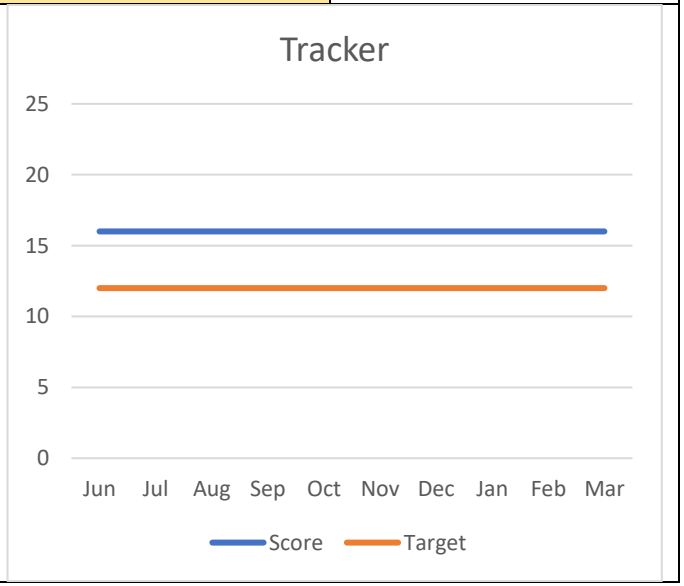
Reductions in non-NHS income streams as a direct result of COVID-19. Impaired operating productivity leading to costs for extended working days and/or outsourcing. Potential for material increase in efficiency requirement from NHS funding regime to support DHSC budget affordability. Unknown funding regime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

RISK 17: There is a risk that the Trust has insufficient resources (financial or otherwise) or has insufficient physical capacity in order to clear the waiting list backlogs that occurred as a result of the COVID-19 pandemic, leading to delays in patients receiving treatment and a potential long-term financial pressure for the Trust through a requirement to deliver higher levels of activity each financial year.

Duplicate of Risk 16 – Recommended for removal

Strategic Objective 7: Being Well Governed and Financially Viable

Strategic Risk	There is a risk that as a result of the COVID-19 pandemic the Trust incurs additional costs, has a reduction in income or is unable to deliver services efficiently leading to financial position being unsustainable.				**Strategic Objective**	Being Well Governed and Financially Viable
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	DoF	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	4	3	**Risk Treatment Strategy**	Treat
Date of Review	30/03/21	**Risk Rating**	16	12		



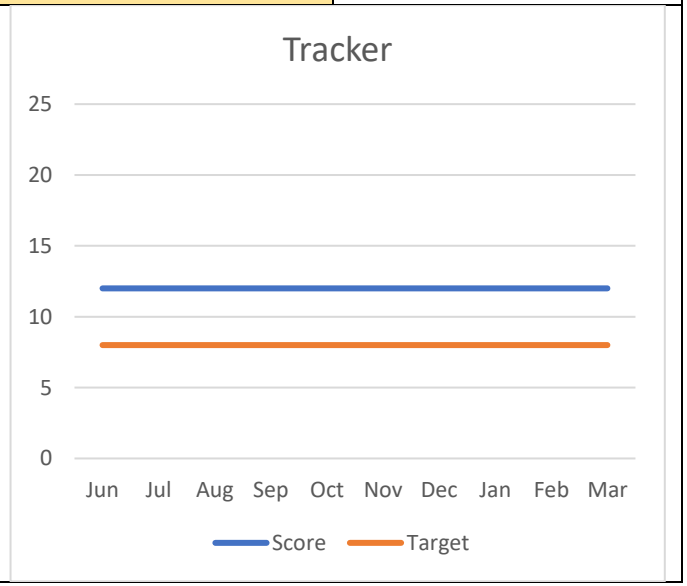
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
The COVID-19 pandemic led to the delay or cancellation of procedures and clinics which resulted in an increase in the size of the waiting list (at the Trust and across the NHS more broadly). On-going measures in response to COVID-19 (such as social distancing measures) have the potential to reduce the available physical capacity at the Trust.	1. Monitoring of the Trust's waiting list through divisional meetings, executive performance meetings, and Trust board sub-committees (including the Finance and Investment Committee); 2. Recovery plans developed in accordance with guidance issued by NHS England and NHS Improvement, including financial forecast to assess the impact of increasing activity alongside COVID-19 measures. 3. Financial incentive scheme in place to provide additional funding for performing activity in excess of baseline levels set by regulators	The Trust has only limited control over the allocation of additional financial resources to support its recover plans.	Continued review	External review and reporting			

	4. Capital and revenue bids submitted to regulators in order to provide additional finance resource to create additional capacity to increase activity volumes at the Trust.						

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

A subject of review for re-allocation

Strategic Objective 7: Being Well Governed and Financially Viable

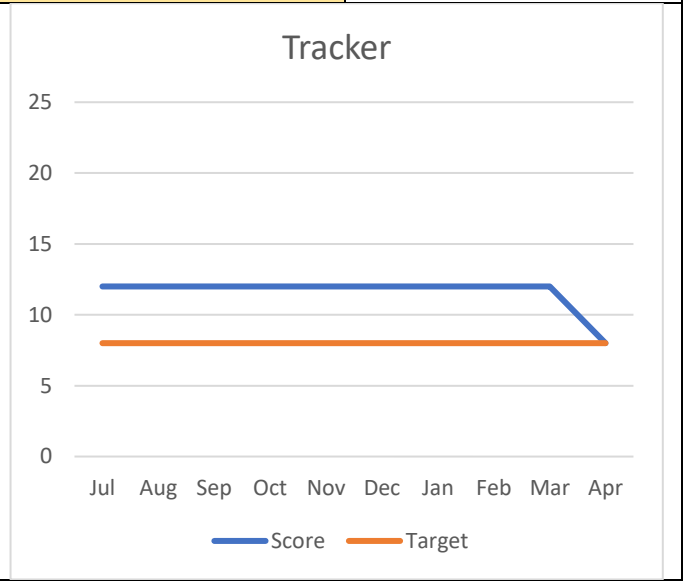
Strategic Risk	Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care						**Strategic Objective**	Being Well Governed and Financially Viable/ Patient Safety
Lead Committee	Finance and Investment and Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial	
Executive Lead	DoF	**Consequence**	4	4	**Risk Appetite**	Cautious	
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat	
Date of Review	30/03/21	**Risk Rating**	12	8			

Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
The current size of the Neonatal Unit does not meet the demands of the service. This risks high numbers of transfers of unwell babies and potential delayed repatriation of babies back to the hospital. There is a risk that if the Trust continues to have insufficient space in its NNU, the unit's current Level 2 status could be removed on the basis that the Trust is unable to fulfil its Network responsibilities and deliver care in line with national requirements.	Reconfiguration of cots to create more space Additional cots to increase capacity Parents asked to leave NNU during interventional procedures, ward rounds, etc to increase available space HIP2 funding for new Women and Children's Hospital announced	External timeframe and approval process for HIP2 funding	Continued review	External review and reporting			

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

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust does not retain staff then posts will be vacant resulting in workforce shortages across the hospital or increased temporary staffing expenditure.				**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	21/04/21	**Risk Rating**	8	8		



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

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

	working experience/ environment. Enhanced Benefits Package						

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

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust does not recruit to vacancies in the short term (0-18 months) then there will be workforce shortages across the hospital and/or increased temporary staffing expenditure.						**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff	At target level – no tracker	
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Cautious		
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Tolerate		
Date of Review	21/04/21	**Risk Rating**	8	8				

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

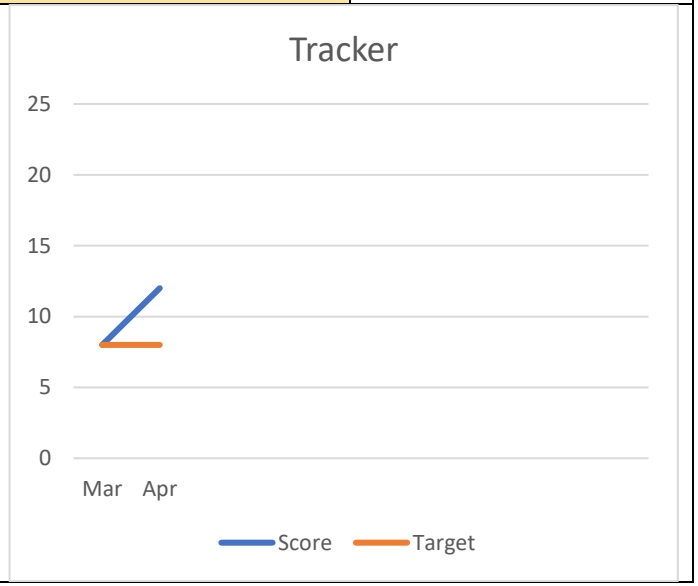
Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply)	Use of recruitment and retention premia as necessary Use of the Trac recruitment tool to reduce time to hire and candidate experience Rolling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

	Targeted recruitment to reduce hard to fill vacancies						

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

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust does not recruit to vacancies in the long term (19+ months) then there will be workforce shortages across the hospital and/or increased temporary staffing expenditure.				**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Tolerate
Date of Review	21/04/21	**Risk Rating**	12	8		



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

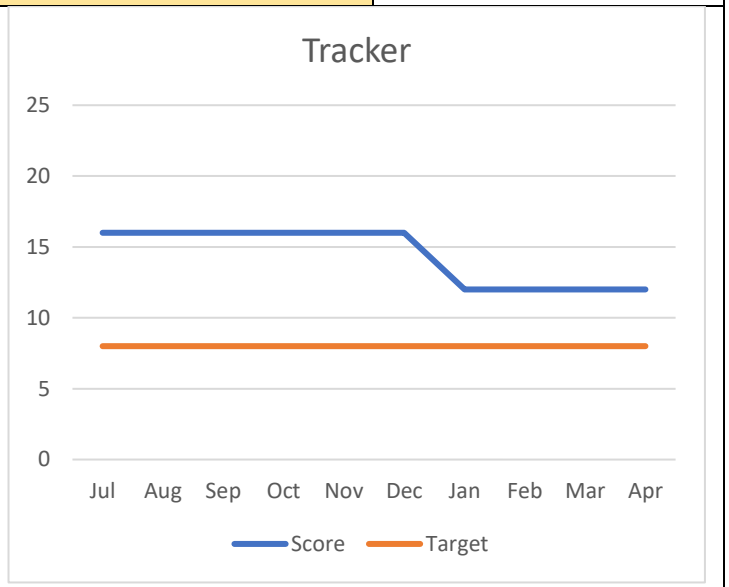
roles, particularly at consultant level Brexit may reduce overseas supply Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply) Large percentage of workforce predicted to retire over the next decade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

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

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

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust is unable to maintain a compliant training environment, 11 postgraduate training posts remain under threat of removal by HEE.				**Strategic Objective**	Investing in Our People/ Patient Safety
Lead Committee	Workforce/ Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	19/04/21	**Risk Rating**	12	8		



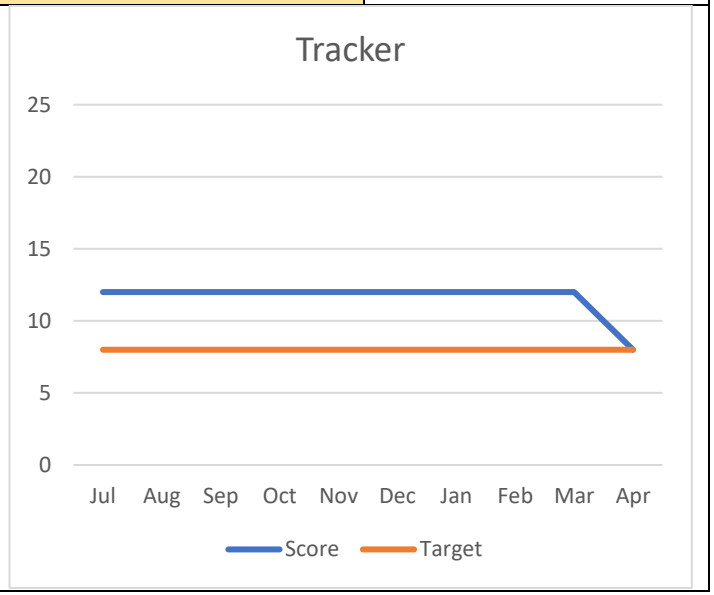
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Poor training environment: lack of standardisation of process; variable levels of	Heavy involvement from clinical leaders outside the department (DD, DME, MD).	To date, we have not recruited to the additional posts approved in order to move	Positive initial work with Professor Belinda	HEETV undertook a virtual visit on 04/12/2020 and the risk score	None Currently	None Currently	

support; and, persistent concerns around behaviours by consultants perceived as belittling / inappropriate / bullying. Risk raised in November 2019 following HEE TV quality meeting.	Change in clinical leadership model within the service. Formative external review (Berendt consulting). Close liaison with HEE TV Head of School. Developmental work with consultant body and other senior clinicians in relation to vision and agreement of an ambitious forward-looking programme of work. Agreement around further investments within the department to improve the working lives of trainees and the quality of the training environment.	away from a single tier middle grade rota 24/7. This currently sits in part with the Head of School as a rotation is envisaged. The COVID-19 situation has resulted in additional complexity (development work etc.)	Dewar (Wee Culture) across the maternity department, using appreciative inquiry.	(HEE intensive support framework) was reduced from 'category 3 – major concerns' to 'category 2 – significant concerns. For further review at the June 2021 Quality Committee.			

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

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust does not maintain stocks of Personal Protective Equipment (PPE) and continue implementing the enhanced infection control measures it will be unable to maintain a safe working environment during the COVID-19 pandemic				**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	21/04/21	**Risk Rating**	8	8		

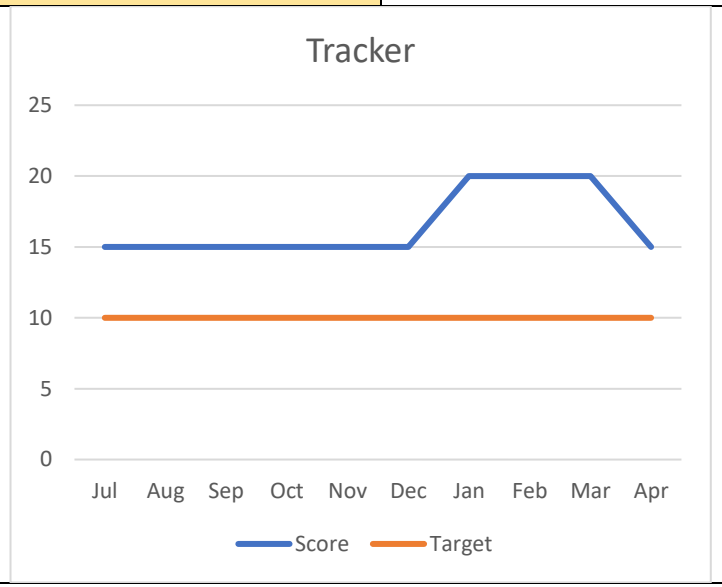


Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Ability to maintain a safe working environment during the Covid-	Incident command structure in place	None currently – noted that this risk may escalate very quickly	None Currently	Completed Risk Assessments	None Currently	None Currently	

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

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

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust does not implement and progress staff health and wellbeing initiatives, there is the risk of staff burning out during or due to the COVID-19 pandemic						**Strategic Objective**	Investing in Our People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff		
Executive Lead	Director of Workforce	**Consequence**	5	5	**Risk Appetite**	Avoid		
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat		
Date of Review	21/04/21	**Risk Rating**	15	10				

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

and other social factors	Staff Hub in use Remote working wellness centre in place 12 weeks of wellbeing focus January to March		with staff about support systems			remote workers	

Agenda item 7.3
Public Board 06/05/2021

Meeting of the Audit Committee held on 23 March 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:
The Committee approved write offs of £94k.

The Committee approved the Conflict of Interest, Hospitality, Gifts, Donations and Sponsorship Policy

Summary of matters considered at the meeting:

External Audit
The Committee noted the external audit plan for 2021-22.

Internal Audit
The Committee noted the final reports on capital expenditure and key financial controls and recommencement of work paused due to the COVID-19 pandemic.

Health & Safety
The Committee noted the organisation's plans in the coming year to address above average levels of violence and aggression. These include joint working with local mental health care provider, Central and North West London Community Services.

Regarding positive tests for COVID-19, all cases contracted on site were reported to the Health & Safety Executive.

Register of Interests of Decision-Making Staff 2020-21
The Committee recommended a review of processes regarding reporting of interests.

Agenda item
Public Board 06.05.21

Meeting of the Finance and Investment Committee held on 29 March 2021

REPORT TO THE BOARD OF DIRECTORS

Matters reported at the meeting:

- Regarding the M11 Performance Dashboard, the Committee noted the continuing efforts to manage patient flow as A&E attendance levels returned to normal following the second surge of COVID.

- Regarding the M11 Finance Report, the Committee noted the actions taken nationally and locally to mitigate the financial impacts of COVID. The Committee noted the ongoing cost implications of treating patients safely as the Trust returns to pre-pandemic activity levels.

- Regarding the Capital Programme, Committee noted the volatility of the capital position in the NHS at the end of the financial year. The Committee noted the advanced level of deployment of available functionality within the Trust's electronic patient record system.

Milton Keynes University Hospital NHS Foundation Trust

Agenda item 7.5
Public Board 06/05/2021

Meeting of the Charitable Funds Committee held on 22 April 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- The Budget Forecast for 2021/22. The target income for the year was £490k, and expenditure was forecasted to be £455k;
- The Charity Fundraising Plan for 2021/22;
- 12-month funding for a 'Meaning Activities Coordinator Role' from the Charitable Funds
- The provision of funding for 'MK Arts for Health' in 2021/22 by the Charitable Funds;
- The Charitable Funds Committee's Self-Evaluation Report.

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:

Fundraising Update –

a. Income for 2020/21 was £542k against a forecast target of £463k;
b. The 3 Draeger BabyLeo incubators, which were procured with funding from the Charitable Funds, will be delivered on 03 May 2021.

Arts for Health –Supporting Health and Wellbeing with MKUH. The Charity's ambition is to embed Arts for Health within the Hospital by providing support on site for staff and patients dealing with the effects of COVID-19.

Milton Keynes University Hospital NHS Foundation Trust

Agenda item 7.6
Public Board 23/03/2021

Meeting of the Quality & Clinical Risk Committee held on 23 March 2021

REPORT TO THE BOARD OF DIRECTORS

Matters Approved by the Committee:

No matters were approved by the Committee.

Summary of matters considered at the meeting:

Clinical Quality Risks on the Board Assurance Framework (BAF) – The Committee focused on the steps being taken to enhance the assurance provided to the members by the BAF. The narrative in the 'Control' will be submitted to an audit by the internal auditors in Q4 of 2021/21.

COVID-19/Site Update- Presentation – The Committee noted that as of 23 March 2021, there were only 28 COVID-19 patients on admission and, the number of COVID-19 wards was down to just one.

Quarterly Highlight Report – The Committee reviewed and discussed four themes:

a. The anticipated CQC Well-Led inspection of the Trust;
b. Staffing issues in the Maternity Unit;
c. Learning from the COVID-19 pandemic, focused on maintaining elements of the pandemic response such as an integrated ICU outreach function and an enhanced Oxygen stewardship process.

Patient Experience Update –

a. The 'Patient Experience Team' had been integrated with the Chaplaincy and the Volunteers Teams, and had been renamed as the 'Patient Experience and Family Team';
b. A patient experience matron had been appointed to support the Trust the team and their initiatives with clinical knowledge.

Response to the Ockendon (Maternity Services) Report – The Committee noted that an Action Plan based on the report's recommendation will be submitted to Trust Board for review in April 2021.

Response to the Cumberlege Report – The report was published in July 2020 after an enquiry into why women were harmed by drugs and implants. The Committee was informed that that the report's recommendations were already being implemented in the Trust. Women were already being provided with cultural support, and the Committee would updated on progress in future recommendations.

Agenda item 7.7
Public Board 21/04/2021

Workforce & Development Assurance Committee Meeting held on 21 April 2021

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:

Staff Story – The Committee received a presentation from the new Workforce Matron who had been recruited to help drive the 'Workforce and Nursing agendas'. The new Matron has been a nurse for 20 years and had both clinical and operational experience.

NHS People Plan, Workforce Strategy and Plan Update – The Committee noted that the Workforce Strategy was due to be refreshed in 2021/22, and the NHS People Plan was being progressed.

Equality, Diversity and Inclusion – The Committee was informed that the Diversity and Inclusion Partners Programme was scheduled to commence at the end of June 2021, and the outline of a Cultural Intelligence Programme was under development.

Objectives Update – Majority of the objectives had been achieved, and would be refreshed as part of the steps being undertaken to refresh the Workforce Strategy.

HR Systems and Compliance – The Committee noted the positives of the Workforce Team effort to fill all healthcare assistant vacancies, and their keenness to demonstrate that the roles were meaningful.

Workforce Information Quarterly Report – The Committee noted the following:

1. Vacancy rate was at 10.5% against a target of 10%,;
2. The leaver turnover rate of 7.1% against a target of 10%;
3. A static group of known agency workers were generally relied upon in the hospital, which helped maintain the quality of care.

Staff Health & Wellbeing (SHWB) Report – A 'long-COVID' group had been established, so members can share experiences and support each other.

Education Update – 'Unconscious Bias' lessons has been incorporated into the Equality and Diversity Training module.

Staff Survey – The presentation on the Staff Survey results indicated that, developing improvement actions to resolve the issue of 'violence and aggression against staff', was of the highest priority for the Workforce Team.

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Board of Directors**	**Date: 6 May 2021**
Report title:	**Use of Trust Seal**	**Agenda item: 7.8**
Lead director **Report author Sponsor(s)**	**Name: Kate Jarman** **Name: Julia Price**	**Title: Director of Corporate Affairs** **Title: Assistant Trust 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 note the use of the Trust Seal since March 2021						

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

Since the last Trust Board, the Trust Seal has been executed as follows:

30 March 2021
Advanced Payment Bond
Galliford Try Construction Limited