Milton Keynes University Hospital NHS Foundation Trust

COUNCIL OF GOVERNORS

Council of Governors' meeting to be held at 10.00 on 12 February 2020 in the Conference Room, Academic Centre, Milton Keynes University Hospital, Milton Keynes

Time	Item		Report	Lead
17.00	**1**	**Chair's Welcome and Announcements**		Chairman
	1.1	**Apologies** To receive apologies for absence	Verbal	Chairman
	1.2	**Declarations of Interest** Governors are requested to declare any interests they have in items on the agenda.	Verbal	Chairman
	1.3	**Minutes and Matters Arising**		Chairman
		(a) Minutes of the Council of Governors meeting held on 7 November 2019	Approve Pg 4	Chairman
		(b) Action Log	Receive Pg 9	Trust Secretary
	2	**(a) Chairman's Report** **(b) Chief Executive's Report**	Verbal	Chairman Chief Executive
	PRESENTATION, INFORMATION and APPROVAL ITEMS			
17.30	**3.1**	**Inter-hospital patient record access**	Verbal	Medical Director
	3.2	**Patient portal update**	Presentation	Director of Corporate Affairs
	3.3	**Non-executive Director recruitment update**	Receive	Chairman
	3.4	**Quality priorities 2020/21**	Approve To follow	Director of Patient Care

				and Chief Nurse
	ASSURANCE REPORTS FROM COMMITTEES			
18.00	**4.1**	**(Summary Report)** **Finance and Investment Committee**	Receive Pg 14	Chairman of the Committee
	4.2	**(Summary Report)** **Charitable Funds Committee**	Receive Pg 16	Chairman of the Committee
	4.3	**(Summary Report)** **Quality and Clinical Risk Committee**	Receive Pg 18	Chairman of the Committee
	4.4	**(Summary Report)** **Workforce and Development Assurance Committee**	Receive Pg 20	Chairman of the Committee
	GOVERNORS UPDATE			
18:15	**5.1**	**Healthwatch Milton Keynes Update Report** • **LGBT+ project report**	Receive Pg 23 Pg 26	CEO Healthwatch Milton Keynes
	5.2	**Lead Governor's Report**	Verbal	Alan Hastings
	PERFORMANCE			
18:30	**6.1**	**Integrated Performance Report Month 4**	Receive Pg 46	Chief Executive
	6.2	**Finance Report Month**	Receive Pg 50	Director of Finance
	GOVERNANCE			
18.40	**7.1**	**Motions and Questions from Council of Governors**	Receive	Chairman
	7.2	**Any other Business**		Chairman
	7.3	**Date and time of next meeting** 14 April 2020; 09:30 – 12:30	Note	Chairman
	7.4	**Resolution to Exclude the Press and Public**		

		The Chair to request the Council of Governors' to 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 other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted."*		

If you would like to attend this meeting or require further information, please contact: Alison Marlow, Trust Secretary Tel: 01908 996234. Email: Alison.marlow@mkuh.nhs.uk

Milton Keynes University Hospital NHS Foundation Trust

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

DRAFT minutes of a meeting of the Council of Governors' of the Milton Keynes University Hospital NHS Foundation Trust, held in public at 10.00 on Thursday 07 November 2019, in the Conference Room, Academic Centre, Milton Keynes University Hospital, Milton Keynes

Present:
Simon Lloyd (SL) - Chairman

Public Constituency Members:
Amanda Anderson (AA)
Alan Hastings (AH)
Alan Hancock (AHa)
Brian Lintern (BL)
Clare Hill (CH)
Ekroop Kular (EK)
Lucinda Mobaraki (LM)
William Butler (WB)

Appointed Members:
Maxine Taffetani (MT) - Healthwatch Milton Keynes
Andrew Buckley (AB) - MK Business Leaders
Richard Alsop (RA) - Clinical Commissioning Group

Staff Constituency Members:
Michaela Tait (MT)

Executive Directors
Joe Harrison (JH) - Chief Executive
John Blakesley (JB) - Deputy Chief Executive
Ian Reckless (IR) - Medical Director

Non-Executive Directors
Helen Smart (HS)
Parmjit Dhanda (PD)
Heidi Travis (HT)
Tony Nolan (TN)
Andrew Blakeman (AB)

Also, in Attendance
Adewale Kadiri (AK) - Company Secretary
Moira Mawuru (MM) - Corporate Governance Administrator

1.	**WELCOME & ANNOUNCEMENTS**

	The Chairman extended a warm welcome to everyone present at the meeting.
1.1	**APOLOGIES**
	Apologies for absence were received from Robert Johnson-Taylor, Carolyn Peirson, John Clapham and Nicky McLeod.
1.2	**DECLARATIONS OF INTEREST**
	There were no new declarations of interest received and no interests received in relation to any other open items on the agenda.
1.3	**MINUTES**
(a)	**Minutes from the Council of Governors meeting held on the 16 April 2019** The draft minutes of the meeting held on 16 July 2019 were accepted as an accurate record except that Alan Hancock was recorded both on the attendance list and apologies. It was acknowledged that Alan Hancock did in fact attend the 16 July meeting.
(b)	**MATTERS ARISING / ACTION LOG**
	Action Log There were no outstanding actions.
2	**CHAIRMAN AND CHIEF EXECUTIVE REPORTS**
(a)	**Update from Medical Director**
	The Medical Director referred to two issues concerning the Coroner for Milton Keynes. It was noted that one of the cases in question had been reported on in the Sunday Telegraph. The Medical Director explained that the coronial process is engaged in relation to any deaths not deemed to have been natural. Inquests are generally held in public. In MK, the Coroner looks at between 10 and 20% of deaths. Some are relatively straightforward, for example where death occurred as a result of exposure to asbestos, but others are more in depth. The Coroner has the option to record different causes of death, such as manslaughter or neglect, and he may also record a narrative verdict. In addition, he may issue what is described as a Regulation 28 report, or a Report to Prevent Future Deaths (PFD). This is a formal exercise that involves writing to the CEO and copying it to CQC. It may also be published on the Judiciary website. The Medical Director indicated that PFD reports help to encourage learning in NHS, but a trust would not want to receive too many. MKUH has already had two earlier in the autumn. The first case was of Mr John Shrosbee who died a few days after admission. The Trust acknowledges that there were some issues with his care. He had some routine blood tests done, but the staff did not look at the results of these for 90 minutes. An earlier consideration would not, however, have changed the outcome. Nevertheless, the Coroner was concerned about medical staffing in A&E, and he issued the PFD on this basis. The Trust is concerned that this decision appears to have been based on the Coroner's subjective opinion, and it has the capacity to damage public trust in the hospital. The point was made that staffing levels in the department are the same as at other hospitals. On that day there were 13 nurses on duty out of a possible total of 14, and the decision was made not to call for additional staff as the department was not particularly busy on the day. This response would go to the Coroner, the Chief Coroner and CQC, but it would not normally be published online. The point was made that the Trust values the coronial process as it can help identify problems that management are not aware of, but in this

	case, it was not thought that the Regulation 28 report had been issued correctly. The case had rightly been covered by the local media as the report had been published online. The Chief executive commented that staffing in ED had not been picked up as an issue at the recent CQC inspection. The Medical Director highlighted the difference between optimal and safe staffing and acknowledged the longer-term issues for the NHS around skill mix. Could AHPs be asked to do some of the things that junior doctors currently do. The second case concerned a patient who had suffered a subdural haemorrhage. It had been identified in A&E and the patient was looked after in Trauma. The patient was on blood thinning medication, which was stopped and then started again two days later – this is usually done two weeks later. The Coroner issued a PFD report on the basis that the clinical information was not readily available. This was difficult criticism and hear or understand. The case raises issues around training and the need for a better audit trail. Brian Lintern enquired about the amount of training that nurses receive ahead of inquests, and in response, the Medical Director explained that this would depend on how experienced the staff member is, and if it is thought that the inquest would be challenging. The point was made that any expenditure on legal fees is a diversion away from patient care. Andrew Buckley clarified that coroners can ask leading questions. The Chief Executive indicated that the Coroner is exceptional in the number of PFDs that he issues. It was noted that there had been a Sunday Telegraph story featuring this hospital. The National Joint Registry has been running for 17 years. Its annual report compares activity levels and presents data on hips, knees, shoulders, elbows and ankle replacements. Patients who have had replacements can from time to time need revision surgery – this could mean replacing the joint or simply cleaning a wound. In its latest annual report, the NJR has labelled MKUH as one 6 trusts and a number of private hospitals with high revision rates. This is a cause for concern and there are several factors that could explain it. The Trust is working to understand the issues and is in the process of collating the work of 10-12 individual surgeons, which is not straightforward. A report will be presented to the Board in January.
(b)	**Chairman's Report**
	The Chairman noted that this is the first public Council of Governors' meeting to be held since Carol Duffy sadly passed away. On behalf of the Council he acknowledged the tremendous support that she had provided to the Governors and to the wider Trust and local community. The Chairman formally announced that two Public Governors – Clive Darnell and Douglas Campbell, had resigned. He thanked them for their contribution. He mentioned that Douglas Campbell had been a valued member of the Charitable Funds Committee, and he had therefore been asked to continue in that capacity and Mr Campbell had agreed. There is therefore a Governor vacancy on that Committee, and any interested person was asked to speak to Parmjit Dhanda or to the Chairman. The Chairman welcomed Lucinda Mobaraki on being elected as Governor for the Outer Catchment area constituency. He also welcomed Richard Alsop who had been nominated to represent MKCCG. The pre-election period of sensitivity has now commenced and will last until just after the election. During this period, the Trust must steer clear of any political debates or any

	decision which could be construed as politically sensitive. This guidance also applies to Governors – they cannot be politically active in their capacity as Governors.
(c)	**CEO Report**
	The chief Executive referred to the Government announcement about capital for the NHS. As part of this, MKUH will gain access to a share of the £100m pot which would enable the trust to work up designs and business cases for new developments. This has come as a pleasant surprise. During his recent visit, the Prime Minister had a conversation with the executive about the Trust's plans which are based on the estates strategy. The organisation already has good ideas about how it wishes to develop the site over the next few years. There is as yet no information on timescales for the full funding or amounts, or indeed the impact that the outcome of the General Election could have. The prime ministerial visit was deemed successful, with many members of staff keen to meet him. It was also noted that the visit did not generate any of the negative press coverage that other recent hospital visits had done. The Trust continues to work closely with its MK partners. The overarching message is that the public expect there to be a single health and care system. It was noted, for example, that complaints about poor treatment at the Urgent Care Centre are linked to the hospital. This highlights the difficulties caused by the multiplicity of providers in the NHS. A way needs to be found to manage urgent care properly rather than focusing on managing contracts. There is an opportunity to work more closely with CNWL and others. The fact that the management of physical health under one roof is now being discussed is a major steps forward. In response to a question about the timescales within which any changes could be made, the Chief Executive stated that a new system may be in place in shadow form by April 2020. There are different models around the country - in Manchester the Council runs health and care, while in Salford, the hospital is in the lead. In response to a question about ambulance provision, the Chief Executive explained that SCAS will continue to be the Trust's main partner in this area. The Trust will also remain within Thames Valley for emergency preparedness. Richard Allsop made the point that much can be achieved through the closer working relationship that now exists between the CCG and the Trust, and he observed that the skills that exist within the CCG are well suited for this journey. Maxine Taffetani raised a question about CNWL's investment into MK, and wondered if the ICP would be in a position to address the lack of transparency on what is being spent, for example, on children's mental health. The Chief Executive explained that BLMK has responsibility for capital spend and has clarity on the total budget for the area. However, he conceded that the revenue position is more challenging where a provider's main focus is outside the geography. As the largest spender in the system, MKUH has the opportunity to connect the levers of change on funding. Regarding the Luton and Bedford merger, it was noted that the £99.5m capital bid has been approved in principle which would allow the acquisition to proceed. It had been promised that no major service change had been linked to the funding. Alan Hancock reiterated the continued inability for patients to access their test results via PatientView. The Chairman indicated that the issue had been raised with OUH and a solution is being sought. The Chief Executive promised to check the specific issues and write to Alan Hancock.

	In response to a comment from Lucinda Mobaraki that some local GPs are unable to provide certain medications, the Chief Executive confirmed that the Trust is following national guidelines not to stockpile. The only shortages that have been noticed so far are in relation to the flu vaccine as a result of one of the production companies going into administration. **Resolved: The Chairman's and Chief Executive's reports were received and noted.**
3.2	**15 Steps Toolkit for People with Learning Disabilities**
	The Patient Engagement Manager presented this item. It was agreed that the slide pack would be shared with Governors. The Trust has worked with Experts by Experience in learning disabilities and autism, and it is noted that people with these conditions suffer poorer outcomes than others, in part because they often find it difficult to provide feedback on their care. As a result of the work that has been done, a number of quick improvements were identified, including producing a new leaflet about making complaints. The team were keen to enable people with learning disabilities to be able to take on 15 steps. It was noted that a variety of toolkits had been produced to enable different categories of staff and volunteers to participate in 15 steps, but none for people with learning disabilities or autism. They tend to prefer imagery and use different font sizes. As a result of this work, they were able to visit outpatients, the X-ray department and the restaurant, and they provided much useful feedback, including recommendations to improve the signage and providing quiet areas for feedback. It is also intended that the Friends and Family Test, which has now been brought in-house, would be made easier to use. **Resolved: The Update on 15 Steps was received and noted**
3.2	**Friends and Family Update**
	The Patient Engagement Manager presented a summary of the results of the 2018 NHS Inpatient Survey. It was agreed that the slide pack would be shared with Governors. The results of this test do provide information that the Trust can use, and some changes are to be made in 2020. Feedback on one of the questions was that it did not work, and the question was changed in response to this. The requirement to provide feedback on a visit to A&E within 24 hours has also been lifted, and the Trust can now engage with patients after they have left the department. conversations can also be held with maternity patients at a later stage. The administration of the process has been brought in-house and this would enable the Trust to be more creative. Some demographical information has also been included. Forms have been added in relation to those with visual impairment and for children. The use of a VR code is also being piloted. In response to a question from Alan Hastings about the provision of religious information, the Patient Engagement Manager stated that this is optional. The forms are available in every ward and department that want them. Helen Smart made the point that this is just one of the ways by which feedback may be provided. **Resolved: The summary of the results of the family and friends test was received**

	and noted
3.3	**Update on new car parking arrangements**
	The Deputy CEO gave this presentation. He indicated that as a result of the changes made the Trust may no longer be able to provide concessions as before. Alan Hancock raised a question about the renal unit car park. In response, the Deputy CEO indicated that this is OUH's unit and it is for them to decide if they wish their patients to have free parking. There are 7 validators around the site. The question was raised about a patient who had driven themselves to an outpatient appointment and was subsequently admitted for 3-4 days. It was accepted that this is an unusual occurrence. The new parking arrangements have been set out on the intranet and internet, but there will be exceptions, and a common-sense approach would be taken. Brian Lintern raised the issue of patients whose appointments are delayed sometimes for hours, meaning that they incur higher charges through no fault of their own. It was agreed that appointment letters will make it clear that patients may face delays. He also reported that despite the fact that the northern loop of the ring road has been made into a one-way system to accommodate more staff parking, the signage has not been amended to reflect this. The Deputy Chief Executive that the signage would be amended to make it clear that there is no public access. He also stated that the spaces sign would soon come back into use. Alan Hastings questioned whether the cash option in the payment machine at the main entrance would be taken away to avoid money getting jammed. In response it was stated that it was necessary to give people different payment options The Deputy CEO agreed to provide an update at the next meeting on the issues raised. **Resolved: The update on the new car parking arrangements was received and noted**
4.1	**(Summary Report from) Finance and Investment Committee 1 July and 5 August June 2019**
	Heidi Travis presented the summary report of the Finance and Investment Committee meetings held on 1 July and 5 August 2019. She stated that the team had put a lot of work into making the new contract a success. The Trust is on plan, but there are challenges. The focus is on making the system as efficient as possible. In response to a question about the ICS element of PSF, Heidi Travis made the point that the Trust is part of a wider system in BLMK and the East of England. Andrew Blakeman raised a question about the added cost of paying some staff on a weekly basis. In response, the point was made that for many staff groups, temp agencies pay weekly. The move to weekly pay for bank staff was one of the measures that the Trust took to reduce its reliance on agency staff. The staff value the flexibility flexible. **<u>Resolved</u> That the Summary Report from Finance and Investment Committee was noted**
4.2	**Audit Committee 16 July 2019**
	Andrew Blakeman presented the summary report of the Audit Committee meeting held on 16 July 2019. He set out the role and function of the Committee. At the July meeting, the Committee received assurance that the Trust has a sound approach to cyber security. It

	has invested in modern equipment and eliminated many potential vulnerabilities. On data quality, there has been a focus on the accuracy of A& waiting times. This is a very important metric but difficult to measure accurately, and the Trust's external auditors have continually discovered errors in their testing. Many other trusts have similar issues, but some have got it right. However, although the Trust's data is sometimes inaccurate, it is not biased. On the third area of focus, managing risk, the Director of Corporate Affairs is making good progress. At the CQC Well Led inspection, the inspectors had queried aspects of the Trust's practice that looked different. The team is reflecting on their feedback and looking to streamline its processes. Alan Hastings noted that it can sometimes be difficult to focus on getting the data right under pressure and wondered how serious this is taken by staff. The Deputy CEO made the point that the auditors check 24 appointments out of a total of 75,000. The Trust also carries out its own audits. Where individual members of staff are highlighted as making more errors than others this is drawn to the team's attention. In response to a question about the management of obsolete drugs, it was noted that some drugs have very short lifespans, and if the patient for whom they have been made does not turn up they are wasted. **<u>Resolved</u> That the Summary Report from Audit Committee was noted**
4.3	**Workforce and Development Assurance Committee 29 April 2019**
	Tony Nolan presented the summary report of the Workforce and Development Assurance Committee meeting held on 29 April 2019. At that meeting, there had been a productive discussion about the staff survey results and staff engagement. The Trust had in recent years found it difficult to improve its scores on engagement, and the discussion had focused on what needed to be done differently. Managers are now holding listening events with their teams – 100 have been held so far, and it is expected that some of the issues that would be raised would be around team working, bureaucratic barriers and a lack of appreciation. Tony Nolan explained that the staff survey is conducted anonymously, and the questions are generic for the whole organisation. The data generated can be analysed both by team and seniority, and it is to be used as a vehicle to drive change. It is important that the Trust listens and acts in response. **<u>Resolved:</u> That the Summary Report from the Workforce and Development Assurance Committee be received.**
4.3	**Summary Report from the Charitable Funds Committee meeting held on 1 July 2019**
	Parmjit Dhanda presented the summary report of the latest meeting of the Charitable Funds Committee. He highlighted the activity that is taking place as part of the Cancer Centre appeal, noting that this was a tough target to meet. Donations are still coming in and applications being made for various grants. The Fundraising Gala in September went very well and managed to raise around £20k, which was a great success. It was confirmed that the Fundraising Practice will continue to work with the Trust until the end of the calendar year. The Trust will continue to work with Arts for Health who have done a fantastic job curating and maintaining artwork around the hospital.

	In response to a question about the event that had ostensibly been organised to raise funds for the Cancer Centre but in relation to which no money has been received, it was noted that the Head of Fundraising has now received an explanation from the organiser, but that the matter is being raised with the Charities Commission and the Fundraising Regulator. **Resolved: That the Summary Report from the Charitable Funds Committee be received**
4.4	**Summary Report from the Quality and Clinical Risk Committee meeting held on 16 July 2019**
	Helen Smart presented the summary report of the Quality and Clinical Risk Committee meeting held on 16 July 2019. It was noted that despite the work being done across the hospital , the number of "super stranded" patients remains high. Progress is being made in partnership with other key players across the patch. There are 4 quality related risks on the BAF, and these are being assessed in detail. The Committee had a good session with the Infection Control team. The Trust has a robust approach to reporting and learning from Serious Incidents. Maxine Taffetani reported a concern from colleagues in Buckinghamshire about ambulance handovers. The Deputy Chief Executive explained that ambulance handovers do go up and down in all hospitals, and this has no connection to eCare. He also clarified that patients are not made to wait in ambulances unless the hospital is extremely busy, and that this has nothing to do with being a frequent attender. The trust does actively signpost people away from A&E towards the Urgent Care Centre, their GP or a local pharmacy. **Resolved: That the Summary Report from the Quality and Clinical Risk Committee be received**
5.1	**Healthwatch Milton Keynes Update**
	Maxine Taffetani remarked that there had been a positive feedback about the paediatrics department. They have so far received thirteen pieces of feedback since April with only one negative for ophthalmology. There were also 2 complaints about urology. An update on urology will be presented at the next meeting. **Action: Director of Operations** **Resolved: That the update from Healthwatch Milton Keynes was received and noted**
5.2	**Lead Governors update**
	Alan Hastings presented his Lead Governor update: • He had attended the Friends of MK Hospital's 40th birthday celebrations on 7 September. This was well attended. • The Trust's Annual Members' Meeting was also held in September • On 29th September, he and other representatives of the Trust attended the memorial service for Carol Duffy. It was a very sad occasion, but a nice service. She will be greatly missed. • He had attended an "Aging Well" conference at the Open University. • On 6 November the Lead Governor attended a PLACE meeting with the Patient

	Engagement Manager • A meeting is to be held on Friday 5 Dec about the future of hospital food with a range of choices. There is a commitment to improve on the current offer. • On 8 November the lead Governor will attend a BLMK Population Health Management workshop and on 14 November, there is an Inclusion for All event organised by the CCG. • Monday will be his first day as a dining companion on Ward 18. Alan Hastings put on record his thanks to Clive Darnel and Douglas Campbell for their contribution as Governors. His tenure as Lead Governor officially ends on 21 of November and he thanked all the Governors who had made his time in the role enjoyable. He wished his successor all the best.
6.1	**Integrated Performance Report Month 4 and Finance Report Month 4**
	The Council of Governors noted the contents of both reports.
7.1	**Motions and Questions from Council of Governors**
	There were none.
7.2	**Any other Business** Clare Hill announced that Ian Wilson had offered to accompany her on one of her rounds to the wards. Others were welcomed to join.
7.3	**Date and Time of next meeting** The date of the next meeting of the Council of Governors is 12 February 2020.
7.4	**RESOLUTION TO EXCLUDE THE PRESS AND PUBLIC** **<u>Resolved:</u> That representative of the press and other members of the public are excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted.**

Council of Governors - Action log updated Feb 2020

Action No	Date of Meeting	Agenda item No.	Agenda item	Action	Lead	Deadline Date	Action Update	Date of Meeting to be Reviewed	Status
1	07/11/2019	5.1	Healthwatch Milton Keynes update	An update on Urology to be presented at the next meeting following two complaints received.	Director of Operations	12/02/2020		12/02/2020	Open

Meeting of the Finance and Investment Committee held on 2 December 2019

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

There were no matters that were approved by the Committee.

Matters referred to the Board for final approval:

No matters were referred to the Board for final approval.

Matters considered at the meetings:

1. Performance dashboard M7

The Committee was informed that performance reflects the national picture with an early onset of winter pressures.

2. Financial Forecast

An overview of the Trust's processes to forecast the full year income and expenditure position for 2019/20 was provided and included an outline of the financial recovery plans and the requirement for 2020/21.

It was reported that month 7 was challenging, but the Trust has plans in place to ensure delivery of the 2019/20 control total. The high level of understanding of the drivers and good processes in place were acknowledged by the Committee.

3. Long Term Plan submission update

The submission of the Trust's Long Term Plan was noted. It was also reported that the Trust is seeking to agree a new contract with its main commissioner Milton Keynes CCG in the New Year, in advance of the national deadline for signing contracts.

4. Finance Report M7

The Trust reported an adverse variance of circa £400k at month 7; however this included some one-off items and plans are in place to ensure delivery of the control total for the full year.

5. Agency update

Agency expenditure in November was similar to September's figures and spend remains well below the ceiling set by regulators.

6. Transformation Programme

The Committee noted the improvement in the performance of the Transformation Programme and acknowledged that further work is needed order to deliver the full Transformation Programme target for the year.

7. Timeline for strategic capital projects

The Committee discussed the strategic capital projects and noted that the Trust remains on plan with regard to spend.

Council of Governors
12 February 2020
Summary Report Charitable Funds Committee

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1. Introduction

The Charitable Funds Committee met on 28 October 2019.

2. Key matters

The following items were presented to the Committee:

2.1 Fundraising update

- The success of the gala ball in September was acknowledged with £24k raised
- Future activities are being explored
- Application to SEMLEP's Local Growth Fund programme is being considered
- A decision on the lottery grant is expected in December 2020
- Progress on legacies and contactless donation points was acknowledged
- Consideration was given to the neonatal unit becoming the next major appeal for the Trust after the Cancer Centre. Future projects being considered are palliative care and bereavement

2.2 Charitable funds finance update

2.2.1 Cancer Centre appeal

- There was a variance of circa £80k between Plan for 19-20 and Actual for the period July-Sept 2019 and the lack of clarity around Brexit was thought to be a contributory factor towards the slow progress on donations
- It was agreed that an options paper on managing the shortfall, should the Appeal target not be met, would be shared with the Board

2.2.2 Non-appeal funding

- It was agreed that the charitable funds strategy would be discussed with the Board in December
- It was acknowledged that 2018/19 income is similar to previous years
- Publicity exercises to highlight that this is not a single cause charity were discussed

2.3 Sign off of Charity Accounts for 2018/19

- The Charity Accounts for 2018/19 were approved

2.4 Committee Terms of Reference

- The Terms of Reference were approved for Board subject to a minor amendment

2.5 Arts for Health – Proposed budget for 2020/21

- Further discussion will take place on public liability costs
- Hospital courtyards will continue to be supported
- The Committee supported the budget but with caveats relating to improved links between MKUH and Arts for Health MK

3. Other business

- A commitment of £12k was agreed by the Committee to improve access to Ward 3
- The Committee approved the decision to amalgamate funds which have lain dormant for one year (previously this applied to funds that had lain dormant for two years)

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

- Escalation to the Board of concerns around not meeting the Cancer Appeal target

Quality and Clinical Risk Committee Summary Report

1. Introduction

The Quality and Clinical Risk Committee met on 19 December 2019.

2. Key matters

The following items were presented to the Committee:

Quarterly highlights report

- MKUH is part of a pilot on average waiting times and it was reported that the Trust's ASI rate (appointment slot issues) is increasing but there is considerable focus on this.
- Radiotherapy. For the past six years patients have mainly been receiving radiotherapy in MK through Genesis. The Genesis/OUH contract came to an end on December 15, 2019. Contingency plans for radiotherapy are now in place for the short term, with patients treated at OUH and NGH, causing significant inconvenience for some patients.
- There had been a further meeting with HEE TV and regarding trainee experience in Obs & Gynae. Feedback from current trainees was negative. Actions are in place and with two new consultants joining the department in early 2020 there is confidence that the trainee experience will improve.
- Orthopaedic elective total hip replacements. Following reports from the NJR that revision rates at MKUH over the past 10 years were high, further investigations were held. A meeting with orthopaedic surgeons highlighted anecdotal cases of infection, and as a precaution joint replacement services were suspended for two weeks. Considerable work has been undertaken and improvements put in place. There had been a deep cleaning of theatres and the piloting of a 'cold/clean' orthopaedic unit, with Ward 12 being trialled for this purpose.
- There had been a significant drop in performance in ED, although the Trust still sits in a reasonable position nationally. ED processes and flow/leadership were cited as factors and two new consultant posts commence in the New Year to strengthen leadership, focus on process and compliance,
- Length of Stay (LoS). Senior leaders were visiting wards teams to engage with this, leading to a shared sense of direction and a forthcoming post-acute bed review.
- Following the CQC inspection in which IPC compliance in ED was highlighted, a handwashing promotion 'High Five Saves Lives' had been launched in the department, with good audits. It is due to be rolled out across the Trust in 2020.
- There had been a cluster of whooping cough (pertussis) cases within community midwifery. With the support of Public Health, the situation was escalated, a number of midwives vaccinated and contact made with 300 women/babies who may have come into contact with the virus

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

It was stated that the Trust needed to identify and articulate key learning actions from reporting incidents, including improving the reporting culture, especially among trainees. It was also stressed that QI was vital once areas for learning had been identified. Greatix, a system of reporting positive incidents, was proving useful: the next stage of learning in this would be to look at why things had gone well.

Quarterly mortality update

- The Committee noted that the Trust's Hospital Standard Mortality Ratios (HSMR) score was 104.7 – higher than previously, but there was no evidence that clinical quality had changed. Two GP medical examiners had been appointed to the team.

Quarterly trust wide progress report – Serious Incidents

- 6 serious incidents have been recorded during the quarter relating to delayed diagnoses, including two regarding ECGs and three delayed recognition of fracture.

Clinical Quality update
The Committee heard that the Patient Safety Board and Patient Experience Boards were working well.

Clinical Audit
A new governance structure had been put in place to gain assurance around level one audits with good progress being made.

Pharmacy
There was an informative presentation on Pharmacy and a focused discussion on staffing, with more pharmacy technician places planned for 2020 and a career progression plan to encourage staff retention.

Infection prevention and control workplan
A presentation was given regarding a one-year programme to drive change by achieving greater compliance through optimised behaviours

3.Conclusions
The Committee was assured that the hospital was busy but remains safe.

The Board is asked to note this report.

Workforce and Development Committee Summary Report

1. Introduction

The Workforce and Development Committee met on 28 October 2019. A summary of key issues discussed is provided below.

2. Workforce

Staff Story
A volunteer working within the Staff Health & Wellbeing Department attended the meeting to provide the staff story. He advised that his work includes welcoming people to the department as well as various administrative duties. He had recently completed a leadership course through Disability Rights UK alongside 16 other people with various disabilities. He has been instrumental in establishing the hospital's Disability Network which now has a membership of 18 people. He hopes that the network helps people with disabilities feel less isolated when arranging reasonable adjustments to their working environment. It was acknowledged that additional education for staff and managers is required on this issue. He expressed the opinion that the hospital is very warm and welcoming. He asked that the Friends and Family Test proformas are made available on the Main Reception desk. It was acknowledged that while the Trust's staffing is reasonably representative of the local community, it is falling behind in terms of disability representation.

The Committee thanked the Volunteer for attending to share his experience.

Workforce Information Quarterly Report

- It was noted that vacancy rates fluctuated by 12% over the year
- While agency spend has reduced significantly over the last 4 years, bank spend has increased twofold and there will be increased focus on bringing this under control going forward
- Sickness absence in August was lower than the previous 3 years, below the KPI target of 4% and the highest reason for absence was Unknown/undeclared but this has reduced from 40% to 31%
- Leaver turnover has reduced from 12.5% to 9.2% on a rolling basis and a review of exit surveys will be added to the annual plan for WADC
- The Committee commended the reduction in nursing/midwifery turnover from 13% to 6% and it was explained that this was achieved largely as a result of the work undertaken on retention 18 months previously. Band 6 development programmes and the new staff benefits package are also having an impact.
- Turnover rates in Pharmacy are a cause of concern and the Clinical Director for that area is addressing this by, for example, looking to provide more variety within senior posts.

Workforce strategy programme management highlight report

The report highlighted the programme of works and objectives that are aligned to the three year strategy. The strategy and plan will be presented to the next meeting.

Staff Health & Wellbeing Report

- The occupational health physician post remains vacant and is recognised nationally as a hard to recruit post. Alternative models of service delivery are being considered.

- The CQUIN flu vaccination target has increased from 75% of staff to 80% for 2018/19 and due to initial problems over supply, frontline staff were prioritised
- A new provider is being considered for staff counselling that is a free offering and gives access to richer information.

Equality, Diversity and Inclusion update
The report provided a detailed breakdown of BAME staff across the organisation and demonstrated that there is a higher proportion of clinical BAME staff than non-clinical within Bands 1-6 but that the opposite is true for Bands 7-9. The overall proportion has decreased from 29% to 20% and this is reflective of the regional position.

Targeted work is being undertaken within Band 6 nursing as it is recognised that staff within this group are not progressing as expected, thought to be due to the lack of role models above Band 6 within the organisation. An inclusion role is being considered to champion this cause. An update on progress will be provided in 6 months.

HR systems and compliance report
There are 11 hard to recruit posts. Roll out of e-rostering continues to new areas and a bid has been submitted for a new, more intuitive, tool to provide greater transparency across the hospital.

Staff survey 2019 update
The Trust's objective is to move into the top quartile nationally for engagement equating to a return rate of 55% or above. It is hoped that better engagement from managers who have held over 100 listening events between them will have had an impact. Themes from the listening events include staff not feeling valued or supported by other teams.

Organisational Development (OD) and Talent Management
- New elements have been added to the New Consultants Development Programme to help increase emotional intelligence
- There is more project work in the Leaders Engaging in Action Programme (LEAP)
- OD workshops are being held for finance and patient pathway coordinators
- The MKGU Rotary Club bursaries are making a real difference in supporting students
- The Director of Service Improvement is involved in ensuring that OD links to Quality Improvement
- There will be a diversity focus to the national talent management work

Annual plan report
The Committee was pleased to note that a third of all staff have received training of some kind, other than statutory or mandatory, within the last year.

Education update
- Appraisal compliance was at 91% with staff contacted when theirs becomes due.
- Meetings with staff unwilling to engage with the process are taking place and they are alerted to the impact such non-engagement will have on pay progression
- Statutory mandatory training compliance was at 93%.
- £121k has been spent by divisions on external courses.
- 65 students were placed across the Trust in Quarter 2.
- The first cohort of students from the Medical School graduated earlier this year
- There is a new Director for Medical Education: Richard Butterworth, Consultant Neurologist
- There were over 1500 participants in simulation and clinical skills sessions
- The contribution to the hospital made by the Library was acknowledged.

Guardian of Safe Working Hours quarterly report
The Guardian explained that junior doctors are required to report instances where they have had to work beyond their hours. Time off in lieu (TOIL) is the preferred form of compensation for this. Where there are too many exception reports in one are the Guardian has the authority to fine departments. Average hours for junior doctors at MKUH are around 44-46 hrs per week with the national average being 48 hrs. A regional network has been established with Guardians across the Oxford Deanery area meeting every 3 months.

Board Assurance Framework
The workforce risk relating to the inability to recruit to short term vacancies was reduced from 12 to 8.

Workforce Risk Register
The register was noted and it was agreed that a sense-check would be made

Workforce Board Review
There was good representation at the last meeting from across the divisions with good engagement and feedback

Terms of Reference update
It was agreed that the Guardian of Safe Working Hours will be added to the remit of this committee.

The Council of Governors is asked to note the summary report.

Report for the Council of Governors of Milton Keynes University Hospital FT

Date of Meeting: February 2020

Healthwatch Milton Keynes Activity

We've completed our Young Peoples' project, which has been running over the Autumn, and are currently analysing the data collected from over 600 under 20yr olds. We expect to develop one or two specific projects from the themes and concerns that this information will provide.

We have completed the Maternity Enter and View visits and the report is with the Hospital team for their response before we publish. Overall, the patient experience of care at the hospital was positive.

We have also completed an Enter and View project at the Campbell Centre, this report is about to be sent to the providers for response and we look forward to sharing with stakeholders once it is finalised.

Our Activity

The Long-Term Plan engagement work Healthwatch undertook to hear what local people had to say about the Long Term Plan and what the priorities should be, has been finished and filming of an ICS funded video to showcase the work has been completed. The Video will be published alongside the launch of the Bedfordshire, Luton and Milton Keynes Long Term Plan around March.

We held an incredibly successful event at the MK Hindu Association recently where 19 Health and Social Care organisations gave up their Sunday to ensure that the Hindu community were aware of services and access pathways. The most popular information stands were the MKUHFT Breast Screening unit – their demonstration/ tutorials were running non-stop all day and they have been invited back to the MK Hindu Association to continue raising awareness.

The Maternity Voice Partnership, who work closely with MKUHFT Maternity unit, were also a big hit within the Hindu Community and gave some interesting feedback as to their priorities around maternity services.

We have had overwhelmingly positive feedback from the Hindu Community and the professionals who attended and are now looking to organise a similar event for the Sikh community.

Healthwatch Milton Keynes are consulting with Healthwatch members on what they would like to see us prioritise, in terms of our projects and activities next year.

If you are not a member you can sign up at www.healthwatchmiltonkeynes.co.uk and have your say about what your independent champion for health and social care prioritises next year.

Patient Feedback

There was an issue raised at a recent Carers Partnership Board around issues with the changes in ordering of medical equipment.

A service user raised concerns about the changes to the process of ordering medical supplies at MK Hospital. The supplies now need to be ordered on a monthly basis and collected (previously they were delivered). This was around syringes and we have had another couple of queries re the same issue with catheters.

This was passed on to the Patient Experience & Engagement Manager lead to find out who the best person to address this would be and, after talking to a helpful member of staff in one department, it seems that not all departments have changed their process so it becomes quite difficult to resolve as a whole. We will now signpost patients and carers back to the issuing department with their concerns.

There are still issues with data protection and protected characteristics being experienced by patients who have undergone gender transition. The guidance from the BMC is very clear and the continuing disregard of the rights of these patients is causing further upset and anger. We have attached the report of the LGBTQ+ project we completed recently for those who may not have read.

We also received some very positive feedback which was passed on to the Patient Experience and Engagement Lead:

"what about a good news story from NHS. Last Friday, handed to lung function clinic sleep study screening. Tuesday afternoon offered outpatient appointment for Wednesday at 8pm Wednesday at 5:17pm hospital rang - can I come earlier. 6:12pm seen by consultant and back home indoors. How about that?"

"Dear Healthwatch,
It's with great pleasure that I want to give a good report of my recent Cataract operations at the MK hospital. Both eyes were operated on within 6 weeks. The treatment in the eye clinic was friendly and caring. The surgeon talked me through his actions and even took the time to draw a diagram of the new lens so I

could understand how they stayed put. The nurses in the clinic were lovely. Altogether a satisfactory experience.
I now just need to wait for my brain to get used to the new sight I now have, then I can be fitted with specs to give me the range of vision I need. Nice to be able to say positive things instead of critical things. Kindest regards".

LGBTQ+ Health

Health Inequalities and Access to Treatment

April 2019

healthwatch Milton Keynes

LESBIAN GAY BISEXUAL TRANS MILTON KEYNES Q:alliance

NHS Milton Keynes Clinical Commissioning Group

Contents

1 Acknowledgements

Healthwatch Milton Keynes would like to acknowledge and thank the patients and service users who contributed, with such openness and honesty, their stories in order to improve the experiences of others.

We would also like to thank the hardworking team at Q:Alliance for their time and support, and their understanding and help to improve our knowledge of the diversity within the LGBTQ+ community.

A selection of the patient stories received during the collaborative project with Q:alliance have been included, verbatim, to provide insight into the issues being experienced by this vulnerable, and often marginalised, group of patients when seeking treatment.

We thank the Milton Keynes Clinical Commissioning Group (MK CCG) team for their willingness to work with us on a very complex area, and the continuing improvements they are making to ensure that local policies do not inadvertently discriminate on the basis of a patient's gender or sexuality. MK CCG have also worked with Healthwatch and Q: Alliance on the issues raised in this report. They have provided insight into policy and have outlined the work they have done, and continue to undertake, in order to improve the patient experience. Their responses and comments are included in each section of the report.

HWMK have attached, in Appendix A, with permission from East Cheshire NHS Trust, the *Transgender Support Policy for Staff and Service Users,* that was developed, and is being used, to improve health outcomes as well as patient and staff relationships. We are appreciative of their willingness to share their ideas and good practice. Our recommendation is that the local Health and Social Care leaders use this document as a foundation to develop a similar approach to equality in Milton Keynes

2 Introduction

In May 2018, staff from Healthwatch Milton Keynes and the Milton Keynes Clinical Commissioning Group were invited to, and attended, an *'Introduction to LGBTQ+ awareness'* CPD/ information event provided by Q:alliance.

During this very informative session it was evident that there was confusion amongst professionals regarding best practice approaches toward people who identified as LGBTQ+, and anxiety about inadvertently offending a person by 'getting it wrong', whether this be related to a person's pronouns, how to provide a good inclusive service, or even how to explain why those needs might not be able to be met. It was reassuring to be told that the best course of action was to simply ask the question.

It also became evident throughout the afternoon that people identifying as LGBTQ+ faced difficulty when trying to access health care. With a focus on listening to and working with under-represented groups Healthwatch Milton Keynes (HWMK) agreed a project with Q:alliance to gather experiences of care and treatment from their members and others who identify as LGBTQ+.

This report highlights the health inequalities experienced by people when health professionals are unsure how to provide treatment or clinical advice to people with specific needs, which may be outside the experience of that professional. The report focusses largely on the inequalities experienced by people with Gender Dysphoria as they are, in the main, the most affected.

Milton Keynes Clinical Commissioning Group

Healthwatch have supported MK CCG to review its equality objectives using NHS England's Equality Delivery System (2) toolkit which supports NHS Organisations to identify and improve NHS performance for people from protected characteristic groups. MK CCG gathered a range of evidence and in October 2018 invited external stakeholders including Q:Alliance and Healthwatch to review how well people from protected characteristic groups faired compared to the rest of the population. As a result of the feedback, MK CCG reviewed and revised its equality objectives to include an objective specifically targeted at Primary Care and the experience of people from the Transgender/Trans* communities. The objectives and evidence template is displayed on MK CCG's equality website: https://www.miltonkeynesccg.nhs.uk/equality-inclusion-and-human-rights/

3 How we collected patient voice

Together with Q:alliance, HWMK collected information regarding issues that people identifying as LGBTQ+ encountered when dealing with health and social care providers. We ran the consultation for 6 weeks and received 17 responses, 2 of which were sent by lesbian or gay respondents with the remaining 15 being sent to us by Transgender respondents.

Q:alliance and HWMK shared the following on their social media and websites:

> Let's Talk GP's and Health Professionals.
>
> Q:alliance are working with Healthwatch Milton Keynes to gain an understanding of the LGBTQ+ community's experience of working with GPs in Milton Keynes. We are specifically interested to know what experiences Transgender or Intersex people have had, following multiple concerns being raised to us by the community. This information will be used by Q:alliance and Healthwatch Milton Keynes to directly challenge GPs and change working practice within our community, where possible.
>
> You can submit your feedback directly on the Healthwatch Milton Keynes website at the following link:
> https://www.healthwatchmiltonkeynes.co.uk/content/speak-out
>
> Alternatively, you can email trans@qalliance.org.uk in confidence. All emails received will be monitored by our Trans representatives.
>
> Healthwatch are also keen to understand the experience of general healthcare within MK from the LGBTQ+ community and are happy to receive this feedback via their link.
>
> Please note that any emails sent to us as part of this campaign will be deleted upon it's conclusion and your details will not be kept. Q:alliance understands that any emails sent to us with your experience will be shared with Healthwatch for the purpose of this campaign and that you consent to this by emailing in.

Many responses from people suggested ways in which the author felt that the situation could be improved and means our recommendations reflect what this cohort of patients believe good care would look like for them.

4 Fertility and LGBTQ+

> "6 months ago, I went to my GP as a same sex couple looking to start a family. I went not knowing the process and booked my appointment stating what we wanted to talk about.
>
> My GP told me they did not know either after I had to explain why we were there. They had clearly not read the notes and therefore it was s wasted trip as they advised they would have to find out what to do.
>
> We have had several tests done now and still have not been told what we are entitled to, what the process is or even how it all works.
>
> We feel quite let down having now been referred to infertility clinic for myself (Some issues with ovulation) and still none the wiser what the process is.
>
> It is a difficult and confusing time and there doesn't seem to be any support or knowledge from our doctor" – *response received via Healthwatch Website*

Although it would have been useful for the research to be done before the patient attended the appointment, our research found that it may be challenging for a GP to gain awareness of local processes.

The NHS states that same sex couples should be offered NHS fertility treatment. NHS Fertility treatment is offered to heterosexual couples who have been unable to conceive after a pre-determined period of unprotected intercourse and to same sex couples who have been unable to conceive after up to six privately funded cycles of intrauterine insemination (IUI), using donor sperm from a licensed fertility unit[1]. After this time, couples can apply to their local Clinical Commissioning Group (CCG) to have further NHS funded IUI.[2]

MK CCG adopted the East Midlands CCGs IVF policy on 01/04/2014. Section 5 of this policy states that: "CCGs will fund IVF treatment for same sex couples provided there is evidence of subfertility defined by no live birth as per local CCG policy following Artificial Insemination". MK CCG's Assisted Conception- IUI and DI Policy says that "Donor Insemination is available for same sex couples if they have undertaken 6 self-funded cycles of Artificial Insemination".

[1] https://www.nhs.uk/news/pregnancy-and-child/new-nice-guidelines-for-nhs-fertility-treatment/

[2] https://www.nhs.uk/conditions/artificial-insemination/

The cost of privately funded IUI ranges from around £800 to £1,300 for each cycle of treatment[3]. These are not costs incurred by heterosexual couples in the period before they are deemed eligible for NHS fertility treatment.

Although we did not have any response specifically regarding fertility from transsexual patients, it is likely that this group of people will face the same difficulties accessing these services as they have in other areas of treatment.

Transitioning treatment results in loss of fertility. The way to prevent this is extraction and storage of eggs and sperm, a process known as gamete extraction and storage, which allows transgender people to have their own biological children post-transition.

NHS England believe that their policies do not discriminate against trans people. However, while patients undergoing other forms of medical treatment which may impact on fertility, such as chemotherapy, are routinely offered access to fertility services, Lui Asquith of the charity Mermaids which supports transgender children and their families, said:

> "Currently, the NHS offers little signposting and assistance to [those] wishing to preserve their fertility prior to necessary gender-affirming treatment, despite it being a well-documented, funded option offered to patients about to undertake other life-enhancing treatments that may impact fertility"[4]

In August 2018, the Equality and Human Rights Commission (EHCR) sent NHS England a pre-action letter, the first step towards judicial review proceedings, if policies which discriminated against transsexual patients were not updated. The EHCR stated that

> "Our laws and our values protect those who seek treatment for gender dysphoria. This means that, where appropriate, treatment should be made available in order to ensure that access to health services is free of discrimination. A choice between treatment for gender dysphoria and the chance to start a family is not a real choice. We have asked NHS England to reflect on the true breadth of their statutory mandate and the impact on the transgender community of these outdated policies" – Rebecca Hilsenrath, Chief Executive, EHCR[5]

In March 2019, the EHRC dropped its legal challenge after NHS said that they would issue new guidance to all CCGs advising that refusal to offer fertility treatments to people who are transitioning will need strong justification and that a failure to provide this could be challenged in court. However, after the legal proceedings

[3] Ibid.

[4] https://www.theguardian.com/uk-news/2018/aug/04/nhs-trans-patients-equal-access-fertility-services

[5] Ibid.

were stopped, NHS England softened its stance and said it would leave decisions to individual over provision of fertility services to individual CCGs.[6]

Milton Keynes Clinical Commissioning Group:

MK CCG recognises that difficulties starting a family can be distressing for any couple and clear information about the NHS support available is key. All MK CCG policies and criteria including for Fertility are openly available on MK CCG's website at the following link *https://www.miltonkeynesccg.nhs.uk/referrals-and-priorities-policies/*

All GPs are required to use policy criteria and proformas to apply for funding. MK CCG has committed to providing clarification to GPs on access criteria for same sex couples or individuals transitioning. Individuals themselves are also welcome to contact MK CCG directly for any policy criteria clarification.

[6] https://www.theguardian.com/society/2019/mar/31/transgender-fertility-row-ends-with-a-draw

5 LGBTQ+ Stories

These are a selection of patient stories as provided to Q:alliance and Healthwatch Milton Keynes to provide a fuller picture of the issues being experienced by people at all stages of their transition journey.

Patient A

"I was diagnosed privately with transsexualism in December 2017. Prior to that, I had to change GP and practice in early 2017 due to my original GP's refusal to co-operate fully in my treatment. I am male to female.

To go back to the start: In November 2016, I booked an appointment and explained about my feelings of Gender Dysphoria to my GP and said that I would like to see a specialist. I was aware that I had had Gender Dysphoria for as long as I can remember. I had been living some of the time as a woman for two and a half years at that point, though at that time I was presenting as male at work.

After two letters from me to chase up whether I would be referred or not, my GP sent a terse letter dated 28th. November 2016, stating that "You have been referred to the Gender Dysphoria Clinic, but we are not prepared to prescribe unlicensed medication in Primary Care". He did not explain what he meant, but I suspected that he meant HRT.

In January, I was copied in on a letter from Dr [X] at Daventry GIC (Gender Identity Clinic) to my GP, stating that my GP should either complete a "memorandum of understanding" or give a detailed explanation of why I should be seen "for assessment only", otherwise he would not accept the referral. I became concerned and booked a short-notice appointment on the 12th January to see my GP. I presented as female at the appointment. He confirmed that the problem was indeed because HRT for transsexuals was not licensed by NICE.

I politely pointed out to him that doctors are allowed to prescribe hormones to us "off license", and that the NHS Interim Protocol on Gender Dysphoria states that GP's should co-operate with the GIC. I also stated that I am a person who is able to understand the risks if he explains them and give informed consent. Additionally, I pointed out that I have transgender friends in Milton Keynes who are being prescribed HRT by their GP's, and that the same hormones are prescribed to menopausal women.

He said that nothing would change his “beliefs” and suggested that if I knew of a GP who was prescribing HRT to a transsexual patient in Milton Keynes, I should transfer to that GP. The impression I got at this point was that he was keen to get rid of the responsibility for me. I transferred to a GP surgery where I know that there is at least one other trans person. However, I was only able to do that because of the support I had from the trans community – if I had been more socially isolated I might not have been able to do that. I was also fortunate in that the new surgery was nearer than the previous one (because the previous one had relocated) so there was no problem of catchment areas.

Incidentally, my original GP showed a disturbing lack of knowledge of the treatment of transgender patients, despite admitting that I was not his first such patient, e.g. he thought that I was asking for a referral to the Tavistock clinic, though even I knew that that clinic is only for people under the age of 18. I felt that he had not taken the time to acquaint himself with guidance from the GMC (General Medical Council), the CCG (Clinical Commissioning Group) or the Gender Identity Clinics. Another thing that concerns me is that he mentioned that I was the third person to come to him with gender dysphoria, and that he told the others the same things.”

Patient B

The patient lives in Milton Keynes and attends a GP practice in MK.

She has had three issues: When she initially told her GP that she was transgender, about four years ago, her GP's immediate reaction was to say that they couldn't help, no help was available on the NHS. A year or so later, she transferred or was transferred to another GP at the same practice who said that help was available and referred her to Daventry GIC.

The second issue is that the patient was then diagnosed as transsexual around about August 2015 at Daventry GIC and her GP agreed to the shared care plan but said that they could not change her name on her patient record to her preferred female name until she changed her name by deed poll.

The reason why this is a particular issue for the patient is that the GP surgery has a display board in the waiting room to call patients forward for their appointments, and she said that if she goes to the appointment presenting as female, she will feel very uncomfortable and exposed to public scrutiny if her male name flashes up. Apparently, the name on the display system had to match her name on the medical record, it can't use her "preferred name".

A third issue is that when her medical records were shared between her GP and Daventry GIC, all her correspondence from Daventry, which had been addressed to her in her female name, started coming addressed to her male name.

Patient C

The patient expressed feelings of Gender Dysphoria to her GP about three to four years ago. However, her GP initially referred her to ASTI, the Mental Health team, for a Mental Health assessment. This is not in accordance with the NHS protocol for treating transgender patients; it was required in the past, but the protocol was updated some years ago.

She felt that ASTI were completely lacking in knowledge about transgender patients (she left because she found the appointment to be insulting) and feels that this referral wasted her time when she could have been on the waiting list for the Gender Identity Clinic. She has now been diagnosed as Transsexual and is receiving HRT.

She said "I found personally the ASTI team member who interviewed me was inadequately trained during interviewing process which was totally irrelevant to me suffering from gender dysphoria. It's also worth pointing the interviewer constantly used wrong gender pronouns which I found disturbing considering other Trans suffering from mental health issues might have to deal with such ignorant staff behaviour during interviews which could put them through considerably more stress."

Patient D

"I am, post op trans female. I have been diagnosed with BPD.

My main issue is that I have been waiting over a year for therapy, with no sign of it any time soon. Also, I am waiting for my Doctor to get me a referral for appropriate medication to be assessed. I have no idea why it is taking so long and I can't get an appointment long enough for me to discuss my issues. In addition, the only way to get an appointment is to queue outside the surgery at 8.00am, take a ticket, and wait until 8.30 for the vague possibility of an appointment that day. I have twice done so, only to find that all appointments are gone by the time I am called back to the reception. This is most diabolical.

I have medication injections that can only be administered by certain doctors.

In general, I feel that the staff are ill advised /trained in dealing with diversity, i.e. the trans and agender community. My medical practice is over crowded with more patients than it is possible to deal with effectively.

Also, mental health services are APPALLING in Milton Keynes. I often feel suicidal, and I can't get any support, or even get anybody to take me seriously I have also experienced prejudice from medical staff, obviously to me, due to my gender status. This is simply not acceptable."

Patient E

"This relates to my experience of healthcare as a transgender person.

I am currently in the early stages of medical transition and have been referred to the Gender Identity Clinic by my GP.

Whilst the GP I saw was empathetic and referred me without me having to fight too much, I do feel that there is a lack of knowledge/training on trans healthcare and the current process. For example, the GP I saw at the appointment where I requested a referral said they'd have to apply for funding which made me feel anxious and that I'd have to try and find money for treatment myself (which I'd struggle to afford). Following a conversation on an online support group, I then discovered that this was part of the old process and was no longer required.

On the whole, the administrative staff and practice nurse at my surgery have been fantastic.

The main issue I had was around getting a GP's letter for sending off to the passport office. I provided a template for them to use which contained the specific wording that the passport office required to change my gender marker on my passport. They initially told me they couldn't do me a letter, then after me pointing them in the right direction did write a letter but the content was incorrect, and the GP didn't sign it. I paid for this service.

Needless to say, the passport office rejected the letter. It took a conversation with the Practice Manager via telephone, where I had to educate them on the correct process and wording to use, to get the correct letter.

This particular experience left me feeling quite angry and upset and happened to catch me at a point when I was feeling quite low.

To date, I am still unsure as to whether my medical records have been updated correctly.

I feel that training would benefit both patients and staff and make the process easier for everyone."

Patient F

“In the case of Urinary problems clinicians need to be able to order a PSA (prostate-specific antigen) test on Trans women to exclude the possibility of prostate problems. Whilst it is possible to do this, it seemingly needs the clinician to send a multitude of emails. This is a less than satisfactory system which can be fixed.

After outing myself to a Nurse, I complained of feeling faint and extremely thirsty to the point where I asked my visitors to bring me some salt and water. However, when I complained about the fact that I had been left just sitting in the Ambulatory emergency unit for 6 hours, I was told that my Blood count at 8:40 was well within in the “MALE” range. Was this called for ? The answer is no ! This actually made me feel like I wanted to just get up and walk away. My friends who are aware of the situation cannot understand how someone can even address me in this manner.

This senior Nurses comment was also made in front of another Nurse, who I had not shared any information with. This was an unacceptable comment but now my Trans status was being shared with an Auxiliary Nurse. This was a clear breach of Section 22 of the Gender Recognition Act.”

Patient G

“My first referral to the GIC didn’t go through to the GIC (so wasted 7 months of waiting), second one went through and had 14 months wait until the first appointment.

Letters from GIC are often late and my report from my first assessment in March 2018 still hasn’t arrived. Staff are fab at the GIC.

Milton Keynes Clinical Commissioning Group:

MK CCG acknowledges the wide range of experiences shared within the report.

In January 2019, MK CCG invited Q:Alliance and Clinicians from NHS England's regional Gender Identity Clinic (provided by Northamptonshire Healthcare NHS Foundation Trust) to provide a full Practice Learning Time session to Milton Keynes GPs to raise awareness about attitudes and access to healthcare difficulties from an individual's point of view. Clarification was provided about NHS England's commissioning pathway for Gender Dysphoria.

MK CCG has previously circulated information to GPs on the Gender Recognition Act, NHS England's process for re-issuing NHS Numbers to individuals and General Medical Council training on appropriate sharing of information. We will ensure that GP updates and awareness raising occurs on a regular basis

6 Data Protection and LGBTQ+

During our experience gathering exercise, representatives of Healthwatch Milton Keynes were invited to take part in a meeting between Milton Keynes Clinical Commissioning Group's (MK CCG) Director of Quality and Nursing, Complaints and Patient Experience Lead, Senior Engagement, Communications and Marketing Lead, and two women who had raised concerns about the way in which the health system identified them as transgender following transition, particularly through clinical correspondence.

The women had raised their concerns with MK CCG previously in 2016 at a meeting attended by MK Hospital, Central North West London Trust and Milton Keynes Council but raised the same issues again at the MK CCG Annual General Meeting in 2018, as they felt they were not being heard. MK CCG had undertaken some work around the areas of concern but had not provided the women with an update on what this work was and what the expected outcomes would be.

During the meeting, MK CCG representatives told us that they had been working with Q;alliance on reducing health inequalities amongst people identifying as LGBTQ+. One of the challenges with this approach is that this group of women have all transitioned and identify as women. Q:alliance is an organisation which celebrates diversity and work toward gaining equality for the LGBTQ+ community. However, this group of women - because they identify as women - did not feel that they were necessarily represented by the organisation.

The group spoke of their objections to health professionals listing their Trans status on clinical referral documents with no explicit consent from them, irrespective of what the referral was for. There was some discussion about the balance of clinical need for the information and the women's' right to be treated as women rather than as Transgender but there has not been a local approach agreed to date that could be disseminated to the local health system.

Milton Keynes Clinical Commissioning Group

While, at the time of the meeting described above, MK CCG had not yet completed the EDS2, we had undertaken a wide range of awareness raising and provided an action plan to the women. MK CCG had shared details of the Gender recognition Act with Primary Care as a result of an additional issue experienced by one of the women. MK CCG have also ensured that their contact with Q:Alliance will mean that there are Trans people around the table at the EDS2 reviews.

MK CCG acknowledge this difficult position for those who have transitioned and expect, through its continuous awareness raising, training links and opportunities, that improvements and reasonable adjustments will be seen going forward.

7 What can be done?

The variety of patient and service user experience shared with us during this project demonstrates that poor or under-developed knowledge of LGBTQ+ citizens' needs, care pathways and information governance impacts on the patient journey and can result in them feeling that they are experiencing health inequalities from the health and care system.

We highly commend the recent provision of a recent GP 'Protected Learning Time' education session put on by MK CCG and delivered by staff and patients from the Daventry Gender Identity Clinic. Healthwatch were invited to attend and we were pleased to see so many Doctors attending the session and engaging positively.

We recommend that further sessions along the LGBTQ+ theme are regularly scheduled as there was a lot of information to take in, in a single session and many professionals were immediately asking how they could further their knowledge in this area.

We recommend that further exploration is made of the engagement session with MK CCG regarding the transfer of information about Trans status in clinical correspondence, so an agreed local system can be adopted, which strikes and appropriate balance between patient rights to privacy and consent, and clinical requirements for information sharing.

Milton Keynes Commissioning Group

The PLT education session was part of MK CCG's revised equality objective action plan which was developed with the support of Healthwatch representatives.

As part of MK CCG's revised equality objectives and action plan, a regular bulletin will be circulated to Primary Care to raise awareness of NHS England and General Medical Council guidance

8 NHS Live Well 'Living my Life'

During our project, we researched whether there were any best practice areas, or guidance available to our local system. We found a section from a very helpful guide called 'Living my Life' on the NHS UK LiveWell webpage which contains information for both service users and professionals about providing the best possible services for trans people.

We have taken the liberty of rearranging the text so that the question of how to strike the balance between patient confidentiality and clinical need is suggested at the top of the list.

Trans people's general health needs are the same as anyone else's. They can be diabetic, have dental problems, get stomach bugs, have high blood pressure, may need to see a podiatrist etc. However, there are additional health needs that may be linked directly to their trans identity such as mental health issues that have their roots in experiences of discrimination and transphobia. It is also important to remember that some trans people experience mental ill health that is completely separate from their gender identity and should be treated as such.

Here are some tips for services that will help them provide an excellent service for trans people

- *Under the Gender Recognition Act it is illegal to disclose someone's trans status without prior consent or to anyone who does not explicitly need this information.*
- *Always use the name and title (e.g. Mr, Mrs, Ms, Mx etc.) that the trans person wants to be called. If you are unsure about a person's gender identity, or how they wish to be addressed, ask for clarification. Doing this shows a level of understanding of trans issues*
- *Make sure that you are aware of local trans support services / support groups and referral pathways.*
- *Do not comment on a trans person's appearance or 'passability' unless they specifically ask for your opinion.*
- *Do not confuse being trans with sexual orientation. It is a gender issue. Trans people can be heterosexual, lesbian, gay, bisexual or asexual.*
- *Become knowledgeable about transgender issues. Get training on trans issues and know where to access resources.*
- *Remember that not all trans people are the same. Like everyone else, different trans people have different identities, experiences, needs, and interests.*

- *Welcome trans people by getting the word out about your services and displaying trans-positive information in your workplaces.*
- *Establish an effective workplace policy for addressing discriminatory comments about and behaviour towards trans people*

This text is contained on page 25 of the booklet '*Living my Life*'[7]

[7] https://www.nhs.uk/livewell/transhealth/documents/livingmylife.pdf

9 Appendix A: Transgender Support Policy for Staff and Service Users

The author of this report, Lyn Bailey, Equality & Patient Experience Manager, has given permission for the report to be used by the Milton Keynes system leads to use as best practice guidance in developing local policies. She has also suggested that she would be happy to talk through any queries and go through the challenges that the trust faced when implementing this.

http://www.eastcheshire.nhs.uk/About-The-Trust/policies/T/Transgender%20Support%20Policy%20ECT2818.pdf

10 Appendix B: Additional Information

- For complaints about GPs or GP Practices individuals should approach the Practice Manager if possible to raise concerns so these can be handled in line with the practices complaints policy and procedures.

- NHS England has retained oversight of Primary Care Complaints and so complainants also have the option to discuss concerns with NHS England:

  NHS England Customer Contact Centre

  Telephone: 0300 311 22 33

  Email: england.contactus@nhs.net

  NHS England

  PO Box 16738

  Redditch

  B97 9PT

- If you need help or support to make a complaint, you may wish to speak with the NHS Complaints Advocacy Service- please see link to their website which has contact details and information https://www.seap.org.uk/ or telephone 0330 440 9000
- For any questions, queries about MK CCG's local policies and criteria or who to approach to raise concerns, contact MK CCG's Patient Experience Lead on 01908 278684 or email MKCCG.complaints@nhs for advice
- For more information about NHS England's specialist commissioning policies and guidelines please see the following links:

  https://www.nhs.uk/conditions/gender-dysphoria/guidelines/

  https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/gender-dysphoria/
- For information about how your GP Practice should advise NHS England's Primary Care Support England service of gender reassignment please see the following link:
  https://pcse.england.nhs.uk/help/registrations/adoption-and-gender-re-assignment-processes/

Trust Performance Summary: M09 (December 2019)

1.0 Summary

This report summarises performance at the end of December 2019 for key performance indicators and provides an update on actions to sustain or improve upon Trust and system-wide performance. *In a change to previous reports, additional narrative has been included (in italics) to report some of the focussed recovery work underway to deliver further improvement. Detail on the drivers for current underperformance and challenges are also included*

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

2.0 Sustainability and Transformation Fund (STF)

Performance Improvement Trajectories

December 2019 performance against the Service Development and Improvement Plans (SDIP):

ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1	ED 4 hour target (includes UCS)		93.0%	91.3%	89.1%	82.5%	✗	▼	✗	
4.2a	RTT mean waiting time - incomplete waiting list (weeks)		9.2	9.2		12.0	✗	▼		
4.9	62 day standard (Quarterly)		85.0%	85.0%		79.1%	✗	▼		

ED performance continued to deteriorate, dropping to 82.5% in December 2019 from 84.7% in November 2019. This was below both the 95% national standard and the 91.3% NHS Improvement trajectory. National A&E performance in December 2019 has been reported at 79.8%, which was again the lowest since the data collection began. The 95% standard was last achieved nationally in July 2015, whilst only one of the 118 reporting trusts with a Type 1 department achieved the 95% standard in December 2019 (Sheffield Children's NHS Foundation Trust).

MKUH remains in the top quartile for ED performance in the East of England region but has enacted an ED Recovery Programme to focus on specific areas of improvement.

- *The greatest performance challenge is in Ambulance handover time where the Trust is significantly underperforming on the time taken to handover patients and offload at peak times, enabling the effective release of the Ambulance crews back into the community.*
- *A review of matching the daily demand on the service to workforce across all staffing groups is being completed to ensure rotas are accurate and have the required capacity.*
- *The optimisation of eCare, is being supported by the Transformation team which will review training delivery and ensure the system maximises the most effective ways of working and accurate reporting.*

Future work will move into the main hospital wards to ensure timely discharge processes deliver the daily capacity required to meet both the emergency and elective pathway demand.

The Trust's average RTT waiting time for incomplete elective pathways at the end of December 2019 was 12.0 weeks. This was an increase from the 10.7 weeks reported at the end of November 2019. Three patients were reported to have been waiting more than 52-weeks for definitive treatment at the end of December 2019; one each in ENT, Hepatology and General Medicine.

MKUH continues to be part of the national Elective CRS programme measuring the average wait for patients, in place of the total wait time over 18 weeks. The deterioration in month is not an unexpected position based on an annual cycle of planning. As emergency activity pressures increase through Winter it is not unexpected to see movement in this direction, and should be planned for. The Trust ability to respond to this seasonal variation and plan effectively is determined by other factors.

Additional drivers for current underperformance include capacity in medical workforce, outpatient waiting times and timely and effective validation processes being delivered. A key focus of recovery work for the elective work programme in the next 3 months is on validation processes and training. Challenged specialties include: ENT, oral Surgery, Trauma and Orthopaedics, Gastroenterology, Respiratory, Neurology and Endocrine.

Cancer waiting times are reported quarterly, six weeks after the end of a calendar quarter. They are initially published as provisional data and later finalised in line with the NHSE revisions policy. The Trust's provisional 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) for Q2 2019/20 was below the national standard of 85% at 79.1%. On a more positive note, the percentage of patients who attended an outpatient appointment within two weeks of an urgent referral by their GP for suspected cancer or breast symptoms in Q2 was 94.5% against a national target of 93%. Also, regarding patients with cancer, the percentage who started treatment within 31 days of a decision to treat was 98.4% against a target of 96%.

MKUH Cancer performance against the 62 days has been beneath national targets for Q1 and Q2. The most challenged specialties is Urology, accounting for nearly half the number, and consistently where complex pathways are referred onto tertiary centres. Radiotherapy provision for a cohort of MKUH patients continues to be discussed between OUH and NGH to ensure there is enough provision.

3.0 Urgent and Emergency Care

Performance in urgent and emergency care continued to operate under increased pressure during December 2019, as reflected by the indicators below:

ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.8%	0.5%	✓	▲	✓	
3.2	Ward Discharges by Midday		30%	30%	23.4%	21.3%	✗	▬	✗	
3.4	30 day readmissions				7.9%	6.7%		▲		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		53	58		75	✗	▲		
3.9	Ambulance Handovers >30 mins (%)		5%	5%	6.7%	17.6%	✗	▼	✗	
4.1	ED 4 hour target (includes UCS)		93.0%	91.3%	89.1%	82.5%	✗	▼	✗	

Cancelled Operations on the Day

In December 2019, the number of operations cancelled on the day for non-clinical reasons fell to 11 from 27 in November 2019. This was just 0.5% of all planned elective operations in the calendar month, which was the lowest that has been reported since May 2019. Of the 11 operations that were cancelled on the day, 6 (55%) were cancelled due to insufficient time, 3 (27%) were due to bed availability and the remaining two were cancelled due to emergency operations taking priority.

Readmissions

The Trust 30-day emergency readmission rate was reduced to 6.7% in December 2019. This was the lowest reported rate in the Trust since September 2016. The rate in Medicine continued to improve (for the fourth consecutive month) and was the lowest since February 2019 at 10.4%. Surgery also reported a reduced rate of 4.5%, which was the lowest since March 2019. Women and Children also contributed to the positive change in this KPI, reporting its lowest rate since May 2019 (2.9%).

Delayed Transfers of Care (DTOC)

The number of DTOC patients reported at midnight on the last Thursday of December 2019 reduced to 27 (from 30 in November 2019). Of these, 19 (70%) were in Medicine and eight (30%) in Surgery.

THE DTOC position is liable to movement during to the Winter period. Collaboration with partners continues through a weekly review of all patients and related escalations to ensure this number is kept to a minimum.

Length of Stay (Stranded and Super Stranded Patients)

The number of super stranded patients (length of stay of 21 days or more) at the end of the month was reduced to 75. This was the lowest reported since November 2018 but still more than the NHS Improvement monthly trajectory of 58. However, it was a notable reduction on recent months and moves the Trust closer to its objective of 53 super stranded patients by the end of March 2020.

MKUH continues to work with the national ECIST team to deliver the improvement to LOS. Sustaining performance improvement and embedding systems and processes remains the focus. The work programme includes, revisiting effective delivery of Board rounds. The recent MAAD (Multi Agency Admission Avoidance Day) and MADE (Multi Agency Discharge Event) have been testing new interventions and different ways of working across the system with partners and will be evaluated.

Ambulance Handovers

In December 2019, the percentage of ambulance handovers to the Emergency Department taking more than 30 minutes increased to 17.6% in December 2019 against a target of 5%. This was the highest that has been reported since the introduction of this indicator in April 2016.

A dedicated piece of work (as previously referenced) has been commenced to ensure at peak periods of activity and limited capacity in ED, the Trust is able to reduce the handover time. This work is focussed on tightening processes and being able to redeploy additional staff to support the process. The Trust is currently an outlier on regional performance, in spite of a significant increase month on month of activity since October 2019.

4.0 Elective Pathways

ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	90.7%	93.2%	✗	▲	✓	
3.5	Follow Up Ratio		1.50	1.50	1.58	1.49	✓	▲	✗	
4.2a	RTT mean waiting time - incomplete waiting list (weeks)		9.2	9.2		12.0	✗	▼		
5.6	Outpatient DNA Rate		5%	5%	7.8%	8.6%	✗	▼	✗	

Overnight Bed Occupancy

Overnight bed occupancy was 93.2% in December 2019, which although was a decrease compared to November 2019 (94.5%), it was notably higher than the cumulative year to date occupancy level

and above the target of 93%. The most recent occupancy data published by NHS England reported the national average occupancy rate for general and acute beds at 90.1% in Q2 2019/20.

Follow up Ratio

The Trust follow up ratio was reduced to within the 1.5 threshold for only the third month since April 2018. Managing the demand for follow up clinic capacity can free up space for new referrals.

RTT Incomplete Pathways

The average waiting time baseline of 9.2 weeks was exceeded, with an average waiting time of 12.0 weeks reported at the end of December 2019 for incomplete pathways. This was a notable increase compared to November 2019, when it was 10.7 weeks. The overall volume of patients on the RTT waiting list also increased to 15,203, which was the largest reported list size since this measure was incorporated into the scorecard in April 2016. Three patients were confirmed to have been waiting for more than 52 weeks for treatment at month-end (ENT, Hepatology and General Medicine).

The reporting of three patients waiting for more than 52 weeks for treatment is in breach of national standards. Training on the RTT pathway rules, timely validation and effective monitoring of patient pathway management are a priority for the elective care work programme.

Diagnostic Waits <6 weeks

The Trust again did not meet the national standard of fewer than 1% of patients waiting six weeks or more for their diagnostic test at the end of December 2019, with a performance of 98.7%.

Capacity issues across Cystoscopy, Urodynamics and Respiratory physiology, in particular are driving the current underperformance in the delivery of diagnostic waits achieving less than 6 weeks.

Outpatient DNA Rate

The DNA rate remained well above the threshold of 5% and it has been 8% or higher in the past four months. DNAs result in lost capacity and represent a challenge that continues to be scrutinised to ensure that services adhere to the Trust Access Policy and understand their impact on capacity.

5.0 Patient Safety

Infection Control

Three cases of Clostridium difficile (C. diff) were reported in December 2019, with two in Medicine (Wards 3 and 18) and one in Surgery (Ward 20). No ‘lapse in care’ had been identified at the time of writing. There was one case of MSSA in Medicine (Ward 1) but no reported MRSA or E. coli cases.

ENDS

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Council of Governors	Date: 5 February 2020
Report title:	**Finance Paper Month 8 2019-20**	**Agenda item: 6.2**
Lead director **Report authors**	Mike Keech Daphne Thomas Chris Panes	Director of Finance Deputy Director of Finance Head of Management Accounts
FoI status:	Public document	

Report summary	**An update on the financial position of the Trust at Month 8 (November 2019)**			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** X	**Decision** ☐
Recommendation	The Trust Board to note the contents of the paper.			

Strategic objectives links	5. Developing a Sustainable Future 7. Become Well-Governed and Financially Viable 8. Improve Workforce Effectiveness
Board Assurance Framework links	
CQC outcome/ regulation links	Outcome 26: Financial position
Identified risks and risk management actions	See Risk Register section of the 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 30th NOVEMBER 2019

PUBLIC BOARD MEETING

PURPOSE

1. The purpose of the paper is to:

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

EXECUTIVE SUMMARY

2. *Income and expenditure* –The Trust's Surplus for November 2019 was £0.2m which is £0.7m adverse to budget in the month and £6.3m adverse YTD. However, since this adverse variance is largely driven by the timing of donations (£5.9m) which is to support the capital programme, the operational deficit at control total level (excluding central PSF/FRF/MRET funding & donations) is significantly better, with an adverse variance of £0.4m reported on a YTD basis.

3. Cash and capital position – the cash balance as at the end of November 2019 was £14.4m, which was £12.3m above plan due to the timing of capital expenditure and receipts from prior year PSF funding. The Trust has spent £10.8m on capital up to month 8. The Trust continues to forecast that it will spend its full capital budget of £28.7m in the 2019/20 financial year.

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

5. *Cost savings* – overall savings of £0.9m were delivered in month against an identified plan of £0.9m and the target of £0.8m. YTD £3.5m has been delivered against a plan of £3.6m and a target of £4.6m. As at month 8, £5.8m of schemes have been validated and added to the cost savings tracker against the full year £8.4m target.

INCOME AND EXPENDITURE

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

All Figures in £'000	Month 8 Plan	Month 8 Actual	Month 8 Var	Month 8 YTD Plan	Month 8 YTD Actual	Month 8 YTD Var	Full Year Plan	Full Year Forecast	Full Year Var
Clinical Revenue	18,152	18,462	310	146,343	147,795	1,452	218,726	222,514	3,788
Other Revenue	1,589	1,798	209	12,836	14,464	1,628	19,085	21,172	2,087
Total Income	19,741	20,260	519	159,179	162,259	3,080	237,811	243,686	5,875
Pay	(14,105)	(14,440)	(335)	(114,466)	(116,530)	(2,063)	(171,023)	(174,861)	(3,838)
Non Pay	(6,441)	(6,675)	(238)	(52,293)	(54,093)	(1,800)	(77,808)	(80,759)	(2,951)
Total Operational Expend	(20,546)	(21,115)	(573)	(166,759)	(170,623)	(3,864)	(248,831)	(255,620)	(6,789)
EBITDA	(805)	(855)	(50)	(7,580)	(8,364)	(783)	(11,020)	(11,934)	(914)
Financing & Non-Op. Costs	(1,048)	(1,017)	31	(8,380)	(8,030)	350	(12,570)	(11,656)	914
Control Total Deficit (excl. PSF)	**(1,853)**	**(1,872)**	**(19)**	**(15,960)**	**(16,394)**	**(433)**	**(23,590)**	**(23,590)**	**(0)**
Adjustments excl. from control total:									
PSF	420	420	0	2,311	2,783	472	4,197	4,669	472
PSF- ICS	92	0	(92)	505	0	(505)	923	0	(923)
FRF	1,481	1,481	0	8,144	8,144	0	14,807	14,807	0
MRET	270	270	0	2,158	2,158	0	3,237	3,237	0
Control Total Deficit (incl. PSF)	**410**	**299**	**(111)**	**(2,842)**	**(3,309)**	**(466)**	**(426)**	**(877)**	**(451)**
Donated income	631	0	(631)	7,866	2,000	(5,866)	8,000	8,000	0
Donated asset depreciation	(66)	(56)	9	(524)	(449)	75	(786)	(615)	171
Rounding	4	0	(4)	69	0	(69)	0	0	0
Reported deficit/surplus	**980**	**243**	**(737)**	**4,569**	**(1,758)**	**(6,326)**	**6,788**	**6,508**	**(280)**

Monthly and year to date review

7. The **deficit excluding central funding (PSF, FRF and MRET) and donated income** in month 8 is £1,872k which is **£19k adverse to plan in month and £433k adverse YTD**. For M8 the Trust recognised a loss of income of £92k (£505k YTD) due to the financial performance of the BLMK ICS which is currently not meeting its control total. The total central funding allocation recognised in the position is £2,171k (£13,085k YTD) which includes additional funding of £472k relating to prior year financial performance.

8. The Trust reported an overall surplus in month 8 of £243k which is £737k adverse to the budget surplus of £980k largely due to the negative variance against plan on donated income relating to the Cancer Centre project.

9. **Income (excluding PSF/FRF/MRET and donations effect)** is £519k favourable to plan in November and £3,080k favourable YTD and is analysed in further detail in Appendix 1.

10. **Operational costs** in November are adverse to plan by £573k in month and adverse by £3,933k YTD. The higher cost base is to support higher levels of activity and also reflects the delays in savings from the CIP programme.

11. **Pay costs** are £335k adverse to budget in Month 8. Substantive pay has increased in month and costs remain high with the use of additional sessions to support higher than budgeted activity levels. Bank and Locum expenditure has remained relatively static from M7 and is significantly above budgeted levels. Negative variances against bank are offset by positive variances against agency which remain within the NHSI/E agency ceiling.

12. **Non-pay** costs were £238k adverse to plan in month and £1,869k adverse YTD. Negative variances can be seen across a number of non-pay categories, the notable variances are against clinical supplies, premises & fixed plant and outsourcing.

13. **Non-operational** costs are marginally favourable in month

    Further analysis of the costs can be found in Appendix 1.

COST SAVINGS

14. In Month 8, £916k was delivered against an identified plan of £930k and a target of £842k. YTD £3,544k has been delivered against a plan of £3,571k and a target of £4,633k.

CASH AND CAPITAL

15. The cash balance at the end of November 2019 was £14.4m, which was £12.3m above plan due to the timing of capital expenditure and receipts from prior year PSF funding – see Appendix 2 for the year to date cash flow position.

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

    - Non-Current Assets are below plan by £36.8m; this is mainly driven by the revaluation of the Trust estate in 2018/19 and timing of capital projects.

    - Current assets are above plan by £12.6m, this is due to cash £12.3m, inventories £0.4m above plan offset by receivables £0.1m below plan. See Appendix 12 and Appendix 13 for further debtor details.

    - Current liabilities are above plan by £5.4m. This is being driven by Trade and Other Creditors £2.8m, deferred income £2.6m and provisions £0.1m above plan offset by borrowings £0.1m below plan.

- Non-Current Liabilities are below plan by £1.1m. This is being driven by provisions £0.3m and borrowings £0.8m below plan.

RISK REGISTER

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

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

The Trust has received confirmation that the total capital spend included in its annual plan is affordable within the CDEL. Schemes are progressing and funding sources have been identified.

b) There is a risk that the Trust does not receive timely confirmation that its revenue loans due for repayment in 2019/20 have been refinanced.

Funding to cover the ongoing funding requirements in 2019/20 is subject to approval by DHSC on a monthly basis and remains a risk in the new financial year. As in previous years the Trust will liaise with NHS Improvement in respect of revenue loans due for repayment in 2019/20.

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

The Trust has a target of £8.4m of which all will need to be delivered through cost reduction, this remains a risk to meeting the Trust's year end control total.

RECOMMENDATIONS TO BOARD

18. The Trust Board is asked to note the financial position of the Trust as at 30th November 2019 and the proposed actions and risks therein.

Appendix 1

Milton Keynes Hospital NHS Foundation Trust
Statement of Comprehensive Income
For the period ending 30th November 2019

	November 2019			8 months to November 2019			Full year
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME							
Outpatients	3,764	3,910	146	30,282	31,518	1,237	45,166
Elective admissions	2,411	2,476	65	19,402	18,683	(719)	28,930
Emergency admissions	6,060	6,273	213	49,074	46,471	(2,602)	73,498
Emergency adm's marginal rate (MRET)	(267)	(256)	11	(2,162)	(2,076)	85	(3,238)
Readmissions Penalty	(279)	(279)	0	(2,235)	(2,235)	0	(3,353)
A&E	1,202	1,269	68	9,612	10,164	551	14,418
Maternity	1,654	1,702	48	13,331	14,445	1,114	19,980
Critical Care & Neonatal	530	644	114	4,267	3,937	(330)	6,362
Excess bed days	0	0	0	0	0	0	0
Imaging	421	458	37	3,388	3,709	321	5,053
Direct access Pathology	394	392	(2)	3,169	3,225	56	4,726
Non Tariff Drugs (high cost/individual drugs)	1,633	1,659	26	13,141	12,461	(681)	19,488
Other	631	215	(415)	5,074	7,494	2,420	7,695
Clinical Income	**18,152**	**18,462**	**310**	**146,343**	**147,795**	**1,452**	**218,726**
Non-Patient Income	**4,483**	**3,969**	**(514)**	**33,820**	**29,549**	**(4,271)**	**50,249**
TOTAL INCOME	**22,635**	**22,431**	**(204)**	**180,163**	**177,344**	**(2,819)**	**268,975**
EXPENDITURE							
Total Pay	**(14,105)**	**(14,440)**	**(335)**	**(114,466)**	**(116,530)**	**(2,063)**	**(171,023)**
Non Pay	(4,804)	(5,016)	(212)	(39,083)	(41,633)	(2,550)	(58,320)
Non Tariff Drugs (high cost/individual drugs)	(1,633)	(1,659)	(26)	(13,141)	(12,461)	681	(19,488)
Non Pay	**(6,437)**	**(6,675)**	**(238)**	**(52,224)**	**(54,093)**	**(1,869)**	**(77,808)**
TOTAL EXPENDITURE	**(20,542)**	**(21,115)**	**(573)**	**(166,690)**	**(170,623)**	**(3,933)**	**(248,831)**
EBITDA*	**2,093**	**1,316**	**(777)**	**13,473**	**6,721**	**(6,751)**	**20,144**
Depreciation and non-operating costs	(983)	(942)	41	(7,864)	(7,612)	252	(11,796)
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**1,110**	**373**	**(736)**	**5,609**	**(892)**	**(6,500)**	**8,349**
Public Dividends Payable	(130)	(130)	(0)	(1,040)	(867)	174	(1,560)
OPERATING DEFICIT AFTER DIVIDENDS	**980**	**243**	**(737)**	**4,569**	**(1,758)**	**(6,325)**	**6,788**
Adjustments to reach control total							
Donated Income	(631)	0	631	(7,866)	(2,000)	5,866	(8,000)
Donated Assets Depreciation	66	56	(9)	524	449	(75)	786
Control Total Rounding	(4)	0	4	(69)	0	69	0
PSF/FRF/MRET	(2,262)	(2,171)	91	(13,118)	(13,086)	32	(23,164)
CONTROL TOTAL DEFECIT	**(1,853)**	**(1,872)**	**(19)**	**(15,960)**	**(16,394)**	**(433)**	**(23,590)**

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

Appendix 2

Milton Keynes Hospital NHS Foundation Trust
Statement of Cash Flow
As at 30th November 2019

	Mth 8 £000	Mth 7 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	564	10	554
Operating surplus/(deficit) of discontinued operations			
Operating (deficit)	**564**	**10**	**554**
Non-cash income and expense:			
Depreciation and amortisation	6,157	5,395	762
(Increase)/Decrease in Trade and Other Receivables	7,485	4,682	2,803
(Increase)/Decrease in Inventories	5	5	0
Increase/(Decrease) in Trade and Other Payables	2,194	2,759	(565)
Increase/(Decrease) in Other Liabilities	2,454	3,035	(581)
Increase/(Decrease) in Provisions	(43)	(43)	0
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	(2,000)	(2,000)	0
Other movements in operating cash flows	(1)	(1)	0
NET CASH GENERATED FROM OPERATIONS	**16,815**	**13,842**	**2,973**
Cash flows from investing activities			
Interest received	71	61	10
Purchase of financial assets	(175)	(175)	0
Purchase of intangible assets	(1,486)	(1,472)	(14)
Purchase of Property, Plant and Equipment, Intangibles	(8,813)	(6,658)	(2,155)
Sales of Property, Plant and Equipment			0
Net cash generated (used in) investing activities	**(10,403)**	**(8,244)**	**(2,159)**
Cash flows from financing activities			
Loans received from Department of Health	2,915	2,915	0
Loans repaid to Department of Health	(1,097)	(938)	(159)
Capital element of finance lease rental payments	(106)	(91)	(15)
Interest paid	(1,106)	(996)	(110)
Interest element of finance lease	(195)	(171)	(24)
PDC Dividend paid	(606)	(606)	0
Receipt of cash donations to purchase capital assets	2,000	2,000	0
Net cash generated from/(used in) financing activities	**1,805**	**2,113**	**(308)**
Increase/(decrease) in cash and cash equivalents	**8,217**	**7,711**	506
Opening Cash and Cash equivalents	**6,175**	**6,175**	0
Closing Cash and Cash equivalents	**14,392**	**13,886**	**506**

Appendix 3

Milton Keynes Hospital NHS Foundation Trust
Statement of Financial Position as at 30th November 2019

	Audited Mar-19	Nov-19 YTD Plan	Nov-19 YTD Actual	In Mth Mvmt	YTD Mvmt	% Variance
Assets Non-Current						
Tangible Assets	147.3	190.5	151.9	(38.6)	4.6	3.1%
Intangible Assets	14.2	12.6	14.1	1.5	(0.1)	(0.7%)
Other Assets	0.5	0.3	0.6	0.3	0.2	38.2%
Total Non Current Assets	**162.0**	**203.4**	**166.6**	**(36.8)**	**4.7**	**2.9%**
Assets Current						
Inventory	3.6	3.2	3.6	0.4	0.0	0.0%
NHS Receivables	23.5	18.7	15.2	(3.5)	(8.3)	(35.3%)
Other Receivables	6.0	3.5	6.9	3.4	0.9	15.0%
Cash	6.2	2.1	14.4	12.3	8.2	132.3%
Total Current Assets	**39.3**	**27.5**	**40.1**	**12.6**	**0.8**	**2.0%**
Liabilities Current						
Interest -bearing borrowings	(80.2)	(81.9)	(81.8)	0.1	(1.6)	2.0%
Deferred Income	(1.7)	(1.6)	(4.2)	(2.6)	(2.5)	146.2%
Provisions	(1.6)	(1.4)	(1.5)	(0.1)	0.1	-4.3%
Trade & other Creditors (incl NHS)	(28.9)	(28.8)	(31.6)	(2.8)	(2.7)	9.4%
Total Current Liabilities	**(112.3)**	**(113.7)**	**(119.1)**	**(5.4)**	**(6.8)**	6.0%
Net current assets	**(73.0)**	**(86.2)**	**(79.0)**	**7.2**	**(6.0)**	**8.2%**
Liabilities Non-Current						
Long-term Interest bearing borrowings	(53.0)	(54.3)	(53.4)	0.9	(0.4)	0.7%
Provisions for liabilities and charges	(0.8)	(1.1)	(0.8)	0.3	0.0	0.0%
Total non-current liabilities	**(53.9)**	**(55.4)**	**(54.2)**	**1.2**	**(0.4)**	0.7%
Total Assets Employed	**35.1**	**61.8**	**33.4**	**(28.0)**	**(1.7)**	**(4.7%)**
Taxpayers Equity						
Public Dividend Capital (PDC)	101.4	103.3	101.3	(2.0)	(0.1)	-0.1%
Revaluation Reserve	58.3	78.7	58.3	(20.4)	0.0	0.0%
I&E Reserve	(124.5)	(120.2)	(126.2)	(6.0)	(1.7)	1.4%
Total Taxpayers Equity	**35.1**	**61.8**	**33.4**	**(28.4)**	**(1.8)**	**(5.0%)**