Bundle Trust Board Meeting in Public 13 January 2022

1.1 10:00 - Agenda

0. Agenda Board Meeting in Public - 13.01.22 v 1.docx

1.2 10:00 - Apologies

2 10:01 - Declarations of Interest

3.1 10:02 - Previous Minutes of the Meeting Held in Public on 4 November 2021

3. Minutes of the Trust Board Meeting in Public 04.11.21 v 1.docx

3.2 10:04 - Matters Arising

4 10:05 - Chair's report

4.1 MKUH Coversheet Jan 2022.docx

4.2 Chair's report.docx

5 10:10 - Chief Executive's Report

Chief Executive
a. Annual Objectives – Update
b. New Hospital Programme - Development of the Programme Outline Business Case
c. CQC Engagement Visits – Update

6 10:30 - Patient Story

7 11:00 - Incident Learning and Quality Improvement Report

7. Incident Learning and QI Report for Board.doc

8 11:05 - Nursing Staff Update

8. Nursing Staffing Report Jan 2022.docx

9 11:10 - Workforce Report Month 08

9. Workforce Report M8 2021.docx

10 11:15 - Performance Report

10.1 2021-22 Executive Summary M08 Coversheet.docx

10.2 2021-22 Executive Summary M08.docx

10.3 2021-22 Board Scorecard M08.pdf

10.4 TEG and Board Report November 2021.pdf

11 11:25 - Finance Report Month 08

11. Finance report M8 Public Board.docx

12 11:35 - Hospital Charity Accounts 2020/21

12.1 Hospital Charity Annual Report and Accounts 2020-21.docx

12.2 Signed accounts 2021.pdf

12.3 Letter of rep MKH - 02.11.21.pdf

13 11:40 - Antimicrobial Stewardship Annual Report

13.1 Antimicrobial cover sheet.docx

13.2 AMS annual report 2020-21.docx

14 11:45 - Enhancing Board Oversight: A New Approach To Non-Executive Director Champion Roles

14. 1 Enhancing Board Oversight - A New Approach To Non-Executive Director Champion Roles kj v 2.docx

14.2 Appendix 2 - Enhancing-board-oversight-a-new-approach-to-non-executive-director-champion-roles_Dec 2021.pdf

15 11:55 - Declaration of Interests Report

15.1 Declarations of Interest - Board Report v 3.docx

15.2 APPENDIX 2 - REGISTER OF INTERESTS OF DECISION-MAKING STAFF.docx

15.3 Appendix 3 -2021-2022 Register of Gifts and Hospitality v 2.docx

16 12:00 - Significant Risk Register

16.1 Risk Report January 2022.docx

16.2 Appendix 1 - Signficant Risk Register - as at 5th January 2022.xlsx

16.3 Appendix 2 - Corporate Risk Register - as at 5th January 2022.xlsx

17 12:05 - Board Assurance Framework

17. Board Assurance Framework January 2022.docx

18 12:10 - Summary Reports

18.1 FIC Summary Report 02 November 2021.docx

18.2 FIC Summary Report 30 November 2021.docx

18.3 Audit Committee Summary Report - December 2021 meeting.docx

18.4 Quality Clinical Risk Committee Summary Report - 13 December 2021 Meeting.docx

18.5 TEC Summary Report 8 December 2021.docx

19 12:15 - Use of Trust Seal

19. Use of Trust Seal Jan 2022.docx

20 12:15 - Forward Agenda Planner

20. Trust Board Meeting In Public Forward Agenda Planner.docx

21 12:15 - Questions from Members of the Public

22 12:15 - Motion to Close the Meeting

23 12:15 - Resolution to Exclude the Press and Public

24 12:15 - Date of Next Meeting

Agenda for the Board of Directors' Meeting in Public

Meeting to be held at 10.00 am on Thursday 13 January 2022
remotely via MS Teams

Item No.	Timing	Title	Purpose	Lead	Paper
Introduction and Administration					
1	10.00	Apologies	Receive	Chair	Verbal
2		Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda	Information	Chair	Verbal
3		Minutes of the Trust Board meeting in held in public on 04 November 2021	Approve	Chair	Attached
		Matters Arising	Note	Chair	Verbal
Chair and Chief Executive Updates					
4	10.05	Chair's Report	Information	Chair	Attached
5	10.10	Chief Executive's Report - Overview of Activity and Developments	Receive and Discuss	Chief Executive	Verbal
		• Annual Objectives – Update		Chief Executive	Verbal
		• New Hospital Programme - Development of the Programme Outline Business Case		Deputy Chief Executive	Verbal
		• CQC Engagement Visits – Update		Director of Corporate Affairs	Verbal
Effectiveness of Care					
6	10.30	Patient Story	Receive and Discuss	Director of Patient Care and Chief Nurse	Presentation

Item No.	Timing	Title	Purpose	Lead	Paper
Patient Safety					
7	11.00	Incident Learning and Quality Improvement Report	Receive and Discuss	Director of Corporate Affairs/ Medical Director	Attached
Patient Experience					
8	11.05	Nursing Staff Update	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached
Workforce					
9	11.10	Workforce Report Month 08	Receive and Discuss	Director of Workforce	Attached
Performance and Finance					
10	11.15	Performance Report Month 08	Receive and Discuss	Chief Operations Officer	Attached
11	11.25	Finance Report Month 08	Receive and Discuss	Director of Finance	Attached
Assurance and Statutory Items					
12	11.35	Hospital Charity Accounts 2020/21	Assurance and Noting	Director of Finance	Attached
13	11.40	Antimicrobial Stewardship Annual Report	Assurance and Noting	Medical Director / Deputy Chief Executive	Attached
14	11.45	Enhancing Board Oversight: A New Approach To Non – Executive Director Champion Roles	Review and Approve	Director of Corporate Affairs	Attached
15	11.55	Declarations of Interests Report	Receive and Discuss	Director of Corporate Affairs	Attached
16	12.00	Significant Risk Register	Receive and Discuss	Director of Corporate Affairs	Attached
17	12.05	Board Assurance Framework	Receive and Discuss	Director of Corporate Affairs	Attached
18	12.10	(Summary Reports) Board Committees • Finance & Investment Committee 02/11/2021 and 29/11/2021	Assurance and Information	Chairs of Board Committees	Attached

Item No.	Timing	Title	Purpose	Lead	Paper
		• Audit Committee 13/12/21 • Quality & Clinical Risk Committee 13/12/2021 • Trust Executive Committee 08/12/2021			
19		Use of Trust Seal	Noting	Director of Corporate Affairs	Attached
Administration and Closing					
20	12.10	Forward Agenda Planner	Information	Chair	Attached
21		Questions from Members of the Public	Receive and Respond	Chair	Verbal
22		Motion to Close the Meeting	Receive	Chair	Verbal
23		Resolution to Exclude the Press and Public The Chair to request the Board pass the following resolution to exclude the press and public and /move into private session to consider private business: "That representatives of the press and members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted.	Approve	Chair	
12.15		Close			
Next Meeting: Thursday, 03 March 2022					

Milton Keynes University Hospital NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Minutes of the Trust Board of Directors Meeting in Public held on Thursday, 04 November 2021 at 10.00 hours via Teams

Present:

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

In Attendance:

Kate Jarman	Director of Corporate Affairs	(KJ)
Jackie Collier	Director of Transformation & Partnerships	(JC)
Nina Roberts	Advanced Nurse Practitioner – Stroke Service (For Item 07)	(NR)
Alexandra Stock	Ward Manager, Ward 7 (For Item 07)	(AS)
Alice Fiancet	Communications Specialist	(AF)
Allan Hastings	Public Governor and Lead Governor	(AHas)
Kwame Mensa-Bonsu	Trust Secretary (Minutes)	(KMB)

1 Welcome and Apologies

1.1 AD welcomed all present to the meeting. There were apologies from Professor James Tooley, Non-Executive Director; and Nicky McLeod, Non-Executive Director.

2 Declarations of interest

2.1 There were none.

3 Minutes of the Trust Board Meeting in Public held on 09 September 2021

3.1 The minutes of the Trust Board Seminar held on 09 September 2021 were reviewed and **approved** by the Board, subject to:

Paragraph 12:2 –: The Board agreed that line 2 - “JB advised that significant progress had been made to secure the funding streams for the construction project, and an Outline Business Case was being developed” should be revised to “JB advised that some progress had been made to secure the funding streams for the construction project, and an Outline Business Case was being developed”.

4 Matters Arising

4.1 There was no Action Log.

5 Chair's Report

5.1 AD presented a written report which included the following highlights:

a. The Inclusion Leadership Council (ILC), a key part of the Trust's Equality, Diversity and Inclusion agenda, was launched on 03 November 2021. The ILC would provide a forum for direct access from the staff networks to the Trust Board of Directors, with a plan for it to grow and evolve so it can fulfil its remit which was to ensure all staff had an opportunity to reach their full potential and ambition.

b. Black History Month was celebrated in October 2021 with a number of online and face to face activities, including a question-and-answer session featuring AD, JH and NBM, which raised suggestions and reflections on a number of different issues including the opportunities for staff progression into more senior roles.

c. The Freedom to Speak Up (FTSU) Month was also observed in October 2021. The FTSU function, as a key element of patient and staff safety agenda, ensured all staff felt confident to raise issues of concern.

d. Work with partners in the Bedfordshire, Luton and Milton Keynes Integrated Care System (BLMK ICS) had progressed, while preparations for the statutory changes to come into force from April 2022 were being undertaken. It was noted that an Integrated Care Board (ICB) and an Integrated Partnership Board (ICP) would be created under the proposed statutory changes.

e. AD noted that she had visited the Lakes Estate in September 2021 with Michael Bracey, CEO of Milton Keynes Council and Rima Makarem, independent Chair of BLMK ICS to see and hear about the proposed redevelopment of the area. The proposed redevelopment provided an opportunity for the involvement of many partners including healthcare and voluntary/third sector.

f. AD had continued with her visits to various areas in September and October 2021, including the Research and Development Department, the HR, IT and Procurement Departments at Witan Gate, the Urgent Care Centre and the Chaplaincy. Other Non-Executive Directors had also begun to visit areas, where appropriate, and subject to the pressures on services.

g. There were steps being undertaken with the Council of Governors to review the Trust's Constitution, and the final version would be presented to the Trust Board in due course.

5.2 AD, on behalf of the Trust Board, thanked AHas who was completing his final term of office as a Governor, for his contributions to the Trust over many years. AD noted that AHas's support had been unstinting and added that he had provided his valuable perspective to the organisation as a 'critical friend', which was likely to continue. AD advised that steps were under way to identify the new Lead Governor. AHas thanked members of the Trust Board for their positive engagements with him over the years and noted that he had received several messages from staff which were very much appreciated.

The Board **noted** the Chair's Report.

6 Chief Executive's Update

6.1 JH provided an update on the Trust's current pressures and stated that there continued to be a significant steep increase in the number of patients attending the hospital, particularly to the Emergency Department (ED). JH advised that the pressure from patient activity in the Trust was being compounded by the increased prevalence of COVID-19 infections in the community, and the consequent impact of patients with COVID-19 who were attending the hospital for treatment. JH stated that for the first time, the Trust had in November 2021 unfortunately had to cancel the appointments of orthopaedic patients. It was noted that these cancellations were a result of the increased demand for emergency care.

6.2 JH advised that though there was increasing pressure, the hospital remained the best performing Trust among its peers in the East of England in terms of the ED's '4-hour waiting time' standard. JH stated that to ensure staffing levels were safe during this period of increasing activity, the Trust had taken steps to encourage the appropriate usage of bank and agency staff across the organisation and was paying the market rate to secure that. JH advised that the Trust was maintaining the controlled COVID-19 related visiting regulations so people could not visit patients unless they absolutely must and added that the Board would be kept updated on developments. JH noted that, in comparison, some NHS providers had re-instituted the visiting regulations implemented at the peak of the COVID-19 pandemic when no visiting was permitted.

6.3 JH noted that the Annual Members Meeting held on 02 November 2021 was very well organised and had been utilised to set out what the organisation had achieved during 2020/21. JH thanked the Executive Team for their efforts, and also thanked AHas for all he's done to represent the Governors and to support the Trust over many years.

6.4 In reference to the 2021 United Nations Climate Change Conference or COP 26, being held in Glasgow, JH stated that the Trust continued to focus on the Green Agenda and had been recognised as a leading 'green' organisation in the NHS. JH advised that the Trust was committed to achieving the Net Carbon Zero target by 2030, which was 10 years ahead of the rest of the NHS and was aligned to the Milton Keynes Council's commitment to achieve the same goal by 2030. JH stated that under the auspices of the Green Agenda, the Trust had reduced food waste from 15% to 2%, invested in solar panels which generated electricity, and encouraged staff usage of electric cars by investing in more and more electric chargers. JH added that the Trust's Cardiology Block had been refurbished with materials which had significantly improved its energy efficiency.

6.5 JH advised that the Trust had submitted a bid for an award of £11m from the Public Sector Decarbonisation Scheme, which was administered by Salix Finance Ltd., a non-departmental public body, sponsored by the UK Government's Department for Business, Energy and Industrial Strategy. The bid for £11m, if successful, would support the Trust's plan to implement energy efficiency upgrades to the hospital's estate.

6.6 JH stated that the final shortlist of nominees for the 2021 Virtual Staff Awards had been published and noted that preparations for the event to be held at the end of November 2021 was almost complete. JH also wished all a Happy Diwali, a Hindu festival which was celebrated on 04 November 2021.

6.7 KJ provided an update on a routine engagement CQC visit to the hospital which had involved inspectors taking walks around the hospital, the Maternity Unit, the ED, and the Cancer Centre. KJ stated that the individuals in this visiting team had never been to the Trust, and it was refreshing guiding them through the hospital while they interacted with staff and reviewed the Trust's services. KJ added that the engagement team had also visited some departments and areas by themselves and provided very encouraging and positive feedback on their observations. In response to AD's query on the CQC's programme of engagement with the hospital, KJ advised that a CQC team was currently in the Trust on another routine engagement visit. KJ added that future engagement visits would, depending on availability and other factors, probably be a mix of 'face to face' and online meetings.

Board **noted** the Chief Executive's update.

7 Patient Story

7.1 NR presented the story which highlighted the lifesaving benefits of the Trust's Stroke Service and noted that the NHS's 'Act FAST Campaign' was crucial in ensuring the public was aware of the symptoms of a person having a stroke and the need for immediate action by calling for an ambulance to save lives. NR stated that quick actions by bystanders was very crucial as stoke victims lost an estimated 1.9m brain neurons every minute while they remained untreated.

7.2 NR highlighted the experience of a patient named Margaret who had suffered a stroke while out walking her dog and whose life was saved by the quick actions of a stranger who found her and called 2222 for

the Stroke Service. Margaret was received in the Trust's ED and, after emergency treatment, transferred to the tertiary Stroke Service at the Oxford University Hospital (OUH) NHS Foundation Trust for specialist treatment. NR stated that, on completion of the specialist treatment programme at the OUH, Margaret returned to the Trust to recuperate before being discharged.

7.3 NR stated that the stranger who found Margaret had also helped to identify her, her home address and other medical details and noted that this had helped the Trust to provide the necessary and correct emergency treatment. NR, in conclusion, suggested that the stranger's actions had been exemplary, and they needed to be commended.

7.4 AS highlighted the experience of a second patient who couldn't talk or swallow, had a lot of right sided weakness after suffering a haemorrhagic stroke. AS noted, that this was a special case because the patient had become quite severely disabled from their stroke and didn't have English as their first language. As such the patient, while having severe speech difficulties, also struggled to understand what was being communicated to them. AS added that the problem was compounded by the COVID-19 related restrictions on visiting, so the patient received no visitors who could help with translation for the Therapy Team as was usually the solution when a patient had such difficulties. AS stated that the Therapy Team instead had to rely on lots of video calls with the patient's family to progress with the treatment being provided.

7.5 AS advised that the second patient was on admission in the hospital for about 3 months, and by the end could eat and drink normal food and was able to walk out of the Stroke Unit for the last time by themselves. The patient's therapeutic treatment for their remaining speech and mobility difficulties was passed on to the Stroke Rehabilitation Team in the community, which mirrored the team in the hospital but also included a psychologist who would help the patient manage their mental health better.

7.6 NR advised that one advantage of having a Stroke Unit in the Trust was that beds were ring fenced specifically for patients with strokes, so that they didn't only receive emergency treatment, but the patients could also attend the Unit after their treatment to be provided with others forms of support. NR stated that the experienced staff in the Unit understood stroke, could comfortably talk to patients with communication problems, and could also quickly recognise any early signs of deterioration in a patient. NR noted that the evidence from the Trust's performance data strongly indicated that the length of stay for patients admitted to the Stroke Unit was significantly decreased.

7.7 NR informed the Board that the Trust's Stroke Service had a strong multidisciplinary team and had been rated as an 'A' in the Sentinel Stroke National Audit Programme (SSNAP) for a few years. The Service also had excellent interprofessional working relationships with other organisations and departments such as the South-Central Ambulance Service and the Trust's ED and MRI department which ensured that patients with stroke had a clear pathway to be delivered at the hospital and to receive speedy lifesaving treatment. It was noted that the SSNAP was a major national healthcare quality improvement programme which measured the quality and organisation of stroke care in the NHS and was the single source of stroke data in England, Wales, and Northern Ireland. The overall aim of SSNAP was to provide timely information to stakeholders on how well stroke care was being undertaken and had been voted the most effective national clinical audit in the UK for nine consecutive years by healthcare professionals involved in audit.

7.8 AS advised that the Stroke Services' staff was supported with relevant training and teaching courses, and steps were being taken to extend training on stroke care to all the Trust's clinical staff. AS stated that NR had established a stroke course, validated by Northampton University, for all of the Trust's registered nurses and had ran a three day course for the Healthcare Assistants as well. AS noted that the Unit also worked closely with the University of Buckingham Medical School to ensure the medical students were provided with the appropriate training on stroke care.

7.9 AS stated that a new kitchenette had enhanced the Unit's capacity to prepare patients to return to their lives prior to suffering their strokes. These preparations included the need to make sure that patients could make a hot drink, a snack or a meal as strokes often affected the ability to sequence the steps

needed to complete such routine tasks. NR advised that the Unit aspired to procure or be provided with other assets which would significantly enhance its capacity including:

a. A 24-hour thrombolysis service

b. More space in-between beds

c. An equipment storage space

d. More speech and language therapists

e. An in-house psychologist.

7.10 AD advised that, on a recent visit to the Stroke Unit, she had been impressed by the work of the multidisciplinary team and the excellent impact that made on the lives of patients with stroke. AD added that considering the devastating impact of a stroke on a patient, the Stroke Service was very crucial, and congratulated the Unit for its SSNAP 'A' rating. JH thanked AS, NR and the staff in the Stroke Unit for their efforts and stated that the 'A' rating was a result of many years of hard work and investment in the Stroke Service. In response to JH's query around whether more beds were needed for patients with stroke, NR stated that the ideal position would be for more rehabilitation beds to be provided in the community as patients recovered more quickly if the appropriate rehabilitation facilities were in place. JH, in agreement, stated that the question was how Milton Keynes as a Place could enhance support for patients with stroke rather than just the hospital providing the relevant treatment and support.

7.11 IR advised that it was important for the Board members to note that before 2016/17 there had been a very major national effort to centralise acute stroke services, which had threatened the survival of the Trust's Stroke Service. The Trust had decided against closing the Service and had instead developed this model, which was both novel and unique, in terms of the involvement of the tertiary Service at the OUH, telemedicine and the acute geriatricians who provided the medical input. IR stated that it was also very impressive that the Trust's Stroke Service was being rated as an 'A' by SSNP, because prior to 2016/17 the annual ratings had fluctuated between 'D' and 'E'.

7.12 IR, in agreement with NR, noted that having the appropriate bed base in the community would be positive for the patients. IR added that it would be important for the Trust to work with the ICS to improve the community Stroke Service as, though the Trust had no control over it, its service quality impacted on SSNAP's rating of the Trust's Service. IR, in conclusion, congratulated AS, NR and the rest of the Stroke Team for sustaining and improving the Service over the years.

7.13 AD, with reference to the need for patients to receive speedy life-saving treatment when having a stroke, commended the Trust for maintaining the Service in Milton Keynes. AD added that the presentation had, in terms of its developmental needs, also provided the Board with some food for thought and a lot of points to discuss.

The Board **noted** the Patient Story.

8 Serious Incident & Inquest Report

8.1 IR presented a report which provided an overview of the 13 new Serious Incidents reported in October 2021, the trends and concerns, and an update on the results of an inquest into the death of a baby in November 2020.

8.2 IR reviewed the incidents and highlighted the following:

a. Two outbreaks of COVID-19 infection on two of the Trust's non-COVID-19 wards, which had resulted in the closure of the wards. IR stated that, though patients were being routinely tested at regular intervals when they were admitted into the hospital, this outbreak provided evidence of the increasing infection rate in the community. IR noted that the COVID-19 positive patients had tested negative

and had no symptoms on admission, but their symptoms of COVID-19 infection had emerged while on admission.

b. Three medicines-related incidents which were rated as low to modest harm incidents. IR advised that the main cause of these incidents was that the Trust's Pharmacy Department had been under staffing pressures over recent months. The staffing pressures had since improved, and steps were being taken to review the staffing establishment for the Pharmacy Department.

c. A no harm never event, which involved the removal of the wrong cyst. The patient had, at a later date, returned to the hospital for the correct cyst to be successfully removed. IR stated that the incident was under investigation, and the issues being reviewed included how the site of the correct cyst was marked and the type of pen used to do so. A report on the investigation, when completed, would be submitted to the Board for review.

8.3 IR updated the Board on the results of an October 2021 inquest into the death of a baby. The baby had died four months after birth in March 2021, and the inquest had concluded that the baby had died because of a spinal cord injury caused by the inappropriate use of Kielland's forceps during delivery. The inquest had also noted that the baby's mother had not given informed consent for the use of the forceps. IR stated that a Prevention of Future Death Notice from the coroner had been issued to the Trust, and a response from the Trust would be provided by December 2021.

8.4 KJ stated that the Trust had switched its incident reporting and risk management system provided by Datix Ltd to a new one provided by Radar Healthcare Ltd. KJ stated the 'go live' date for the new Radar system had been delayed till 15 November 2021 to enable the Trust to test NHS England's new 'Learn from patient safety events service' (LFPSE). The LFPSE was being rolled out to replace the current National Reporting and Learning System (NRLS), and the Trust would be the first NHS provider to adopt it. KJ noted that the LFPSE would be a central portal for the recording and analysis of patient safety events that occur in healthcare in England.

8.5 KJ informed the Board of a new requirement from NHS England for NHS provider Boards to seek assurance that their organisations were compliant with the existing Human Tissue Authority (HTA) regulatory guidance. KJ stated that checks had indicated that the Trust was compliant with the regulatory guidance and a report would be submitted to the January 2022 Board Meeting in Public.

Action: A report on the Trust's compliance with the HTA's regulatory guidance on Mortuaries in January 2022.

8.6 In response the HS's query on the position around the steps being taken to reduce the number of deep tissue injuries to heels, NBM advised that one of the steps was that a member of the Trust's safeguarding specialist nursing was providing cover for the tissue viability nurse while they were on long term leave. NBM noted that the few recent occurrences had not been caused by devices, but by other causes such as plasters. NBM stated that the training and preventive tools which had been provided to the Trust's nurses, along with the tissue viability nurse's oversight, would ensure that the significant reduction in injuries was not reversed.

8.7 HH highlighted the concern for the risk of patients developing venous thromboembolism (VTE) due to inaccurate prescribing against their weights, caused by a lack of an alert flag if an incorrect dose was prescribed. In response to HH's query whether the Trust had asked the provider of the electronic patient records (EPR) system, Cerner, to provide that functionality, JB stated that the Trust had procured new scales and height machines which were electronically linked to the EPR system. JB advised that these machines would bypass the flag problem on the Cerner EPR system and ensure that there was a consistent and correct transcription of the heights and weights of patients into record.

8.8 AD stated that she was encouraged by the piloting of the SAFE team approach to review certain events/incidents and was looking forward to reviewing reports on the progress of the pilot.

The Board **noted** the Serious Incident & Inquest Report.

9 Research and Development (R&D) 2020/21 Annual Report

9.1 IR presented the R&D 2020/21 Annual Report and noted that the Trust's R&D team had performed very well by recruiting many patients to both COVID-19 and non-COVID-19 clinical trials. IR also introduced the draft 2021 – 2026 R&D Strategy, which was under consultation with stakeholders.

9.2 IR advised that the COVID-19 trials in the Trust had, for example, contributed to proving the efficacy of steroids as a treatment for COVID-19, which had led to a significant increase in improvements in mortality worldwide. The R&D team had also supported COVID-19 antibody testing trials in the Trust, volunteered to support the effort to treat COVID-19 patients on the wards, and taken on responsibility for the fit testing of PPEs and masks. IR stated that the significant contributions of the R&D team during the COVID-19 pandemic needed to be recognised.

9.3 IR advised that the R&D team had also significantly embedded National Institute for Health Research (NIHR) studies in the Trust, which had given the hospital's patients the chance to be involved in studies to improve treatments for themselves and others. IR added that there was a draft strategy which was also focused on improving the income earned from NIHR studies to match the increase in the number of studies being conducted, with the aim of ensuring that studies were available in all the specialties and all the services that the Trust provided.

9.4 IR stated that stakeholder events and discussions were being held to complete the draft strategy, which would focus on several objectives including the provision of career development support for clinical staff like nurses and allied health professionals who want to become the principal investigators for clinical studies. IR advised that when the strategy was completed, there should be a discussion at the Board on issues such as how the income from R&D activity could be increased as required and if a clinical research facility could be set up in the Trust.

The Board **noted** the R&D 2020/21 Annual Report and the draft 2021 – 2026 R&D Strategy.

10 Maternity Update

10.1 NBM provided a presentation which provided a summary of the progress of the recent initiatives and developments in the Trust's Maternity Services. The presentation noted that these initiatives and developments were based mainly on recommendations from the National Maternity Review's 'Better Births' report in 2016 and the Ockendon Review in 2020. The presentation also highlighted that the 'Better Births' report had set out a vision for safe and personalised births with the recommendation for the implementation of the 'Continuity of Carer model', while the Ockenden Review recommended a workforce gap analysis with the purpose of achieving a workforce transformation.

10.2 The presentation provided the following highlights:

a. Continuity of Carer (CoC)Model – 43% of baby deliveries in the Trust were on the CoC pathway.

b. Awaiting a comprehensive implementation plan before rolling out more CoC teams – this included a plan to increase international recruitment activity. Midwifery and medical staffing had been increased to provide support for the initial implementation of the CoC model, and this included the successive piloting of placing registered nurses on Ward 9 to support midwives to undertake midwifery-focused activity.

c. The Trust had also recently implemented a very well received medical staffing system which ensured that registrars were always present in the hospital out of hours, which enhanced both their training requirements and the services provided at the hospital. Funding had also been received from the East of England to improve consultant time in the Maternity Unit and to ensure that there was sufficient consultant time available for consultant-focused activity.

d. There had been a significant increase in patient activity in the Maternity Unit.

e. Bi-monthly meetings between NBM, IR and the senior maternity and neonatal teams to discuss their issues and concerns.

f. Monthly meetings between NBM and the Maternity Voice Partnership to discuss any feedback from women and discuss suggestions on improvements. An example of the improvements implemented was around visiting hours, where the Trust had extended the visiting time afforded to partners. It was noted that visiting times had been impacted by COVID-19 related controls.

10.3 HS noted that though a lot of actions remained to be implemented, feedback from stakeholders indicated that the Trust had made significant progress in implementing the recommendations from the different maternity-related reviews and was doing very well with the progress of the CoC model's rollout. In response to HS's query around the impact of the new eCare patient record system on data quality, patient safety and patient experience, NBM advised that though Maternity Services had been able achieve their maternity datasets the transition to new system had not been a smooth one. JB advised that though all the required information was available on eCare, it was not always available in a structured format which would allow for it to be easily drawn down for statistical analysis. JB stated that progress was being made towards resolving this, as well as to ensure that all relevant maternity documents were available through the patient portal.

10.4 IR advised that it was important for the point to be made that the CoC model clearly delivered better outcomes for women, and particularly for disadvantaged women. IR stated that as such, despite the current challenges, the CoC model should be supported and fully implemented. IR added that even though, in this challenging period, patient experience was not what the Trust would like it to be, the obstetricians and midwives were working well together on a day-to-day basis to ensure that patient safety was maintained.

The Board **noted** the presentation on the Trust's Maternity Services.

11 Nurse Staffing Report

11.1 NBM presented the report and highlighted the following:

a. The vacancy rates had increased for both Band 5 and Band 6 nurses. The Trust was looking to step up its international recruitment activity to fill those vacancies.

b. Student nurses had been fast tracked, on a voluntary basis, onto the bank rota as Health Care Support Workers (HSCW). The Trust would take steps to ensure that they had a good learning environment and that they were adequately supervised and supported. This initiative would be reviewed when the vacancy rate improved.

c. Local recruitment activity, focusing on 'harder to recruit-to posts', had been stepped up in the Trust.

d. Agency nursing costs increased in August 2021, due to increased capacity, annual leave and sickness absence.

e. Following a successful recruitment, 5 members of the nursing staff had been offered the opportunity to undertake a Chief Nurse BAME Fellowship Programme commencing December 2021. HS offered to mentor them, if necessary.

11.2 HT thanked NBM for her leadership in these challenging times, especially for her efforts to improve the Maternity Service, and stated that the Trust was lucky to have someone as resilient in the role of Chief Nurse. NBM noted that she was supported by a good team.

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

12 Nursing and Midwifery Strategy: 2022 – 2025

12.1 NBM advised that the document provided an outline of the Nursing Directorate's strategic ambitions over the next three years and added that it had been co-produced with the nursing and midwifery staff, who wanted to build on the foundations of the varying extra skills they gained during the COVID-19 pandemic. NBM informed the Board that the Strategy would be rolled out in the Trust in January 2022.

12.2 NBM stated that there had been a lot of engagement with the staff during the development of the Strategy and supporting each of the strategic ambitions was a workstream with an associated action plan. NBM noted that the progress made against the action plans would be overseen by the Nursing, Midwifery and Therapies Advisory Group, and each workstream would be collaboratively managed by a senior nurse and a senior midwife. HS congratulated NBM and the Nursing Directorate leadership for the Strategy and noted that the collaborative thread between the nurses and midwives was clear throughout the document. HS stated that it would be very good if a similar strategy could be developed for the staff groups such as the Allied Health Professionals (AHPs). NBM advised that there was an ambition to develop a strategy for the AHPs however, the process was not ready yet.

12.3 In response to HH's query around the Strategy's ambition to develop and utilise apps, NBM stated that it was about developing smart solutions to meet the learning needs of all the relevant stakeholders including student nurses and student midwives. The feedback from the staff during the development of the Strategy was that the staff and students wanted information in one place so that if they needed to, they could access it for a detailed review of the relevant information they required.

12.4 AD noted that the Strategy was a very good document, adding that it was very easy to read and understand. NBM suggested that she would like to credit the former Deputy Chief Nurse, Sam Donohue, for managing a lot of the engagement work which supported the strategic development process.

The Board **approved** the Nursing and Midwifery 2022 -2025 Strategy

13 Infection Prevention and Control 2020/21 Annual Report

13.1 NBM presented the Infection Prevention and Control (IPC) 2020/21 Annual Report and highlighted the critical role the IPC Team had played during the COVID-19 pandemic and were still playing. NMB noted that there had been a collaborative approach by the IPC team to help manage the response to the COVID-19 pandemic from cleaning through to the bed management and patient flow.

13.2 NBM stated that in 2020/21 there had been a reduction in C.Diff cases with 7 reported against a threshold of 13 while cases of both gram negative and gram positive bacteraemia had, in line with the national position, increased partly due to the impact of the use of steroids to treat COVID-19 patients. NBM advised that though the Trust had a 'zero-tolerance' approach to 'Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia, one case was reported in 2020/21 and that was related to a lifesaving emergency intervention for a gentleman that came from abroad. NBM noted that though the patient may have already been infected before attending the hospital, an investigation could not definitely determine the origin of infection. NBM stated that the IPC team investigated all infections to see whether they were avoidable, and whether there was a change in practice needed.

13.3 IR stated that the Antimicrobial Stewardship agenda was actively being progressed and added that the Trust Antimicrobial Pharmacist had made great strides in the last few years to make sure antibiotic usage was appropriate in the hospital. IR noted that there was constructive challenge between the microbiologists, pharmacists, nurses, and medical prescribers and this had improved the Trust's benchmark position.

13.4 LJ advised that the data from the Surgical Site Infection Surveillance (SSIS) reporting on Caesarean Section deliveries, as well as data on hip and knee replacement surgeries, needed to be presented better and placed in the context of the activity. IR stated this had not been done because the national benchmarking scheme had been suspended during the COVID-19 pandemic, but the Trust had decided to carry on collating data locally.

The Board **noted** the IPC 2020/21 Annual Report.

14 Complaints 2020/21 Annual Report

14.1 NBM presented the Complaints 2020/21 Annual Report and noted that, because of the COVID-19 pandemic, there had been a reduction in the number of complaints. NBM stated that, with the decline in COVID-19 infections, there had been an increase in the number of complaints around historic issues and this had resulted in an increase in response times. The Annual Report noted that communication, and staff behaviour and attitude accounted for most of the causes of patient's complaints in 2020/21, as was the case in 2019/20.

14.2 In response to AD's query around whether there was a tool for shared learning from complaints, NBM stated the Complaints team conducted a thematic review of all complaints filed by patients every month and where appropriate, the Trust website was updated. NBM added that if specific themes continued to arise from the monthly reviews, actions were taken in conjunction with the problem area to resolve the issue causing patients to complain and then lessons shared across other divisions.

The Board **noted** the Complaints 2020/21 Annual Report.

15 Workforce Report Month 06

15.1 DP presented the Workforce Month 04 report and highlighted the following:

a. The vacancy rate had stabilised at 10.6% in Months 05 and 06, which was higher than expected. The HR Business Partners (HRBP) and the Recruitment Team continued to support the divisions' recruitment activities. Overall, the Trust had various recruitment campaigns planned, including a large-scale media campaign and international recruitment activity.

b. The absence rate for staff with COVID-19 infections stabilised at 0.6% in Months 05 and 06.

c. Staff turnover increased slightly from 7.5% in Month 05, to 7.8% in Month 06.

d. The statutory and mandatory training compliance rate was at 96% in Month 06 from 95% in Month 05, while appraisals compliance rate was at 91% in Month 06 from 90% in Month 05.

e. The first meeting for the Trust's 'Inclusion Leadership Council' had been held in November 2021.

f. National guidance on the management of the rollout of the booster COVID-19 vaccines was being awaited.

The Board **noted** the Month 06 Workforce report.

16 2020 Staff Survey Update

16.1 DP presented an update on the progress made against the action plans related to the results of the 2020 Staff Survey. DP stated that the HRBPs had worked with their relevant divisions and triumvirate leads to continue to engage with staff to address the themes and areas requiring improvement, and to also learn from best practice in other divisions.

16.2 DP highlighted some of the themes being discussed and acted on by the teams and these included:

a. Logging hours worked above and beyond normal working hours – It was important that staff got paid for or got the time back for extra hours worked looking after patients or completing tasks. Teams were being supported to discuss ways that they could make sure this happened.

b. Introducing regular feedback meetings between staff and managers – This had been embedded to enable staff to provide feedback to their managers as a group.

c. Staff Health & Well Being (SHWB) – The Trust would provide mental health support to all staff and run Wellbeing sessions on Teams, including counselling for traumatic events.

16.3 DP stated that two working groups had been established to work on advancing improvements in the two areas of, staff working beyond their normal hours and the reduction in violence and aggression. DP advised that one of the groups had reviewed rostering practices, to make sure that if staff worked extra hours, they had a choice in that and that no one was working excessive hours because of rostering practices or unfair shift patterns. The other group working on reducing violence and aggression against staff had been split into several mini groups and have had excellent engagement with staff from across the Trust. DP informed the Board that the mini groups had reviewed Trust policies and procedures and completed assessments and tests to show where improvements could be made. Other planned actions included a poster campaign designed at highlighting to patients and staff that violence and aggression from service users and patients were unacceptable. DP stated that a series of listening events were also being held to allow staff to come forward and report any violent or aggressive behaviour they may have experienced and the impact thereof.

16.2 In response to HT's query around the reasons provided by leavers, DP stated that this was closely monitored by the HRBPs, but no significant difference had been detected over the last 12 months compared to two years ago. DP noted that the main reason provided by leavers was stresses and strains of the last year, adding that the Trust was monitoring how the COVID-19 pandemic continued to affect the staff and had provided some good support. DP acknowledged that the Trust could still work on providing more support to the staff.

The Board **noted** the 2020 Staff Survey Update.

17 Performance Report Month 06

17.1 EL presented the report and noted that:

a. The ED's performance against the 4-hour waiting target declined from 82.3% in Month 05 to 82.1% in Month 06, due to the continued pressure of increasing emergency activity.
b. Ambulance handovers which were over 30 mins was at 12.1% in Month 06. Actions had been taken to ensure that ambulance staff were released quickly so this improvement in the ambulance handover would be entrenched.
c. For length of stay, the number of patients who had stayed in hospital for 21 days or more after their treatment was at 62 in Month 06, from 77 in Month 05.
d. Performance against the 62-day Cancer national standard of 85% was at 74.6% in Q1 of 2021/22, and the performance against the 31-day standard of 96% was at 94% in Q1 of 2021/22. This was due to a focus on the treatment of long waiting patients and getting through the backlog.

17.2 EL, with reference to the increasing activity and the staffing pressures, noted that there had been some improvement in the Trust's elective capacity in the Outpatient Department and in the ED where the performance against the 4-hour standard had stabilised. EL stated that the Trust had managed to maintain the flows of both elective and emergency patients through September 2021 despite the staffing challenges caused mainly by increased staff sickness and vacancy rates in month. EL advised that though staff sickness rates had increased, the agency spend had decreased as there was a limited number of agency staff to recruit. EL also noted that considering the hospital's bed capacity had been reduced as part of the Trust's infection control measures, bed occupancy in the hospital was effectively full.

17.3 EL highlighted the challenging number of stranded patients and stated that the Trust was working with its partner organisations in the community to speedily discharge this cohort of patients. EL advised that this discharge effort was being slowed down by the loss of staffing capacity in the community due to the outbreak of COVID-19 infections in the community. The Trust and other stakeholders were looking at how capacity in the community partner organisations, such as in domiciliary and social care, could be increased through online or virtual solutions. In response to LJ's question around the poor diagnostic

waits performance, EL stated that as there was no extra capacity to draw on the Trust was preparing a business case to procure an external Imaging services provider to help improve performance. EL suggested that, due to vacancies and an inability to enhance the available mobile capacity, it was also a good opportunity to transform the Trust's imaging capacity by working differently and improving the skill mix in those services.

The Board **noted** the Month 06 Performance Report.

18 Finance Paper Month 06

18.1 KH presented the Month 06 Finance Report and noted that:

a. On a Control Total basis, the Trust reported a deficit of £28k in Month 06 compared to a £162k planned deficit.
b. Overspends on pay related to the wage award were offset by additional clinical income.
c. In terms of pay there was a negative variance to plan in August 2021 of £2.5m, of which £1.9m cost related to the wage award.
d. In terms of non-pay there was a negative variance in September 2021 of £0.7m, of which £0.3m was due to additional Elective Recovery Fund activity and £0.2m was due to a higher than planned prescribing of high-cost drugs.
e. The cash balance at the end of September 2021 was £54.9m.
f. The Capital spend year-to-date was at £5.8m, which was £0.7m. behind plan.

The Board **noted** the Month 06 Finance report.

19 Significant Risk Register

19.1 KJ presented the Significant Risk Register report and advised that the change of the Trust's risk and incident management systems to a new provider was almost complete and risks entries were being transferred from Datix to the new system, Radar.

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

20 Board Assurance Framework (BAF)

20.1 KJ presented the BAF and noted that the risk score for risk entry 20 had increased from 8 to 12. Risk entry 20 related to the risk that if the Trust did not recruit to vacancies in the short term (0-18 months), then there would be workforce shortages across the hospital and/or increased temporary staffing expenditure.

The Board **noted** the BAF Update.

21 Terms of References

21 a **Audit Committee**

The Board **reviewed** and **approved** the revised Terms of Reference for the Audit Committee.

21 b **Quality and Clinical Risk Committee**

The Board **reviewed** and **approved** the revised Terms of Reference for the Quality and Clinical Risk Committee.

21 c **Finance and Investment Committee**

The Board **reviewed** and **approved** the revised Terms of Reference for the Finance and Investment Committee.

21 d **Workforce and Development Assurance Committee**

The Board **reviewed** and **approved** the revised Terms of Reference for the Workforce and Development Assurance Committee.

21 e **Remuneration Committee**

The Board **reviewed** and **approved** the revised Terms of Reference for the Remuneration Committee.

21 f **Charitable Funds Committee**

The Board **reviewed** and **approved** the revised Terms of Reference for the Charitable Funds Committee.

22.1 Summary Report for the Audit Committee Meeting – 20 September 2021

The Board **noted** the report.

22.2 Summary Report for the Finance and Investment Committee Meeting – 07 September 2021

The Board **noted** the report.

22.3 Summary Report for the Finance and Investment Committee Meeting – 05 October 2021

The Board **noted** the report.

22.4 Summary Report for the Charitable Funds Committee Meeting – 14 October 2021

The Board **noted** the report.

22.5 Summary Report Workforce and Development Assurance Committee – 20 October 2021

The Board **noted** the report.

22.6 Summary Report Quality and Clinical Risk Committee – 20 September 2021

The Board **noted** the report.

23 Forward Agenda Planner

23.1 HH advised that the Trust Secretary included an 'Annual Digital Review' item on the Forward Agenda Planner.

The Board **noted** the Forward Agenda Planner.

24 Questions from Members of the Public

24.1 There were none.

25 Any Other Business

25.1 AD informed the Board that feedback from Shazia Gulfraz after the November 2021 Inclusion Leadership Council meeting indicated that the Trust's Equality, Diversity and Inclusion (EDI) Team were an inclusive and diverse team, and this had been enhanced with steps to ensure that the team's members were tuned into the Trust. A messaging screen had been erected in the EDI department and dynamically utilised for sharing the messages being shared in the Trust. AD added that the feedback had also

suggested the reinstatement of the ‘Milton Keynes Managers’ Way’ as that been very helpful in terms of staff wellbeing.

25.2 The meeting closed at 12 noon.

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: 13.01.2022**
Report Title	**Chair's Report**	**Agenda Item: 4**
Lead Director	**Name: Alison Davis**	**Title: Chair**
Report Author	**Name: Alison Davis**	**Title: Chair**

Key Highlights/ Summary	An update for the Board on activity and points of interest			
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Noting** x	**For Review** ☐

Strategic Objectives Links	*N/A*
Board Assurance Framework (BAF)/ Risk Register Links	*N/A*

Report History	*N/A*
Next Steps	*N/A*
Appendices/Attachments	*None*

Chair's report

To provide details of activities and matters to note, to the Trust Board:

1. I am delighted to report that Babs Lisgarten has been appointed as the new Lead Governor for the Trust. We have started our regular 1:1 discussions and I have also had introductory meetings with the new Governors. I look forward to working with Babs and the Council of Governors.
2. I met with the Mayor of Milton Keynes in December, Councillor Mohammed Kahn. He passed on his thanks to all staff for the incredible work they have done and continue to do, especially through the height of the pandemic.
3. I have been introduced to and am making links with the MK Business Leaders Partnership; continuing the involvement undertaken by the previous Chair, Simon Lloyd.
4. During Interfaith Week in November, I attended a meeting at the Chaplaincy with representatives of the schools whose pupils had provided reflections on what faith meant to them. Interestingly, one of the key themes was kindness, which was also a theme in the cultural development work undertaken by staff at MKUH.
5. I chaired an interview panel for the appointment of consultants for Cellular Pathology.
6. I am currently involved in the recruitment process for the appointment of the Non-Executive Directors to the Integrated Care Board. The Board will not become substantive under legislation until July 2022 as the original date of April 2022 has had to be delayed due to the continuing pressures of and focus on the pandemic.
7. I have been speaking with prospective candidates for our two Non-Executive Director posts at MKUH which become vacant between February and March 2022.
8. The national Race Equality Code was launched on the 01.12.2021, which provides a framework to enable organisations to address inequity at senior levels. Details can be found at theracecode.org

Meeting title	**Trust Board (public)**	13 January 2022
Report title:	**Incident, Learning and Quality Improvement Report**	Agenda item: 7
Lead director **Report author** **Sponsor(s)**	Tina Worth	 Head of Risk & Clinical Governance
FoI status:	Public document	

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

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

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

Serious Incident Report November 2021

There were eight new SIs reported on STEIS in December 2021. The following table provides a summary of those incidents:

STEIS number	Category	Location	Details
2021/24753	New pressure ulcer	Ward 18	Deep tissue injury to heel.
2021/24779	Surgical complication	Theatres/Day Surgery	Wrong site surgery. Local anaesthetic block in the wrong eye. Incident identified after administration of anaesthetic in the eye – surgery was not undertaken on the wrong eye, the surgery was subsequently undertaken on the correct eye. The category of 'wrong site surgery' includes where a patient receives anaesthesia, an error is identified, and the anaesthesia has to be repeated.
2021/25218	New pressure ulcer	Ward 23	Deep tissue injury from skin traction.
2021/25219	New pressure ulcer	Ward 19	Deep tissue injury to sacrum
2021/25220	Obstetric incident (mortality)	Labour Ward	Intrauterine death. Presented to Labour Ward with no fetal movements at 39 weeks and three days. Investigation ongoing, with initial findings: Learning from good: • Risk assessment for serial growth assessments at booking highlighting the centile and need for aspirin. • Good continuity in pregnancy. • Good documentation of regular conversation about fetal movements using Tommy's advice in pregnancy. • Efficient management of the care with respect of wishes once diagnosis of in utero death made. • Appropriate referral to fetal medicine. Multi-disciplinary team (MDT) discussion points: • Missed opportunity to have more in depth discussion and documentation about the risks linked with obesity - diabetes • Missed ultrasound at 38 weeks for estimated fetal weight which could potentially have indicated further growth restriction so there was a missed opportunity to offer an earlier induction.
2021/26446	Obstetric	Labour Ward	Intrapartum stillbirth at 37 weeks and 4 days

	incident (mortality)		gestation. Reported to the Healthcare Safety Investigation Branch (HSIB). The woman's partner contacted the Labour Ward to say she thought she was in labour. Arrived on Labour Ward and stated she was unsure when last felt movements due to the contractions. The Midwife attempted to listen in to the fetal heart with a handheld doppler and had difficulty. The registrar performed a bedside scan, and the fetal heart was visualised but was less than 60bpm. Call to proceed to an emergency lower segment caesarean section (LSCS), however in theatre confirmed no fetal heart was visible, and that the baby had sadly died.
2021/26447	Delayed diagnosis	Gastrointestinal (GI) team	Referred on the cancer pathway to Gastroenterology for investigation of anaemia in July 2019. At a colonoscopy a removable rectal polyp was identified, and a repeat procedure was arranged and booked for October 2019 but this did not take place. Patient re-referred in September with more advanced symptoms and repeat investigations have unfortunately shown that the original lesion has progressed to a malignancy.
2021/26448	Unexpected adult death	Intensive Care Unit (ICU)	Patient admitted to ICU - transferred from Oxford ICU. Sudden deterioration and death.

Trends

Deep tissue injury (pressure ulcer). Deep tissue injuries remain the most frequently reported category of serious incident in the hospital. The Serious Incident Review Group (SIRG) triangulate action plans to link actions and be assured on how preventative work and learning from previous incidents is being embedded.

Medication incidents. Medication incidents with no/minor harm are also frequently reported. SIRG received an in-depth review into administration errors relating to Gentamicin (an antibiotic) in maternity. This audited all existing action plans to review consistency and effectiveness. This review will be made available to the Quality and Clinical Risk Committee.

Documentation. Of particular note this month, is the importance of risk/benefit conversations with patients for surgical procedures and clear documentation to reflect this.

Incident Reporting System

The hospital moved to a new incident reporting system called Radar on 15 November 2021, making us the first Trust in the first in the country to link to the Learning from Patient Safety Events (LFPSE), previously known as the National Reporting and Learning System (NRLS) for national data collection. This continues to require significant work to embed the change in reporting standards – this is mainly due to the new national requirements for the LPSE rather than the system change. The Governance and Risk team will increase training support and provision over the next two months to ensure that incident reporting rates are not adversely affected.

Quality Improvement and Learning

There is a planned pause in quality improvement activity in January and February as organisational capacity is very limited. The focus during this time is on recruitment to a Head of Quality Improvement role and a QI Manager role, and on QI training (for those staff able to attend).

Training Plan

The vison for MKUH is that every member of staff would have the ability to undertake QI, and where required they would be supported by the QI coaches and mentors. QI should be an integral part of every member of staffs' role and therefore linked to appraisal.

An ambitious approach would also be to provide opportunities for service users to join the improvement network and potentially lead improvement.

Several levels of QI expertise would be available within the Trust that the workforce could be part of and draw upon. This is an ambitious proposal for the Trust to consider as part of with journey to outstanding.

- 15 dedicated QI leads with advance QSIR (quality service improvement redesign) training
- 30 QI network facilitators/ peer supporters (with QSIR training)
- All staff trained in QI fundamentals

The creation of a central team of 10-15 expert **QI Leads** who are responsible for co-ordinating and promoting the quality improvement approach and embedding an improvement culture.

These would be the most highly trained (QSIR Accredited) and QI experienced people for whom improvement is part of their job role (quality, safety, experience).
The Improvement Leads would lead Trust wide programmes, and support others in local projects, they would also be key in engaging as part of the wider Improvement network across the ICS by working on training and project delivery with other ICS QSIR accredited staff

They may work from the Improvement Hub (physical space) and will co-ordinate all quality improvement activity across the Trust, registering all QI programmes, using and providing access to Life QI and reporting to Quality and Improvement Board/ Patient Safety Board as appropriate.

They will support the delivery of quality improvement, coach fellows and facilitators, provide overarching governance of QI projects and transformation programmes, and lead on AI, through the use of the caring conversations framework and principles, and the "Clear Pathway" (appreciative inquiry model).

This central team will include at least one expert by experience to support the engagement of patients, carers and families in our quality improvement projects, with the opportunity for a patient to become a QI lead employed by the Trust.

Improvement Leads will be experienced in improvement methodologies and will have/ be completing QSIR accredited training, QI Coaching training, have led a range of QI programmes, and have a passion for continual improvement.

During 2022 the QI Leads will develop the expertise to deliver bite sized QSIR training (aligned to the Model for Improvement) by becoming QSIR accredited, and AI leads, also teaching on QI methodologies, and using the AI caring conversations framework.

The **QI facilitators** would be trained and experienced in QI however QI is not a main part of their job role. QI facilitators would lead QI programmes with support from a QI Lead as part of the QI network.

The creation of 30 QI facilitators will support the QI and transformation programmes. QI facilitators will lead teams to deliver service transformation and small-scale change projects within their area and help others. They will have completed training QI training programmes and may progress to QSIR accredited training to ensure continuity of resources as staff leave, and will be able to apply AI principles, the caring conversations framework and use and promote the Clear Pathway.

We aim to empower all **MKUH staff** at every level to use QI methodology to make changes within their own teams, should they wish to.

There will be opportunities for every member of staff to be supported in developing their quality improvement skills and empowering them to put it in to practice through small scale change projects.

Currently, and for 2022, access to online training will be provided via the Improvement Hub (intranet), and ongoing training in existing programmes (preceptorship, band 6 & 7 leadership).

In recognition of the range of improvement methodologies in use, QI (Model for Improvement), Appreciative Inquiry, (AI), Human Factors, Audit, Research and Development, and the Cultural Change Programme; a virtual **Improvement Hub***,* team and network is being established.

This aims to bring together the approaches in one virtual intranet area. This will provide staff a central point of access to log, and access information on the appropriate tools, training, techniques, and to contact staff who lead and are skilled in a particular area to support improvement ideas.

This will facilitate central capture of the improvement work being undertaken, to share and celebrate the small and large improvement work being delivered and enable reporting organisationally.

It is envisaged that a physical Improvement Hub space (by the PALS office) will be re-established once the pandemic subsides, with the opportunity for the wider Improvement team to be able to work more closely together and provide service users and staff a physical point of access to share improvement ideas.

The improvement network aims to provide all staff access to improvement skills, learning, ideas and to other staff interested in improvement for mentoring and support.

Meeting title	Board of Directors		**Date:** 13th January 2022	
Report title:	Nursing Staffing Report		**Agenda item:** 8	
Lead director **Report author** **Sponsor(s)**	**Name:** Nicky Burns-Muir **Name:** Matthew Sandham Emma Thorne		**Title:** Director of Patient Care/Chief Nurse **Title:** Associate Chief Nurse Workforce Matron	
FoI status:				
Report summary				
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [x]	**Decision** [ ]
Recommendation	That the Board receive the Nursing Staffing Report.			

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

Report history	To every Public Board
Next steps	
Appendices	Appendices 1

Board of Directors Report on Nursing and Midwifery staffing levels
Amalgamated report for October and November 2021

1. Purpose

To provide Board with: -

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

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

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

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

$$\text{CHPPD} = \frac{\text{hours of care delivered by Nurses and HCSW}}{\text{Numbers of patients on the Ward at midnight}}$$

CHPPD	Total Patient Numbers	Registered Midwives/Nurses	Care Staff	Overall
October	14128	4.1	2.8	6.9
November	13410	4.4	2.6	7.0

Month	**RN/RM Day % Fill Rate**	**HCA/MCA Day % Fill Rate**	**RN/RM Night % Fill Rate**	**HCA/MCA Night % Fill Rate**
October	67.4%	71.2%	92.3%	108.0%
November	70.8%	72.2%	96.8%	102.4%

- *October and November 2021 data are included in Appendix 1.*

Areas with notable fill rates

During the months of October and November the Trust saw a continued rise in attendance which has affected the CHPPD hours in the month of October. The Day % fill rate has improved in November due the arrival of the newly qualified nurses.

Are we safe ?

3. Recruitment Overview

The Tables below are the residual numbers of vacancies.

Medicine

Band	WTE Vacancy	Percentage	Turn over percentage
Band 2	11 WTE	6%	6.9%
Band 5 & 6	45 WTE	13%	6%

Medicine's Band 5's has decreased due to recent recruitment in the ED.

Surgery

Band	WTE Vacancy	Percentage	Turn Over percentage
Band 2	7 WTE	4 %	6%
Band 5 & 6	21.16 WTE	7 %	5%

Surgery has reduced the number of Band 2 vacancies.
Band 5 vacancies have slightly decreased mainly on Ward 20.

Women's and Children

Band	WTE Vacancy	Percentage	Turn Over percentage
Band 2	1.89 WTE	4%	6 %
Band 5 & 6	19.61WTE	9 %	2%

Women's and Children have been successful in their recruiting.

4. Recruitment

4.1 Trainee Nursing Associates

The Nursing Associate role was introduced nationally to bridge the gap between health care assistants and registered nurses. Here at MKUH we acknowledge the value that this role brings in complementing our existing nursing workforce and in recognising their contribution in providing safe effective care to our patients.

In December 2021 MKUH commissioned the University of Northampton to be the main educational provider for Nursing Associate training and collaboratively interviewed and appointed 18 candidates for the January 2022 Trainee Nursing Associate programme.

This opportunity provides:

- An attractive employment opportunity for new recruits to MKUH and we received additional monies subsidised by Health Education England in order to attract new people into healthcare roles.

- Provides a supply of qualified nursing associates upon completion. Successful candidates will now commence a 2-year foundation degree with placements at MKUH gaining NMC registration upon completion.

4.2 Student Nurses

The Trust continues to work with the University Learning Environment Leads to offer recruitment education workshops for Student Nurses to ensure that MKUH is their first choice to work.

Currently we have 13 Student Nurses due to qualify in March/April 2022 and MKUH will offer those undertaking their sign off placement with us the opportunity of employment with the organisation. Students will meet with the Divisional Chief Nurses in January 2022 to undertake a career discussion regarding their aspirations and preferred area of work.

This initiative provides a supply of newly registered nurses familiar with our organisation three times a year.

4.3 International Nurse Recruitment

To support the Trusts current registered nurse vacancies alongside planned hospital growth and developments the organisation has committed to an International Nurse Recruitment Programme with the aim to recruit 125 nurses throughout 2022.

To date 25 nurses have been interviewed and offered employment with the Trust subject to satisfactory pre-employment checks with the 2nd stage interviews scheduled for 6th January 2022.

The first 16 of our International Nurse recruits will arrive on the 27th January 2022, ready to commence in the Trust on the 31st January.

This recruitment programme will see registered nurses arriving in cohorts of 16 every month. The nurses will be provided with a bespoke induction programme and ‘host ward’ for the first three months, (alongside 3 of their peers) to allow for training and education, supervision, and peer support while they prepare for their Objective Structured Examination (OSCE) and adjust to life in the United Kingdom.

Are we effective?

5. SafeCare Tool Update

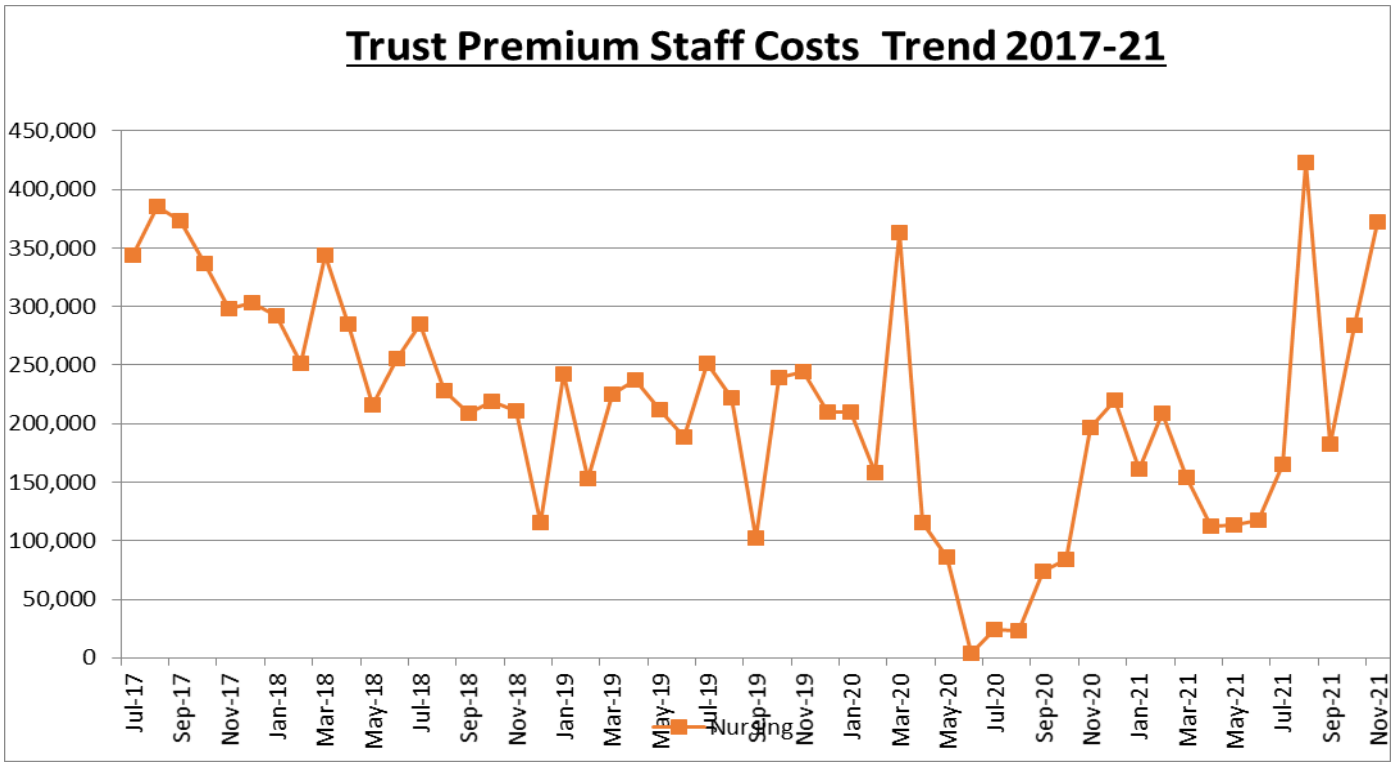
The SafeCare 'live system' allows organisations to compare their staffing with the actual acuity/dependency of its patients. It provides organisations with transparency and informs if staffing levels match the current demands.

This invaluable tool allows for Matrons and Senior Managers to 'see at a glance', areas with high acuity and respond to the needs of the ward or department.

In November 2021 the Trust invited a Senior Workforce Transformation Manager (with extensive SafeCare and Safer staffing experience), to undertake an external review of our SafeCare process. The focus for the visit was to validate the data entry submitted by wards.

Feedback suggests that there is still a need to provide more education to staff to ensure that patients are being classified correctly using the Safer Nursing Care Tool.

6. Agency graph



During the period of October and November, we saw the agency cost rise. This has been driven by increased bed capacity and staff isolating.

We celebrate.

Vaccination Centre

To support the National Vaccination Agenda the Trust opened a vaccination POD at Saxon Court to assist Hertfordshire Community Trust to meet the demand for COVID-19 vaccinations for the local population.

The POD was run in line with a COVID-19 Pfizer National Protocol allowing for non-registrants to administer vaccines following face to face training, e-learning and competency assessment under the supervision of a protocol lead.

Medical Students, Pre-Reg Pharmacists, Administrators, and members of the Executive team were among the individuals who offered to undertake vaccination training and became members of the core team over the festive period.

A total of 60 vaccinators were signed off as competent during the three-week period (for both vaccination and documentation), with a further 20 individuals trained as competent to manage the administrative/documentation aspect of vaccinations.
There is now a robust governance structure that can be adopted to support vaccination hubs in the future should the need arise for future booster campaigns.

In January 2022 the BAME Chief Nurse Fellows commenced on programme. This is a leadership programme which is designed to empower the fellows to develop their leadership ability. They will be delivering a number of Trust-wide improvement projects, and gain knowledge and experience in change management, influencing, negotiating and self-awareness to enable them to reach their full potential.

In December we welcomed Andrea Piggott, Deputy Chief Nurse, into the corporate nursing leadership team. She comes with a breadth of knowledge and experience across community, commissioning, safeguarding, mental health and learning disabilities, BLMK and ICS development.

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
AMU	67.5%	67.0%	94.4%	83.9%	655	5.0	1.8	6.8
ICU	67.7%	68.4%	83.1%	-	212	22.9	1.2	24.2
Ward 2	62.8%	74.2%	93.3%	97.5%	688	3.9	2.5	6.4
NNU	69.2%	52.4%	83.1%	98.9%	324	11.5	1.8	13.4
Ward 14	68.6%	70.7%	98.9%	102.2%	721	3.2	3.3	6.5
Ward 10	3.2%	80.1%	6.5%	67.7%	16	2.3	37.1	39.3
Ward 15	71.6%	81.1%	96.2%	132.3%	804	3.6	2.5	6.1
Ward 16	67.3%	77.9%	89.3%	114.1%	823	3.0	2.3	5.3
Ward 17	70.1%	74.6%	96.1%	124.2%	789	3.8	2.0	5.8
Ward 18	65.4%	70.8%	96.7%	131.1%	783	2.8	3.4	6.2
Ward 19	76.7%	77.1%	100.8%	131.3%	869	2.8	3.2	6.0
Ward 20	63.9%	56.8%	101.6%	98.9%	734	3.4	2.4	5.9
Ward 21	61.8%	70.7%	87.9%	88.6%	476	4.9	2.6	7.6
Ward 22	69.5%	71.7%	95.9%	99.0%	504	4.9	4.7	9.5
Ward 23	71.5%	84.7%	101.6%	132.4%	1113	3.1	3.8	6.8
Ward 24	66.4%	61.6%	86.0%	87.1%	376	4.9	3.1	8.0
Ward 3	69.4%	66.6%	98.9%	102.2%	545	4.2	4.2	8.4
Ward 5	74.4%	61.1%	118.5%	106.5%	508	7.8	1.8	9.6
Ward 7	69.2%	70.8%	98.9%	101.1%	724	3.3	3.2	6.5
Ward 8	66.9%	71.1%	101.6%	112.9%	761	3.0	2.3	5.3
Ward 9	57.2%	53.4%	65.6%	64.4%	1108	2.1	1.2	3.3
Ward 25	69.4%	77.7%	98.9%	137.0%	595	4.6	3.4	8.0

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

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
AMU	63.3%	59.8%	97.3%	93.6%	577	5.4	2.0	7.4
ICU	71.9%	48.4%	91.1%	-	199	25.5	0.8	26.4
Ward 2	66.5%	59.4%	100.1%	95.2%	607	4.7	2.4	7.1
NNU	73.5%	70.2%	87.4%	100.0%	317	12.4	2.1	14.5
Ward 14	69.6%	71..7%	98.9%	102.2%	701	3.2	3.3	6.5
Ward 10	3.3%	80.8%	3.5%	86.5%	35	0.7	18.0	18.8
Ward 15	82.3%	86.6%	101.1%	122.8%	834	3.8	2.4	6.2
Ward 16	73.7%	84.1%	102.8%	110.8%	854	3.3	2.2	5.4
Ward 17	66.9%	74.5%	99.3%	103.4%	770	3.7	1.8	5.4
Ward 18	63.0%	72.4%	99.9%	104.4%	807	2.6	2.9	5.5
Ward 19	77.7%	80.2%	105.6%	127.7%	855	2.9	3.2	6.1
Ward 20	66.0%	63.7%	107.6%	93.2%	704	3.6	2.3	5.9
Ward 21	68.3%	75.8%	86.7%	92.6%	526	4.6	2.4	7.0
Ward 22	80.5%	66.3%	102.0%	91.1%	491	5.9	4.2	10.1
Ward 23	74.4%	82.7%	103.4%	123.5%	1125	3.1	3.4	6.5
Ward 24	78.1%	68.6%	105.7%	96.7%	431	4.9	2.9	7.8
Ward 3	76.1%	67.5%	105.4%	116.9%	709	3.5	3.3	6.8
Ward 5	78.2%	77.4%	120.6%	80.0%	514	8.4	1.8	10.2
Ward 7	74.5%	79.2%	100.0%	100.1%	692	3.5	3.5	7.0
Ward 8	70.6%	71.7%	106.7%	106.7%	730	3.2	2.3	5.5
Ward 9	62.9%	60.7%	74.5%	68.8%	1047	2.5	1.4	3.8
Ward 25	64.2%	63.9%	82.2%	90.8%	586	4.6	3.4	8.1

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: 5 January 2022**
Report Title	**Workforce Report**	**Agenda Item: 9**
Lead Director	**Name: Danielle Petch**	**Title: Director of Workforce**
Report Author	**Name: Louise Clayton**	**Title: Deputy Director of Workforce**

Key Highlights/ Summary	This report provides a summary of workforce Key Performance Indicators for the full year ending 30 November 2021 (Month 8) and relevant Workforce and Organisational Development updates to Trust Board			
Recommendation *(Tick the relevant box(es))*	**For Information** ☑	**For Approval** ☐	**For Noting** ☐	**For Review** ☐

Strategic Objectives Links	Objective 8: Investing in our people
Board Assurance Framework (BAF)/ Risk Register Links	BAF risks 19-24

Report History	
Next Steps	WFB, WFDAC, January 2022
Appendices/Attachments	

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators as at 30 November 2021 (Month 8), covering the preceding 13 months.

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

Indicator	Measure	Target	11/2020	12/2020	01/2021	02/2021	03/2021	04/2021	05/2021	06/2021	07/2021	08/2021	09/2021	10/2021	11/2021
Staff in post (as at report date)	WTE		3256.5	3251.3	3250.0	3284.0	3311.6	3337.3	3304.1	3310.7	3328.5	3321.9	3328.6	3342.5	**3347.7**
	Headcount		3738	3729	3730	3765	3795	3826	3793	3797	3810	3799	3807	3823	**3827**
Establishment *(as per ESR)*	WTE		3630.6	3634.2	3635.5	3635.4	3635.4	3662.8	3677.7	3681.7	3675.1	3714.0	3724.7	3730.4	**3725.7**
	%, Vacancy Rate	10%	10.2%	10.5%	10.6%	9.5%	8.7%	8.9%	10.2%	10.1%	9.4%	10.6%	10.6%	10.4%	**10.1%**
Staff Costs (12 months) *(as per finance data)*	%, Temp Staff Cost		11.7%	11.7%	11.6%	11.6%	11.6%	11.3%	11.3%	11.4%	11.6%	11.7%	11.9%	12.1%	**12.3%**
	%, Temp Staff Usage		11.9%	11.8%	11.8%	11.8%	11.8%	11.7%	11.8%	12.0%	12.2%	12.4%	12.6%	12.7%	**12.8%**
Absence (12 months)	%, 12 month Absence Rate	4%	4.7%	4.8%	5.0%	5.1%	4.8%	4.5%	4.4%	4.5%	4.6%	4.7%	4.8%	5.0%	***5.0%***
	- %, 12 month Absence Rate - Long Term		*2.6%*	*2.7%*	*2.7%*	*2.8%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.8%*	*2.8%*	*2.8%*	*2.9%*	***3.1%***
	- %, 12 month Absence Rate - Short Term		*2.1%*	*2.2%*	*2.4%*	*2.3%*	*2.1%*	*1.8%*	*1.8%*	*1.8%*	*1.8%*	*1.9%*	*2.0%*	*2.0%*	***1.9%***
	%,In month Absence Rate - Total		5.0%	6.1%	6.7%	4.7%	3.6%	3.3%	4.2%	4.4%	4.6%	5.0%	5.4%	6.1%	***5.4%***
	- %, In month Absence Rate - Long Term		*2.6%*	*3.6%*	*2.9%*	*2.9%*	*2.4%*	*2.3%*	*2.9%*	*2.8%*	*3.3%*	*3.2%*	*3.0%*	*3.5%*	***3.3%***
	- %, In month Absence Rate - Short Term		*2.4%*	*2.5%*	*3.8%*	*1.8%*	*1.2%*	*1.0%*	*1.3%*	*1.6%*	*1.3%*	*1.9%*	*2.4%*	*2.5%*	***2.1%***
	- %, In month Absence Rate - COVID-19 Sickness Absence		1.1%	2.1%	3.3%	1.3%	0.5%	0.4%	0.4%	0.3%	0.5%	0.6%	0.6%	0.6%	***0.6%***
Starters, Leavers and T/O rate (12 months)	WTE, Starters		329.9	329.2	313.0	318.0	311.6	322.2	321.3	330.7	331.7	327.9	333.0	349.4	**347.1**
	Headcount, Starters		376	373	358	363	356	367	367	376	377	374	376	393	**395**
	WTE, Leavers		244.7	240.1	233.7	229.3	203.4	204.5	215.6	219.7	223.0	216.8	227.7	232.0	**241.5**
	Headcount, Leavers		291	286	278	273	241	244	255	259	264	258	271	276	**289**
	%, Leaver Turnover Rate	10%	8.5%	8.4%	8.2%	8.0%	7.1%	7.1%	7.4%	7.5%	7.7%	7.5%	7.8%	7.9%	**8.3%**
	%, Stability Index		86.9%	87.2%	87.1%	87.0%	87.8%	87.6%	87.5%	87.1%	86.6%	86.5%	86.2%	85.6%	**85.2%**
Statutory/Mandatory Training	%, Compliance	90%	95%	95%	95%	96%	97%	95%	95%	96%	96%	95%	96%	95%	**96%**
Appraisals	%, Compliance	90%	91%	90%	92%	93%	95%	95%	93%	92%	89%	90%	91%	91%	**91%**
Medical and Dental Appraisals	%, Compliance	90%	87%	90%	86%	79%	83%	97%	96%	91%	93%	94%	94%	87%	**72%**
Time to Hire (days)	General Recruitment	35	41	56	49	39	43	48	44	47	48	46	59	53	**56**
	Medical Recruitment (excl Deanery)	35	32	49	34	53	52	49	68	62	68	52	53	81	**65**
Employee relations	Number of open disciplinary cases		25	22	19	23	14	11	14	9	6	6	7	9	**10**

2.1. The Trust's **vacancy rate** (10.1%) is improved from M7. The establishment has increased by 95.1 wte compared to the same period last year. The resourcing team are working with comms to launch a nationwide campaign to advertise MKUH as an employer of choice and agency options are currently being explored. The team are also currently implementing attraction schemes such as Refer a Friend and Recruitment and Retention Premia. The International Nurse Recruitment campaign is in progress and the first interviews took place in M9, with 28 offers of employment made.

2.2. Overall **staff absence** has remained at 5% while Covid related absence remains in line with previous months from 2021/22. Absence rates will increase significantly in M9 due to the community prevalence of the Omicron Variant. Occupational Health are dealing with a significant increase in management referrals, and additional resource is being explored to support the reduction of the backlog.

2.3. The **stability index figure** (defined as *proportion of staff in post at end of period who were in post at beginning of period)* has deteriorated slightly in-month to 85.2%. Similarly, **staff turnover** has increased slightly, however, remains well below target; in part attributable to increased support through Staff Health and Wellbeing, engagement through Teams sessions and debriefs to support staff and managers affected by Covid and the ever-improving staff rewards and benefits package.

2.4. **Time to hire** overall is higher than the same period last year, with General Recruitment being above the KPI. There has been a significant increase in recruitment activity following a detailed department-level vacancy review by the HRBPs. This has resulted in an increased number of posts being advertised in M7 and interviews held in M8 which has impacted on time to hire. Medical Staffing have also had a number of medics starting that required visas and Certificates of Completion of Training. The team have also increased bank advertising to prepare for winter pressures and high staff absence.

2.5. The number of **Open Disciplinary Cases** has started to increase, with a high number of absence management cases in progress. A detailed Employee Relations case report is produced on a quarterly basis for Workforce Board and JCNC.

2.6. **Statutory and mandatory training** compliance is at 96% and **appraisals** compliance has remained at its agreed tolerance of 91% as the Trust's reporting period enters the winter period. The Medicine Division was below tolerance at 89% and Surgery at 90% for M8. It is anticipated there may be further reduction in appraisal compliance in M9. Divisions are addressing this locally.

3. Continuous Improvement, Transformation and Innovation

3.1. During M8 bank rates were enhanced to improve shift fill rates, with additional rates for Maternity Services. These were reviewed in detail at the end of M8 to ensure their continued attraction. The HR Services team also secured longline agency staff to support winter pressures across the Trust.

3.2. The Trust's process for managing staff who had shielding requirements and restrictions or amendments to duty due to medical reasons during the pandemic is being updated with notification of the changes to all those impacted planned for M9. Staff side and Occupational Health are engaged with this piece of work.

4. Culture and Staff Engagement

4.1. The **Inclusion Leadership Council** has had its first meeting, this council is the network of networks providing a voice for the staff networks at Trust Board level.

5. Current Affairs & Hot Topics

5.1. The Trust's **Vaccination Centre** for the Covid-19 booster was re-instated at the end of M8, working in partnership with HCT to create a provision at Saxon Court to minimise impact on MKUH staffing levels and service delivery.

5.2. **Vaccination as a Condition of Employment (VCOD)** law went through parliamentary passage on the 17th December 2021. The VCOD Task and Finish Group have created a toolkit and guidance for early conversations with staff who are not fully vaccinated or have not declared their statement. Roll-out will commence in M10.

6. Recommendations

6.1. The Board is asked to note and receive the Workforce Report for Month 8.

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: January 2022**
Report Title	2021-22 Executive Summary M08	**Agenda Item: 10**
Lead Director	**Name:** John Blakesley	**Title:** Deputy CEO
Report Author	**Name:** Performance and Information Team	**Title:**

Key Highlights/ Summary	Please refer to the Executive Summary			
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Noting** ☐	**For Review** ☐

Strategic Objectives Links	Summary Sustainability and Transformation Fund Urgent and Emergency Care Elective Pathways Patient Safety
Board Assurance Framework (BAF)/ Risk Register Links	

Report History	
Next Steps	
Appendices/Attachments	ED Performance – Peer Group Comparison

Trust Performance Summary: M08 (November 2021)

1.0 Summary

This report summarises performance in November 2021 for key performance indicators and provides an update on actions to sustain or improve upon Trust and system-wide performance. This commentary is intended only to highlight areas of performance that have changed or are in some way noteworthy. It is important to highlight that the NHS Constitution Targets remain in situ and are highlighted in the table below.

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

Given the impact of COVID-19, the performance of certain key constitutional NHS targets for November 2021 have been directly impacted. To ensure that this impact is reflected, the monthly trajectories for 2021/22 are currently under review to ensure that they are reasonable and reflect a level of recovery for the Trust to achieve and have not yet been finalised.

2.0 Sustainability and Transformation Fund (STF)

Performance Improvement Trajectories

November 2021 performance against the Service Development and Improvement Plans (SDIP):

ID	Indicator	DQ Assurance	Target 21-22	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)		95%	95%	85.1%	81.8%	✗	▲	✗	
4.2	RTT Incomplete Pathways <18 weeks		92%	92%		56.2%	✗	▼		
4.9	62 day standard (Quarterly)		85%	85%		77.2%	✗	▲		

In November 2021 the ED performance was 81.8%; an improvement in performance when compared to 80.7% in October 2021. Further, MKUH performance was significantly higher than both the national overall performance of 74.0% and the majority of its Peer Group (see Appendix for details).

The Trust's RTT Incomplete Pathways <18 weeks performance stood at 56.2% at the end of November 2021. This was a deterioration on the performance at the end of October 2021 of 58.7%.

The Trust has put in place robust activity recovery plans, which will support further improvement in RTT performance and closely manage the cancellation of any non-urgent elective activity and treatment for patients on an incomplete RTT pathway.

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

For Q2 2021/22, the Trust's provisional 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) was 77.2% against a national target of 85%.

The provisional performance of the percentage of patients who started treatment within 31 days of a decision to treat was 95.9% against a national target of 96%. The percentage of patients who

attended an outpatient appointment within two weeks of an urgent referral by their GP for suspected cancer was 86.3% against a national target of 93%.

3.0 Urgent and Emergency Care

In November 2021, three of the six key performance indicators measured in urgent and emergency care showed an improvement:

ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.4	Cancelled Ops - On Day		1%	1%	0.86%	1.25%	✗	▲	✓	
3.2	Ward Discharges by Midday		25%	25%	15.4%	16.2%	✗	▼	✗	
3.4	30 day readmissions		7%	7%	7.3%	7.7%	✗	▲	✗	
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		53			74	✗	▼		
3.9	Ambulance Handovers >30 mins (%)		5%	5%	12.1%	15.5%	✗	▲	✗	
4.2	RTT Incomplete Pathways <18 weeks		92%	92%		56.2%	✗	▼		

Cancelled Operations on the Day

In November 2021, there were 32 operations cancelled on the day for non-clinical reasons as detailed below:

Cancellation Reason	Number of Cancellations
Staffing Issue	13
Insufficient Time	6
Patient Circumstances	5
Bed Availability	4
POA not updated	2
Equipment Availability	1
Site Issues	1

Readmissions

The Trust's 30-day emergency readmission rate in November 2021 was 7.7% (please note that the readmission rate in November 2021 may include patients that were readmitted with Covid-19).

Performance showed a slight improvement compared to the October 2021 rate of 7.9%.

Delayed Transfers of Care (DTOC)

The number of DTOC patients reported at midnight on the last Thursday of November 2021 was 38 patients: 32 in Medicine and six in Surgery.

This was a deterioration in performance when compared to the number of DTOC patients reported at midnight on the last Thursday of October (27).

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 74. This was a slight increase compared to the 72 super stranded patients reported at the end of October 2021.

Ambulance Handovers

In November 2021, the percentage of ambulance handovers to the Emergency Department taking more than 30 minutes was 15.5%.

This was an improvement in performance when compared to the October 2021 value of 17.5%.

4.0 Elective Pathways

ID	Indicator	DQ Assurance	Target 21-22	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%	88.2%	91.2%	✓	▼	✓	
3.5	Follow Up Ratio		1.5		1.30	1.26	✓	▲	✓	
4.2	RTT Incomplete Pathways <18 weeks		92%	92%		56.2%	✗	▼		

Overnight Bed Occupancy

Overnight bed occupancy was 91.2% in November 2021. This was a deterioration compared to the October 2021 occupancy of 86.6% and the highest value year to date. However, it remains within the 93% threshold.

Follow up Ratio

The Trust outpatient follow up ratio in November 2021 was 1.26 which was an improvement in performance when compared to the October 2021 ratio of 1.28.

RTT Incomplete Pathways

The Trust's RTT Incomplete Pathways <18 weeks at the end of November 2021 was 56.2% and the number of patients waiting more than 52 weeks without being treated was 841. These patients were in Surgery (716 patients), Medicine (70 patients), Women and Children (53 patients) and Core Clinical (2 patients).

Diagnostic Waits <6 weeks

The Trust 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 November 2021, with a performance of 71.6%.

This was a deterioration in performance when compared to the October 2021 performance of 73.6%.

5.0 Patient Safety

Infection Control

In November 2021 there were no reported cases of MRSA, E.Coli, C.Diff or MSSA.

ENDS

Appendix 1: ED Performance - Peer Group Comparison

The following Trusts have been historically viewed as peers of MKUH:

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

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

September 2021 to November 2021 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	Sep-21	Oct-21	Nov-21
Homerton University Hospital NHS Foundation Trust	86.2%	85.8%	86.5%
Milton Keynes University Hospital NHS Foundation Trust	82.1%	80.7%	81.8%
Southport And Ormskirk Hospital NHS Trust	78.1%	77.4%	79.0%
The Hillingdon Hospitals NHS Foundation Trust	69.7%	73.1%	72.4%
Buckinghamshire Healthcare NHS Trust	72.1%	74.5%	72.1%
Northampton General Hospital NHS Trust	73.6%	70.0%	70.3%
North Middlesex University Hospital NHS Trust	72.2%	64.0%	68.7%
Oxford University Hospitals NHS Foundation Trust	72.1%	69.4%	67.8%
Mid Cheshire Hospitals NHS Foundation Trust	62.4%	63.9%	67.4%
Barnsley Hospital NHS Foundation Trust	70.2%	68.4%	62.3%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	64.5%	62.3%	60.6%
The Princess Alexandra Hospital NHS Trust	62.9%	61.1%	59.6%
Bedfordshire Hospitals NHS Foundation Trust	-	-	-
Kettering General Hospital NHS Foundation Trust	-	-	-

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

Board Performance Report 2021/22
November 2021 (M08)

NHS
Milton Keynes University Hospital
NHS Foundation Trust

OBJECTIVE 1 - PATIENT SAFETY										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
1.1	Mortality - (HSMR)		100	100		94.3	✓	▼		
1.2	Mortality - (SHMI)		100	100		113.63	✗	▼		
1.3	Never Events		0	0	1	0	✓	▲	✗	
1.4	Clostridium Difficile		10	<7	5	0	✓	▬	✓	
1.5	MRSA bacteraemia (avoidable)		0	0	1	0	✓	▬	✗	
1.6	Falls with harm (per 1,000 bed days)		0.12	0.12	0.14	0.07	✓	▲	✗	
1.7a	Midwife to birth ratio (Required by Birth Rate Plus)		28	28	28	28	✓	▬	✓	
1.7b	Midwife to birth ratio (Actual for Month)					33		▲		
1.8	Incident Rate (per 1,000 bed days)		60	60	51.35	32.88	✗	▼	✗	
1.9	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▬	✓	
1.10	E-Coli		18	12	8	0	✓	▲	✓	
1.11	MSSA		5	<4	6	0	✓	▲	✗	
1.12	VTE Assessment		95%	95%	97.7%	96.9%	✓	▼	✓	

OBJECTIVE 2 - PATIENT EXPERIENCE										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.2	RED Complaints Received				0	0		▬		
2.3	Complaints response in agreed time		90%	90%	92.0%	84.3%	✗	▼	✓	
2.4	Cancelled Ops - On Day		1%	1%	0.86%	1.25%	✗	▲	✓	
2.5	Over 75s Ward Moves at Night		1,800	1,200	818	103	✓	▲	✓	
2.6	Mixed Sex Breaches		0	0	0	0	✓	▬	✓	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS										
ID	Indicator	DQ Assurance	Target 21-22	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%	88.2%	91.2%	✓	▼	✓	
3.2	Ward Discharges by Midday		25%	25%	15.4%	16.2%	✗	▼	✗	
3.3	Weekend Discharges		70%	70%	59.2%	55.1%	✗	▼	✗	
3.4	30 day readmissions		7%	7%	7.3%	7.7%	✗	▲	✗	
3.5	Follow Up Ratio		1.5		1.30	1.26	✓	▲	✓	
3.6.1	Number of Stranded Patients (LOS>=7 Days)		184			199	✗	▲		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		53			74	✗	▼		
3.7	Delayed Transfers of Care		20			38	✗	▼		
3.8	Discharges from PDU (%)		15%	15%	7.9%	9.8%	✗	▲	✗	
3.9	Ambulance Handovers >30 mins (%)		5%	5%	12.1%	15.5%	✗	▲	✗	

OBJECTIVE 4 - KEY TARGETS										
ID	Indicator	DQ Assurance	Target 21-22	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)		95%	95%	85.1%	81.8%	✗	▲	✗	
4.2	RTT Incomplete Pathways <18 weeks		92%	92%		56.2%	✗	▼		
4.4	RTT Total Open Pathways		33,715	30,985		33,320	✗	▼		
4.5	RTT Patients waiting over 52 weeks		1,252	914		841	✓	▼		
4.6	Diagnostic Waits <6 weeks		99%	99%		71.6%	✗	▼		
4.7	All 2 week wait all cancers (Quarterly)		93%	93%		86.3%	✗	▲		
4.8	31 days Diagnosis to Treatment (Quarterly)		96%	96%		95.9%	✗	▲		
4.9	62 day standard (Quarterly)		85%	85%		77.2%	✗	▲		

OBJECTIVE 5 - SUSTAINABILITY										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
5.1	GP Referrals Received		Not Available		59,268	6,182	Not Available	▲	Not Available	
5.2	A&E Attendances		103,529	69,583	68,258	8,264	✓	▲	✓	
5.3	Elective Spells (PBR)		24,474	16,946	16,423	2,229	✗	▲	✗	
5.4	Non-Elective Spells (PBR)		39,224	27,100	21,754	2,775	✓	▼	✓	
5.5	OP Attendances / Procs (Total)		392,098	264,965	273,661	34,957	✓	▼	✓	
5.6	Outpatient DNA Rate		6%	6%	6.3%	6.8%	✗	▲	✗	

OBJECTIVE 7 - FINANCIAL PERFORMANCE										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
7.1	Income £'000		316,858	212,728	211,934	25,330	✗	▼	✗	
7.2	Pay £'000		(203,273)	(137,082)	(136,884)	(16,345)	✓	▲	✓	
7.3	Non-pay £'000		(96,446)	(64,552)	(64,386)	(7,822)	✓	▼	✓	
7.4	Non-operating costs £'000		(18,239)	(12,194)	(12,236)	(1,223)	✓	▲	✗	
7.5	I&E Total £'000		(1,100)	(1,100)	(1,572)	(60)	✗	▲	✗	
7.6	Cash Balance £'000		25,668	36,975		62,101	✓	▲		
7.7	Savings Delivered £'000		6,850	4,604	0	0	✗	▬	✗	
7.8	Capital Expenditure £'000		50,799	18,908	10,058	2,055	✓	▼	✓	

OBJECTIVE 8 - WORKFORCE PERFORMANCE										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
8.1	Staff Vacancies % of establishment		10%	10%		10.1%	✗	▲		
8.2	Agency Expenditure %		5%	5%	3.8%	4.3%	✓	▼	✓	
8.3	Staff Sickness % - Days Lost (Rolling 12 months)		4%	4%		4.9%	✗	▼		
8.4	Appraisals		90%	90%		91.0%	✓	▬		
8.5	Statutory Mandatory training		90%	90%		96.0%	✓	▲		
8.6	Substantive Staff Turnover		9%	9%		8.3%	✓	▼		

OBJECTIVES - OTHER										
ID	Indicator	DQ Assurance	Target 21-22	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
O.1	Total Number of NICE Breaches		10	10		4	✓	▬		
O.2	Rebooked cancelled OPs - 28 day rule		95%	95%	81.3%	80.5%	✗	▲	✗	
O.4	Overdue Incidents >1 month		0	0		121	✗	▲		
O.5	Serious Incidents		20	<14	68	8	✗	▲	✗	
O.8	Completed Job Plans (Consultants)		90%	90%		90%	✓	▼		

Key: Monthly/Quarterly Change

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

YTD Position

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

Data Quality Assurance Definitions

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

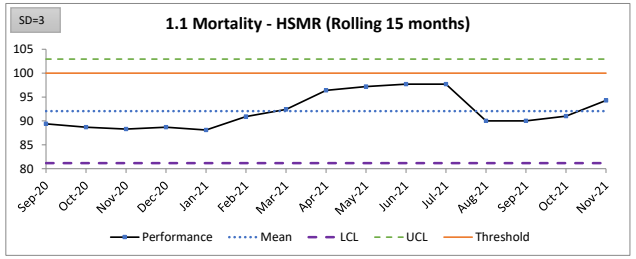
* Independently Audited – refers to an independent audit undertaken by either the Internal Auditor, External Auditors or the Data Quality Audit team.

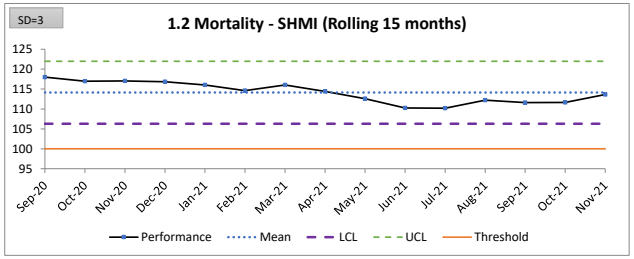
Date Produced: 14/12/2021

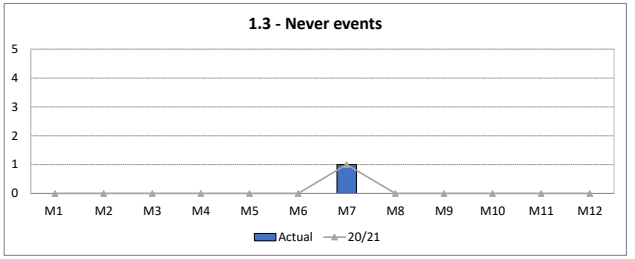
Board Performance Report 2021/22

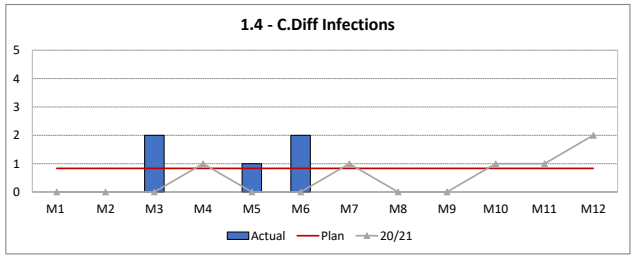
OBJECTIVE 1 - PATIENT SAFETY

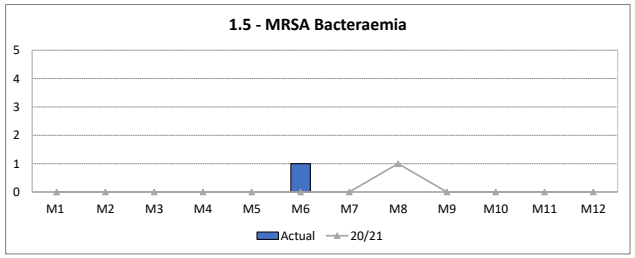
Milton Keynes University Hospital NHS Foundation Trust

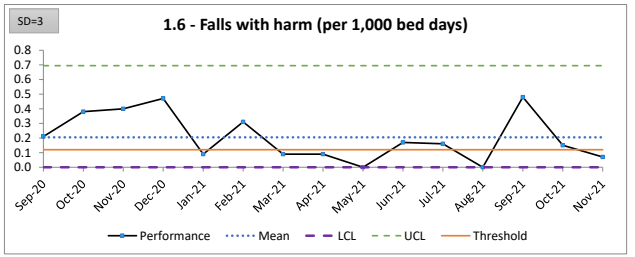


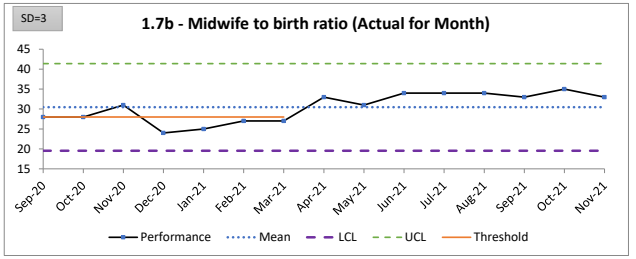


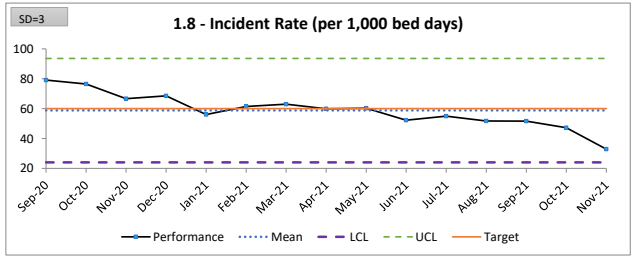


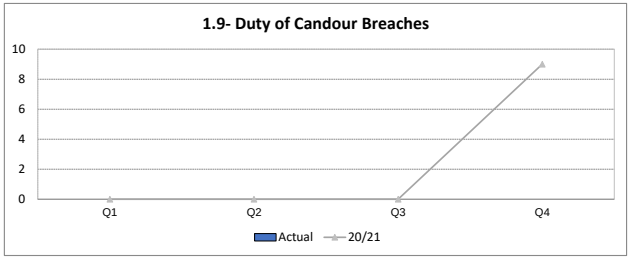


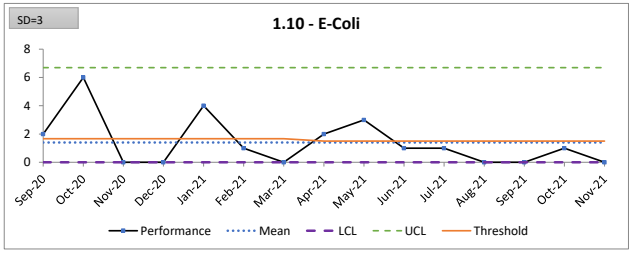


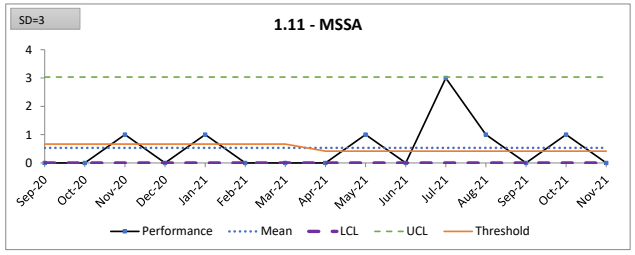


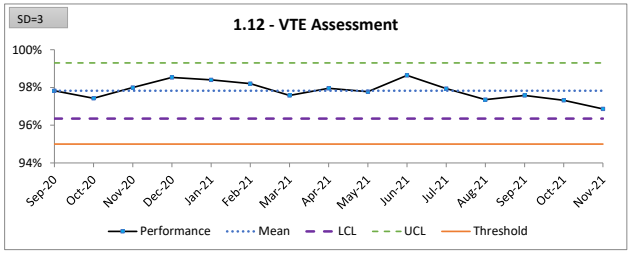












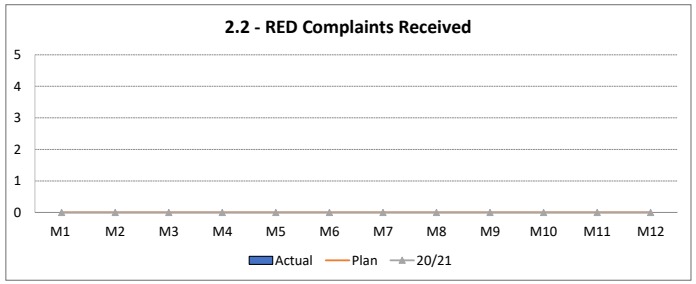
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

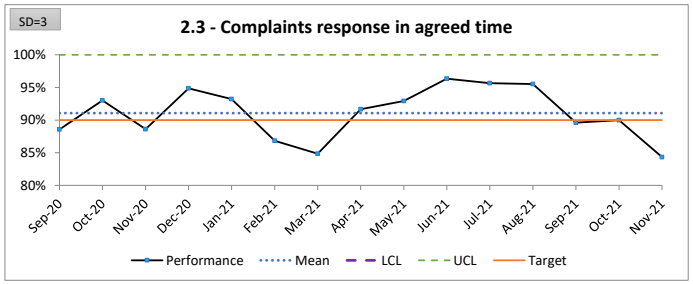
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

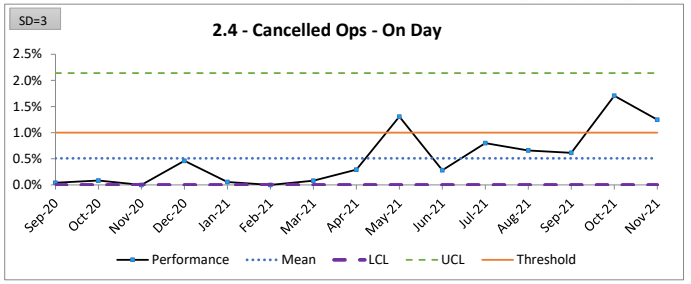
Board Performance Report 2021/22

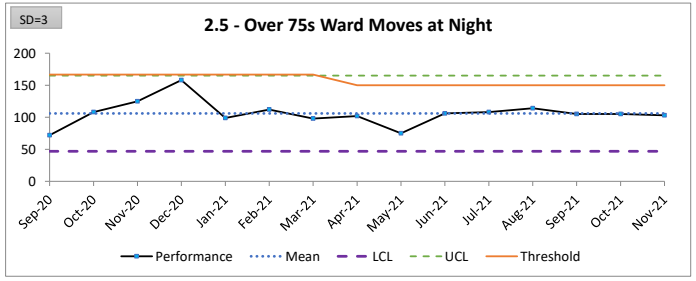
OBJECTIVE 2 - PATIENT EXPERIENCE

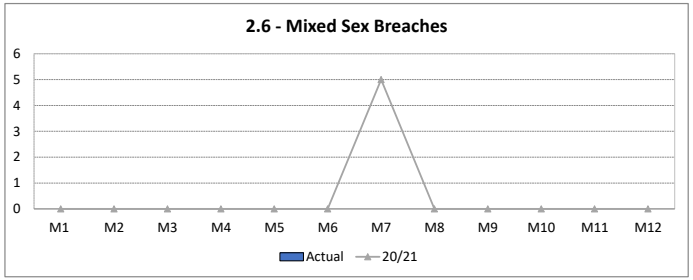
NHS
Milton Keynes
University Hospital
NHS Foundation Trust











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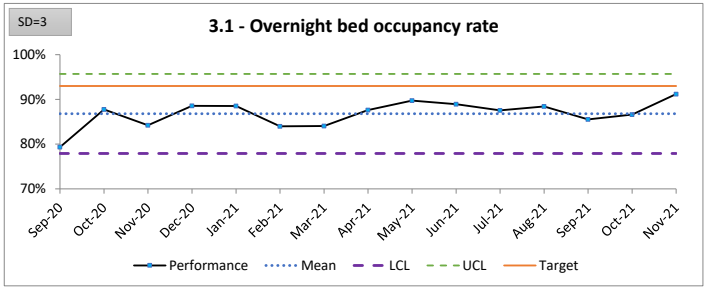
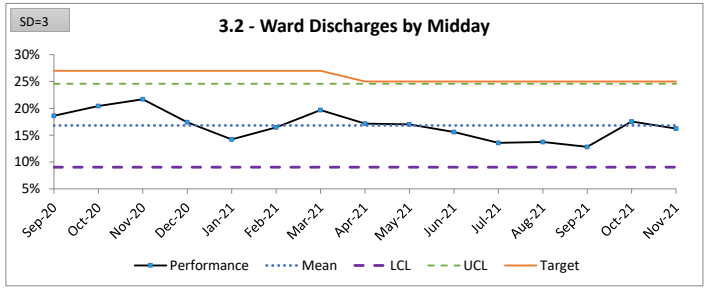
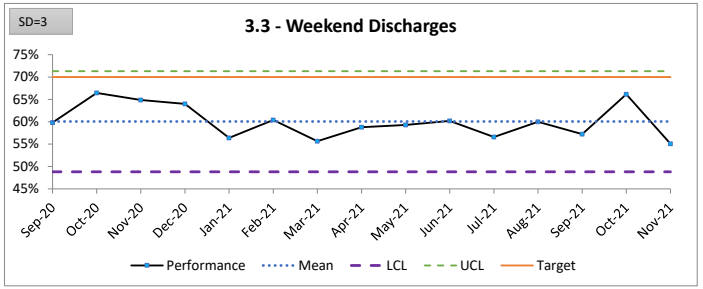
Board Performance Report 2021/22

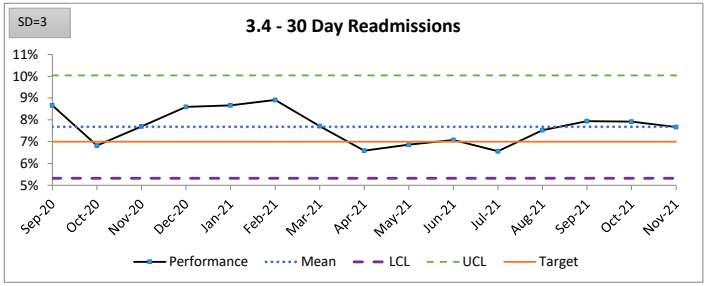
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

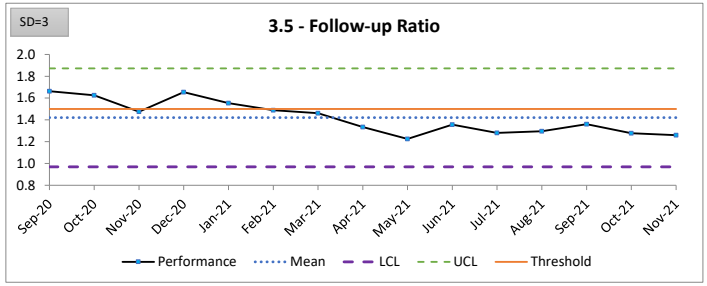
Milton Keynes University Hospital NHS Foundation Trust

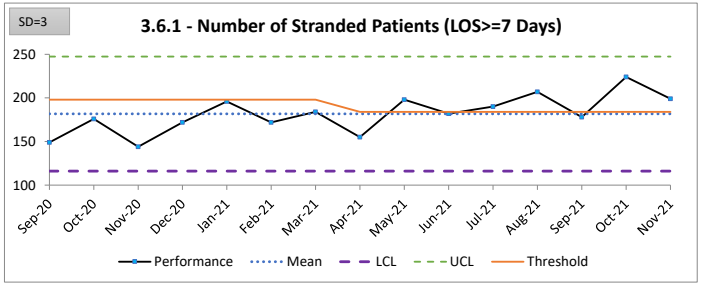


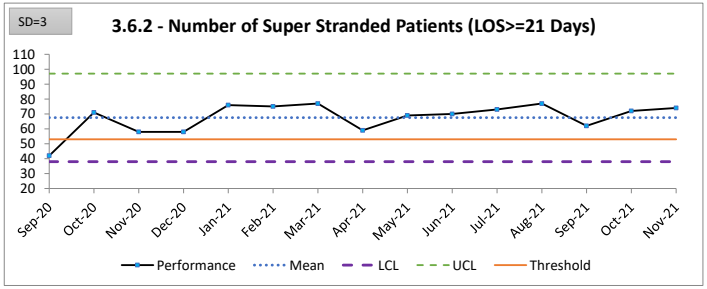


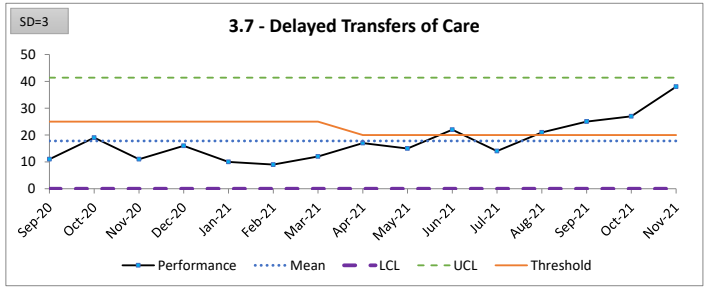


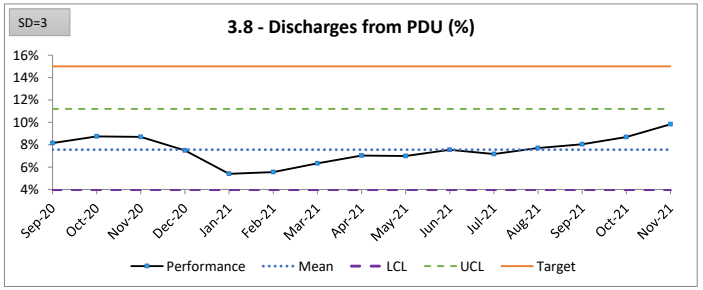


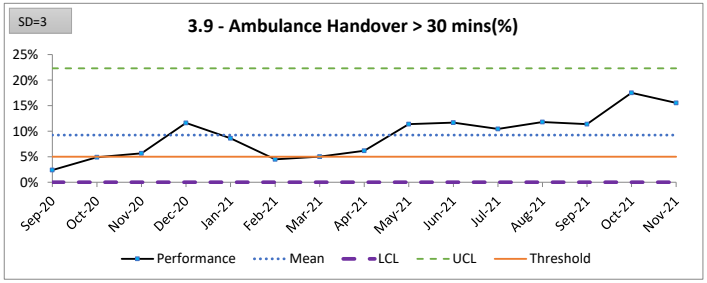












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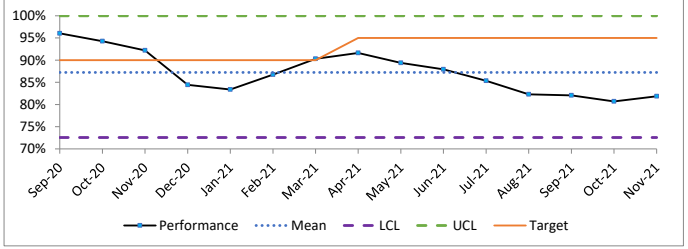
Board Performance Report 2021/22

OBJECTIVE 4 - KEY TARGETS

Milton Keynes University Hospital NHS Foundation Trust

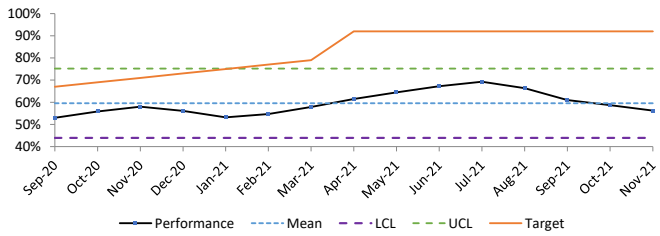
SD=3

4.1 - ED Hour Target (includes UCS)

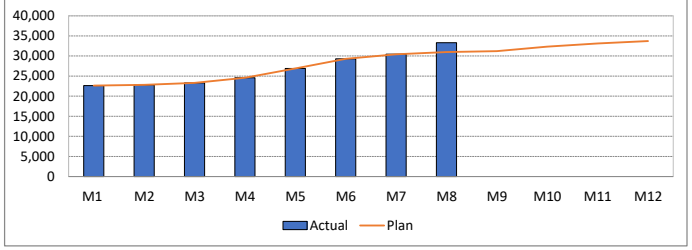


SD=3

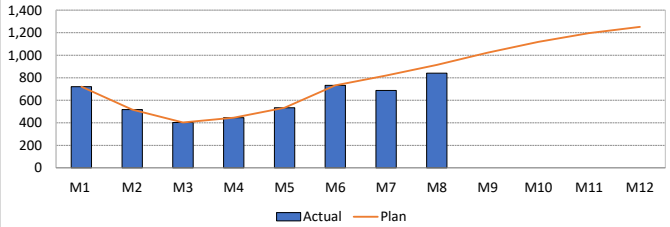
4.2 - RTT Incomplete Pathways <18 weeks



4.4 - RTT Total Open Pathways

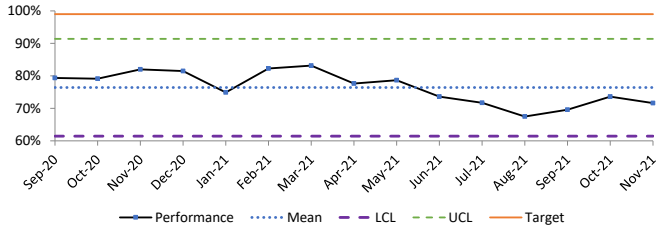


4.5 - RTT Patients Waiting Over 52 weeks



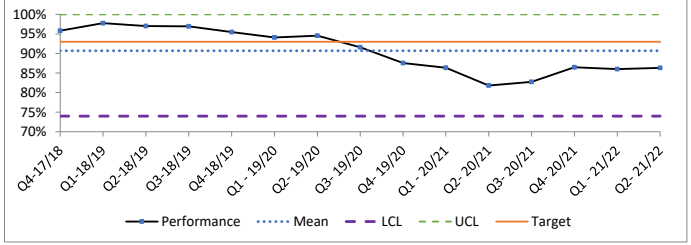
SD=3

4.6 - Diagnostic Waits < 6 weeks



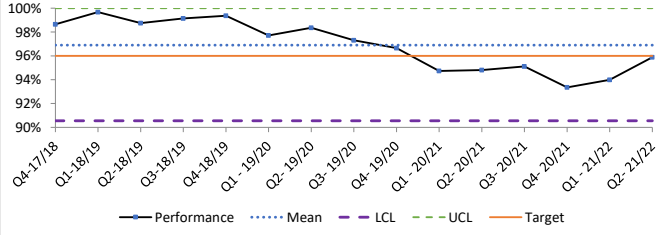
SD=3

4.7 - 2 Week Wait - Cancer



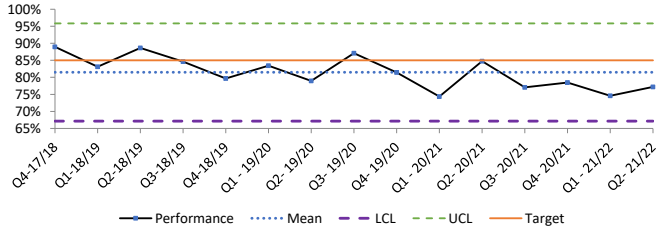
SD=3

4.8 - 31 day diagnosis to treatment - Cancer



SD=3

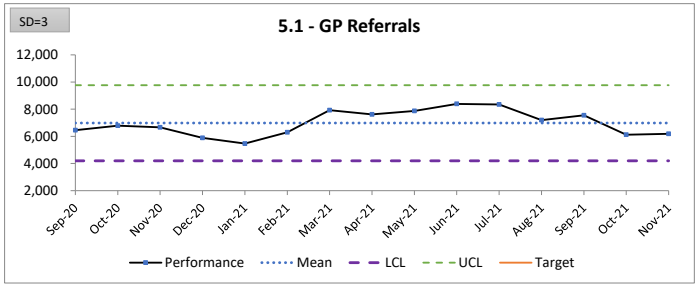
4.9 - 62 day standard - Cancer

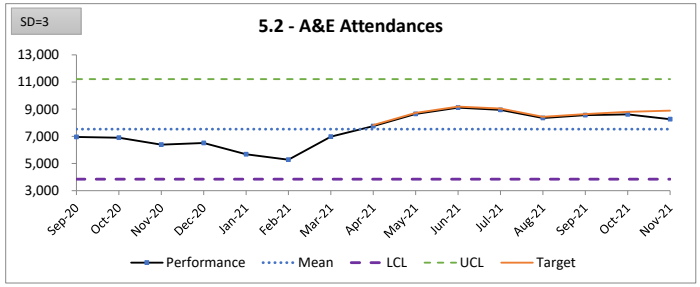


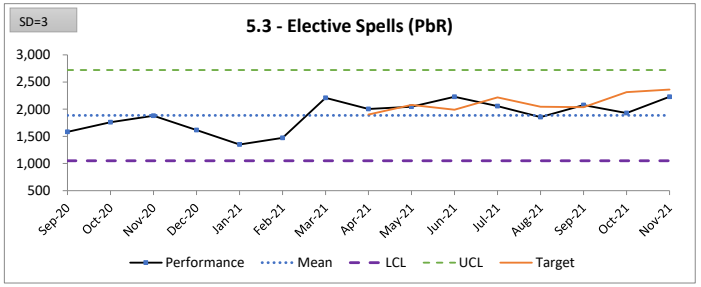
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

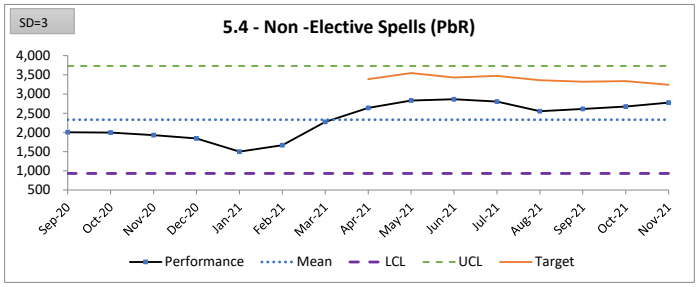
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

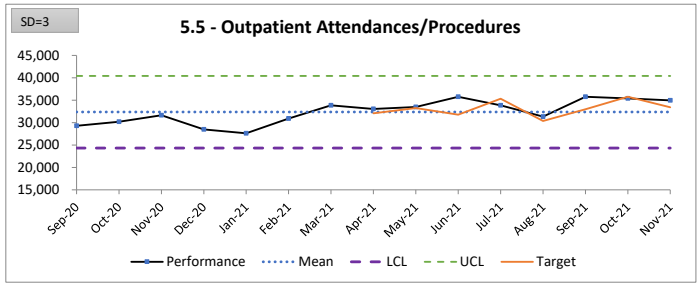
OBJECTIVE 5 - SUSTAINABILITY

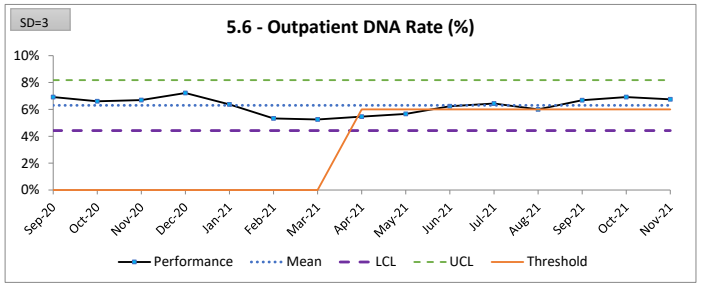












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- Average on a rolling 15 months/quarterly
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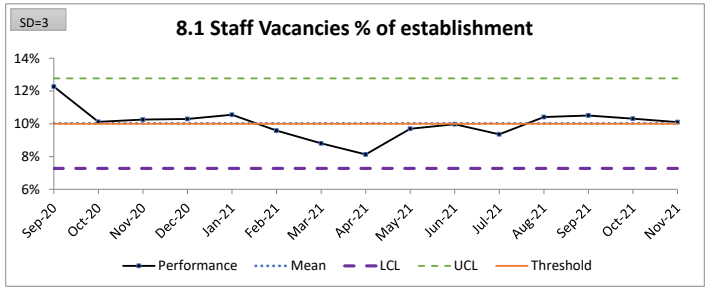
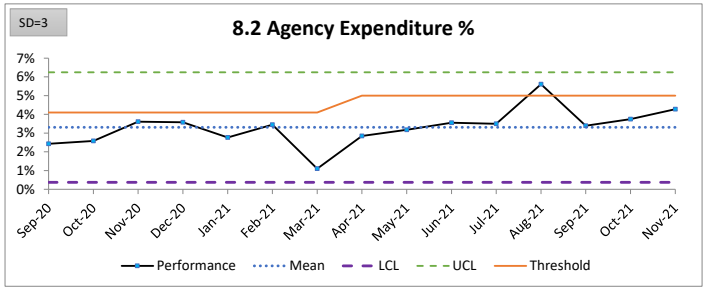
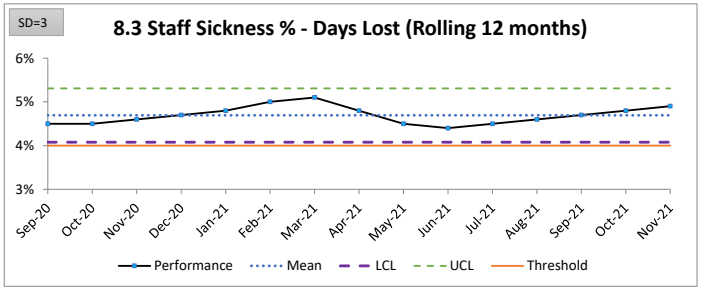
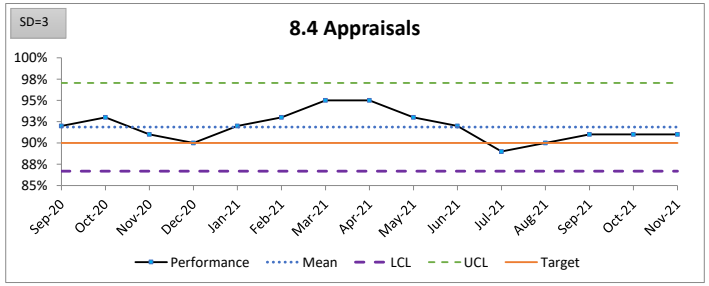
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

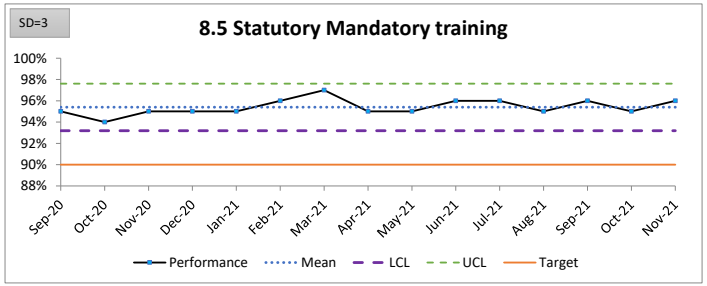
OBJECTIVE 8 - WORKFORCE PERFORMANCE

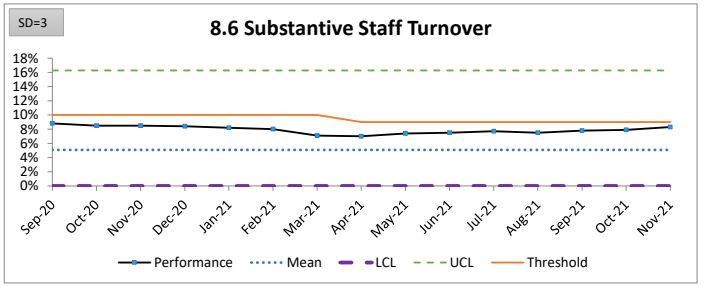












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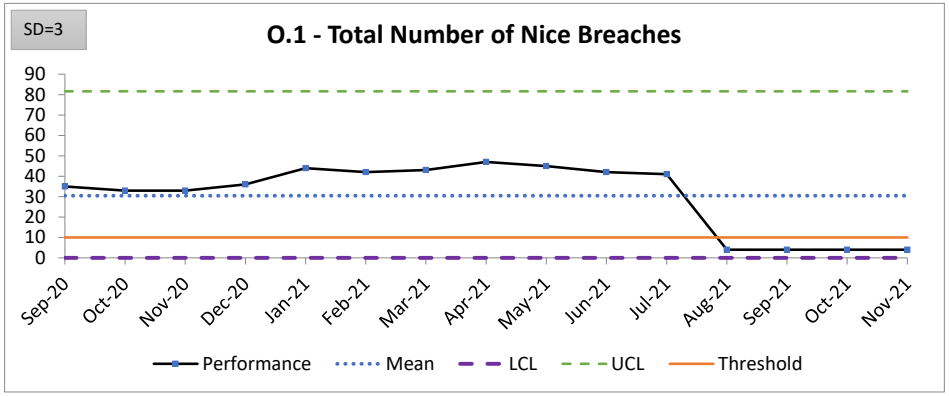

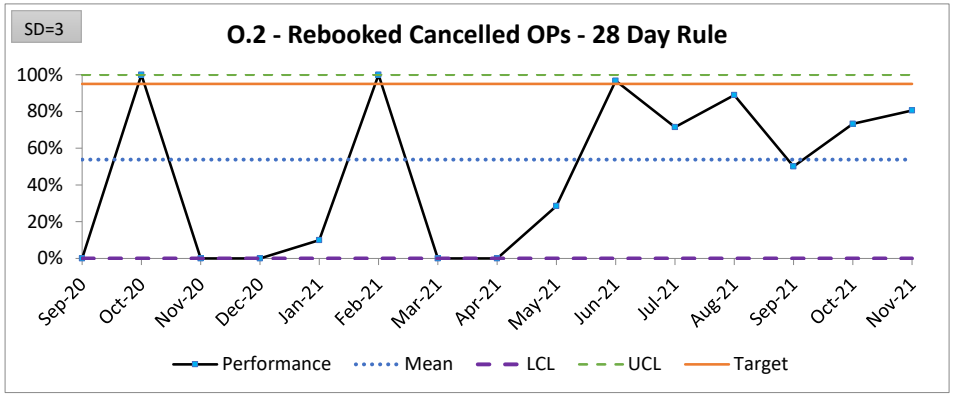

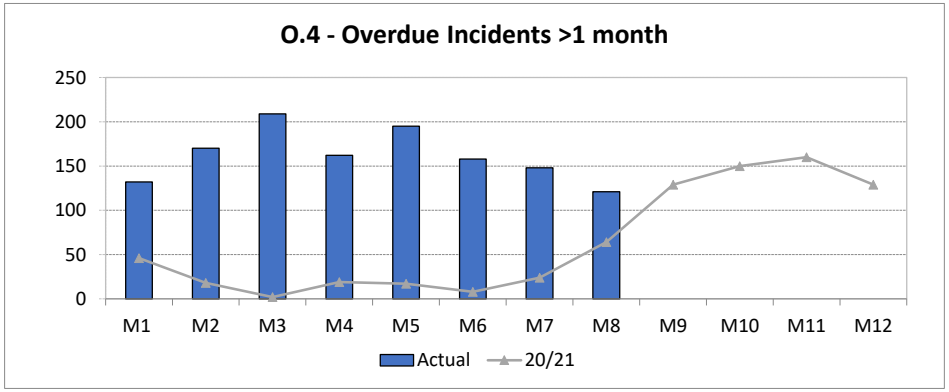

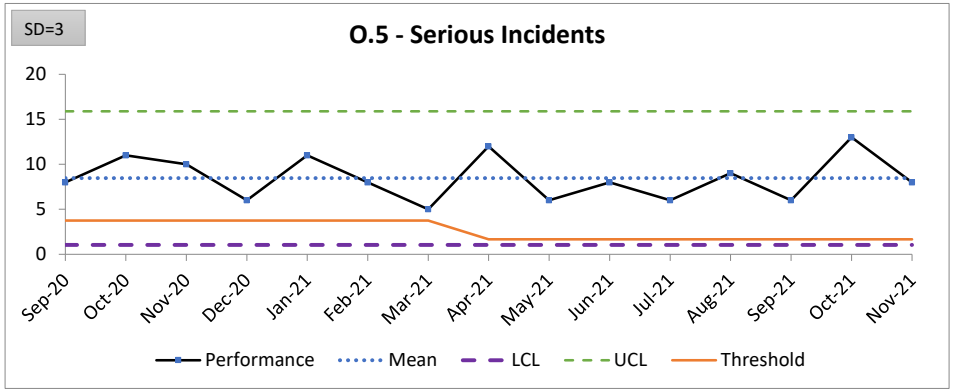

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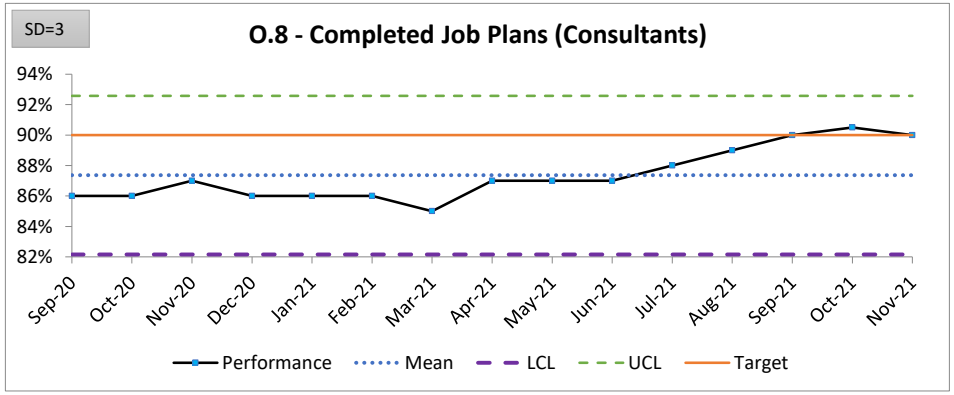
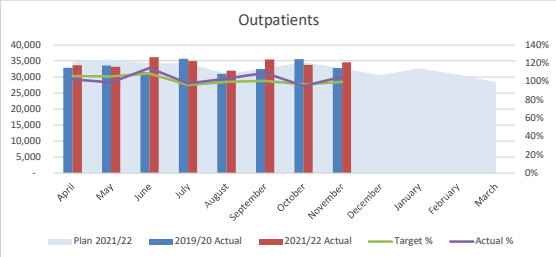
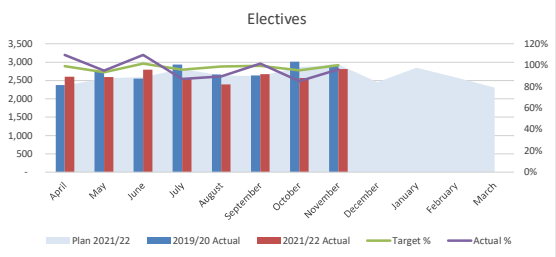


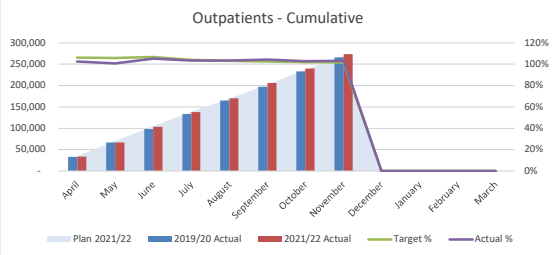
Accelerator Comparison

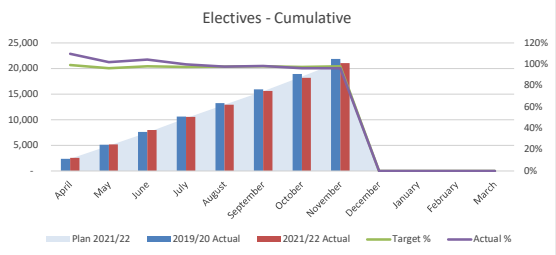
Elective and Outpatient Plan Vs Actual Accelerator Comparison

Include		Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N
Month		April	May	June	July	August	September	October	November	December	January	February	March
Outpatients	2019/20 Actual	32,884	33,527	31,520	35,695	31,035	32,479	35,585	32,779				
	Plan 2021/22	34,840	35,432	34,281	34,271	30,913	32,644	34,512	32,632	30,522	32,640	30,732	28,388
	Target %	106%	106%	109%	96%	100%	101%	97%	100%				
	2021/22 Actual	**33,733**	**33,190**	**36,179**	**34,986**	**32,005**	**35,513**	**33,790**	**34,516**				
	Actual %	103%	99.0%	114.8%	98.0%	103.1%	109.3%	95.0%	105.3%				
Electives	2019/20 Actual	2,378	2,732	2,551	2,935	2,667	2,638	3,011	2,926				
	Plan 2021/22	2,360	2,556	2,590	2,810	2,638	2,622	2,868	2,931	2,453	2,852	2,584	2,308
	Target %	99%	94%	102%	96%	99%	99%	95%	100%				
	2021/22 Actual	**2,606**	**2,597**	**2,795**	**2,557**	**2,393**	**2,673**	**2,565**	**2,815**				
	Actual %	110%	95.1%	109.6%	87.1%	89.7%	101.3%	85.2%	96.2%				





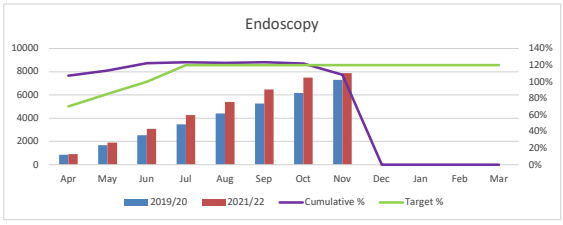


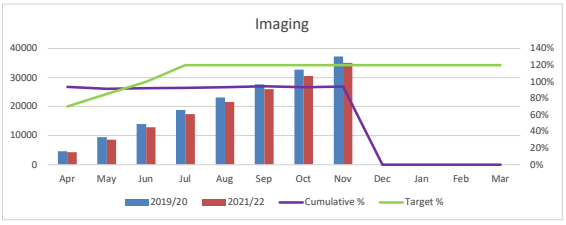


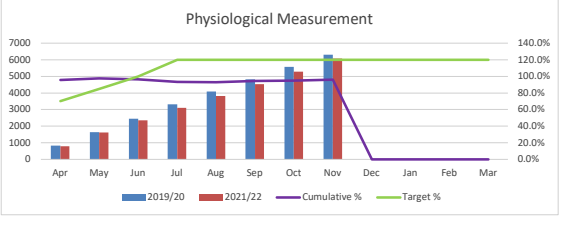
Key:
2019/20 Actual - represents the actual activity associated with FY 2019/20
Plan 2021/22 - represent the divisional planned activity that have been provided by each of the clinical divisions for FY 2021/22
Target % - represents that anticipated "Target Percentage" based on the divisional planned activity for FY 2021/22 against the actual activity during FY 2019/20
2021/22 Actual - represents the actual activity associated with FY 2021/22
Actual % - represents that "Actual Percentage" based on the divisional plan for FY 2021/22 against the FY 2021/22 Actual

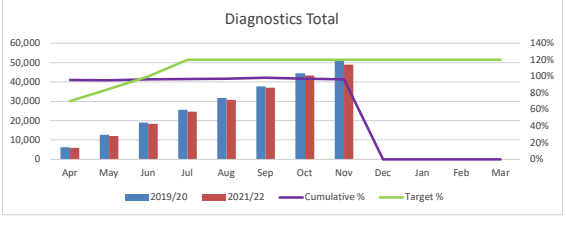
Diagnostics Accelerator Comparison

Include		Y	Y	Y	Y	Y	Y	y	Y	N	N	N	N
Month		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Endoscopy	Colonoscopy	355	409	473	411	408	392	414	98				
	Cystoscopy	168	190	268	286	268	277	218	202				
	Flexi sigmoidoscopy	87	85	104	122	106	77	78	21				
	Gastroscopy	299	311	329	379	347	325	308	70				
	Total	**909**	**995**	**1,174**	**1,198**	**1,129**	**1,071**	**1,018**	**391**	-	-	-	-
	Total as % of 2019/20	**107.1%**	**119.6%**	**140.1%**	**125.7%**	**119.9%**	**126.6%**	**113.0%**	**34.7%**				
	Target	70%	85%	100%	120%	120%	120%	120%	120%	120%	120%	120%	120%
Imaging	Computed Tomography	850	940	796	888	967	796	947	1,006				
	Magnetic Resonance Imaging	460	497	592	651	643	556	619	537				
	Non-obstetric ultrasound	3,007	2,846	2,891	2,922	2,647	3,069	2,900	2,957				
	Total	**4,317**	**4,283**	**4,279**	**4,461**	**4,257**	**4,421**	**4,466**	**4,500**	-	-	-	-
	Total as % of 2019/20	**93.5%**	**89.3%**	**93.2%**	**93.6%**	**97.1%**	**99.5%**	**88.0%**	**98.3%**				
	Target	70%	85%	100%	120%	120%	120%	120%	120%	120%	120%	120%	120%
Physiological Measurement	Audiology - Audiology Assessments	180	166	128	106	107	123	133	141				
	Cardiology - echocardiography	303	409	355	413	336	383	323	364				
	Cardiology - electrophysiology	238	203	210	190	193	164	214	220				
	Respiratory physiology - sleep studies	56	22	44	32	64	63	56	71				
	Urodynamics - pressures & flows	17	16	13	4	-	4	4	3				
	Total	**794**	**816**	**750**	**745**	**700**	**737**	**730**	**799**	-	-	-	-
	Total as % of 2019/20	**95.8%**	**99.6%**	**94.2%**	**84.7%**	**90.3%**	**103.1%**	**96.7%**	**107.8%**				
	Target	70%	85%	100%	120%	120%	120%	120%	120%	120%	120%	120%	120%
Grand Total	Grand Total	6,020	6,094	6,203	6,404	6,086	6,229	6,214	5,690				
	Grand Total as % of 2019/20	95.6%	94.5%	99.7%	97.1%	99.8%	103.8%	92.3%	88.3%				
	Target	70%	85%	100%	120%	120%	120%	120%	120%	120%	120%	120%	120%



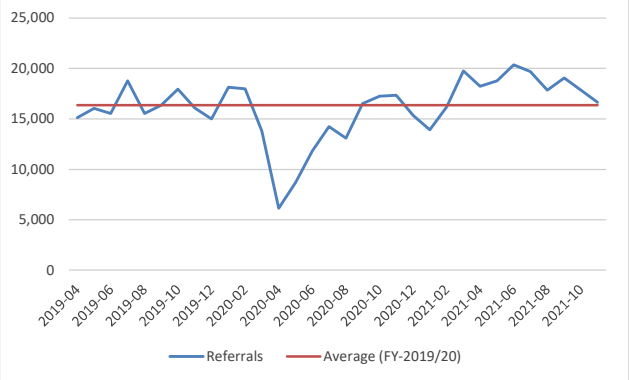




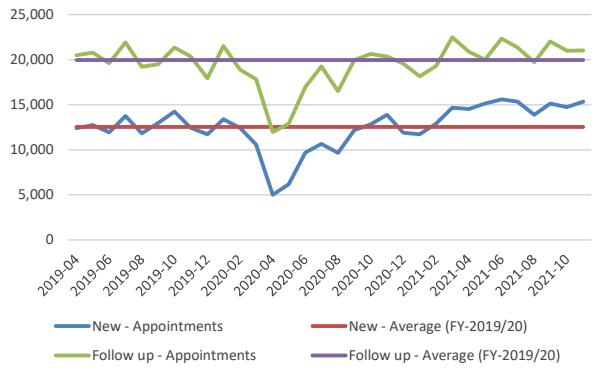


Recovery Plan Graphs

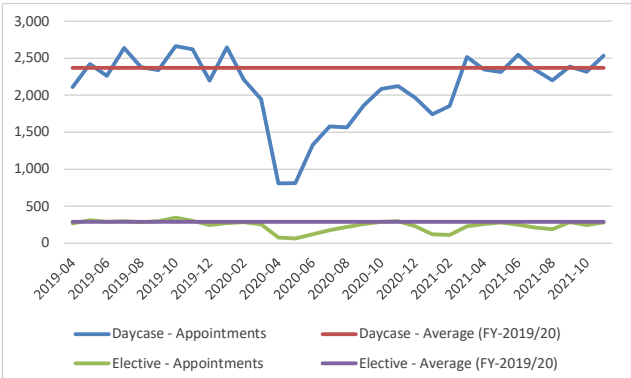
Referrals



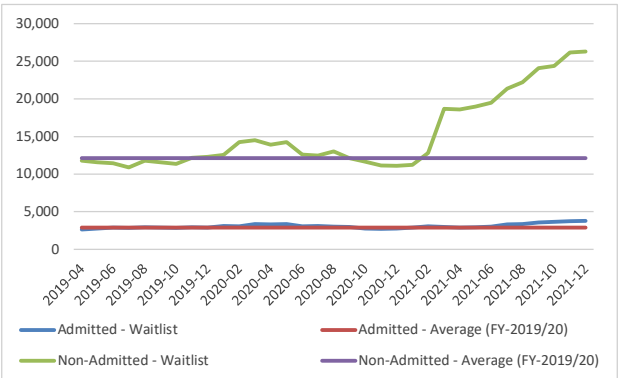
Outpatients



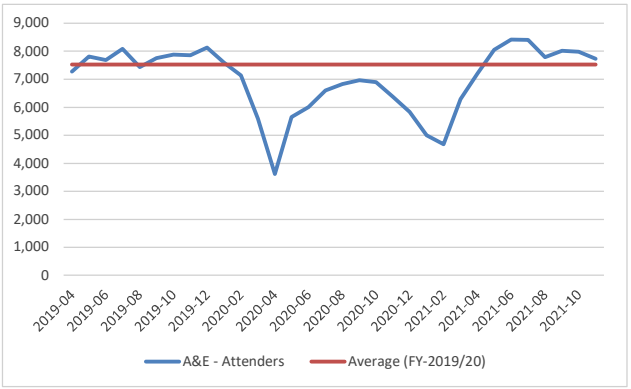
Elective



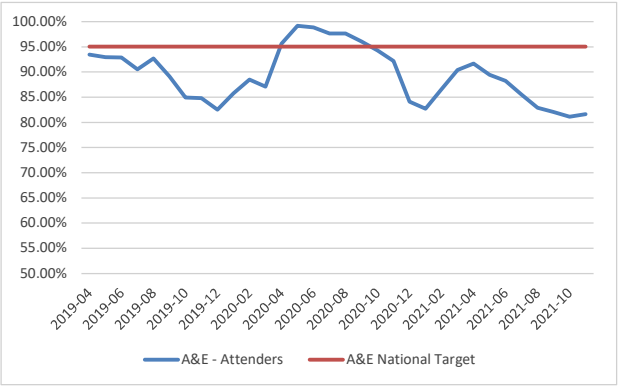
Waiting List



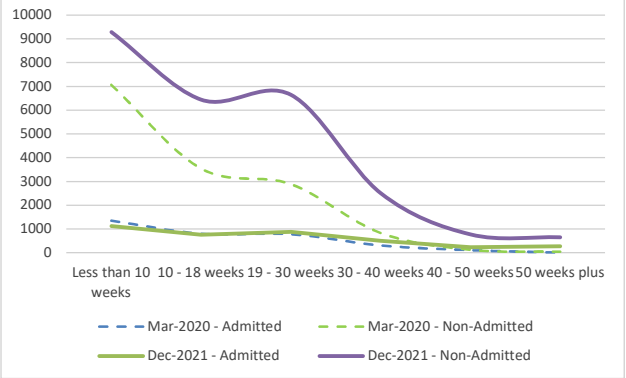
A&E Arrivals



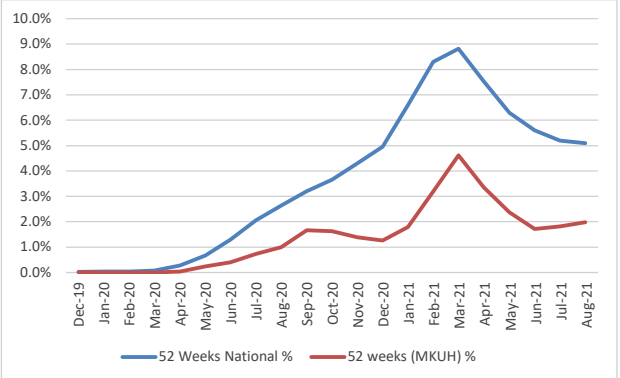
A&E Performance



Waiting List Shape



% 52+ weeks waiters



NHS
Milton Keynes University Hospital
NHS Foundation Trust

Meeting title	**Public Board**	**Date: 13 January 2022**
Report title:	**Finance Paper Month 8 2021-22**	**Agenda item: 11**
Lead director **Report authors**	Terry Whittle Sue Fox	Director of Finance Deputy Head of Financial Management
FoI status:	Public document	

Report summary	An update on the financial position of the Trust at Month 8 (November 2021)			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** [x]	**Decision** ☐
Recommendation	Trust Board is asked to note the financial position of the Trust as of 30th November and the proposed actions and risks therein.			

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	
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	
Appendices	Pages 13-15

FINANCE REPORT FOR THE MONTH TO 30th NOVEMBER 2021

TRUST BOARD

CONTENTS

EXECUTIVE SUMMARY

(1. & 2.) Revenue – Clinical revenue is paid as part of a block contract. Clinical revenue is below plan due to income for the Accelerator programme which has not been recognised (£1m). Non-clinical revenue is higher than plan due to additional maternity (Ockenden) funding.

(3. & 4.) Operating expenses – Pay is on plan with higher temporary staffing costs offset by substantive vacancies. Non-pay is underspent due to lower than planned spend on elective activity (e.g., on clinical consumables).

(5.) Non-operating expenditure – Non-operating expenditure is underspent due to a reduction in depreciation.

(8.) Covid expenditure– Additional direct costs attributed to Covid (e.g., swab pods and enhanced cleaning).

(10.) Financial Efficiency– Financial efficiency is being delivered by managing operating costs within our allocated funding envelope (which included a 1.1% efficiency requirement) and transactional saving schemes.

(11.) Cash – The Trust cash balance is £62.1M, equivalent to 74 days cash to cover operating expenses. Balances include £19.5m for capital schemes.

(12.) Capital – The Trust is £2.5m lower than plan excluding the New Hospital Programme (NHP). The variance is driven by timing differences on the Maple Centre scheme. The Trust is forecasting a CDEL breach due to b/fwd capital expenditure plans for FY21.

(13.) Elective Recovery Fund– Lower than planned levels of ERF were recorded up to Month 8 (October). Operational issues and increased annual leave impacted delivery against plan.

(14.) ICS Financial Position – BLMK ICS is on plan at a breakeven position YTD.

Ref	All Figures in £'000	Month 8 YTD Plan	Month 8 YTD Actual	Month 8 YTD Var	Full Year Plan	Full Year Forecast	Full Year Var	RAG
1	Clinical Revenue	199,809	198,470	(1,339)	297,314	297,314	-	
2	Other Revenue	12,858	13,464	606	19,542	19,542	-	
3	Pay	(136,963)	(136,883)	80	(203,271)	(203,271)	-	
4	Non Pay	(64,762)	(64,386)	376	(96,446)	(96,446)	-	
5	Financing & Non-Ops	(12,493)	(12,235)	258	(18,634)	(18,634)	-	
6	Surplus/(Deficit)	(1,551)	(1,571)	(20)	(1,495)	(1,495)	-	
7	Control Total Surplus/(Deficit)	(1,100)	(1,100)	-	(1,100)	(1,100)	-	
8	Inc. COVID expenditure	(7,464)	(3,237)	4,227	(11,196)	(4,856)	6,341	
9	High Cost Drugs	(12,627)	(14,679)	(2,052)	(21,821)	(21,821)	-	
10	CIP Delivery	4,640	-	(4,640)	6,850	6,850	-	
11	Cash	36,975	62,101	25,126	25,668	33,768	8,100	
12a	Capital Plan (excluding NHP)	10,559	8,035	(2,524)	28,008*	35,008	7,000	
12b	Capital Plan (including NHP)	18,399	8,260	(10,139)	29,005*	36,005	7,000	
13	ERF Delivery	9,532	7,532	(2,000)	9,532	7,532	(2,000)	
14	ICS Financial Position	-	158	158	-	-	-	

* is revised CDEL allocation for 21/22

Key message

The Trust is reporting a £1.1m deficit for the period April to November, this position is consistent with the plan. The Trust is forecasting a £1.1m deficit for the year-end as part of a balanced BLMK aggregate system plan. The Trust has income surety based on a block contract. Funding is adequate to cover cost pressures (e.g., premium pay costs) associated with the current operating environment.

The Trust has a robust cash position and is paying creditors promptly. The capital programme is behind plan due to timing differences (plan phasing) in the Maple Centre scheme, this is forecast to be on plan by the end of the year.

FINANCIAL PERFORMANCE- OVERVIEW MONTH 8

2. **Summary Month 8**

For the month of November 2021, financial performance (on a Control Total basis) is a breakeven position, consistent with the plan.

3. Clinical Income
Clinical income shows a negative variance of £0.4m which is due to unrecognised Accelerator income. This is partly offset by catch up funding from specialist commissioning.

4. Other Income
Other income shows a favourable variance of 0.1m. This is due to additional income related to maternity staffing.

5. Pay
Pay spend is on plan with additional temporary staffing costs being offset by substantive vacancies. Further detail is included in Appendix 1.

6. Non-Pay
Non pay is also roughly on plan with variances on clinical consumables offset by drugs spend. Further detail is included in Appendix 1.

7. Non-Operating Expenditure
Non-operating expenditure is lower than plan in-month due to a reduction in depreciation costs.

	Month 8			Month 8 YTD			Plan		
All Figures in £'000	Plan *	Actual	Var	Plan	Actual	Var	Plan	Forecast	Var
Clinical Revenue	19,570	19,159	(411)	169,268	167,929	(1,339)	244,958	244,958	0
Other Revenue	1,725	1,799	74	12,734	13,330	596	19,051	19,051	0
Total Income	21,295	20,958	(337)	182,002	181,259	(743)	264,009	264,009	0
Pay	(16,355)	(16,345)	10	(136,963)	(136,883)	80	(203,271)	(203,271)	0
Non Pay	(7,869)	(7,822)	47	(64,762)	(64,386)	376	(96,446)	(96,446)	0
Total Operational Expenditure	(24,224)	(24,167)	57	(201,725)	(201,269)	456	(299,717)	(299,717)	0
EBITDA	(2,929)	(3,209)	(280)	(19,723)	(20,011)	(288)	(35,708)	(35,708)	0
Financing & Non-Op. Costs	(1,434)	(1,154)	281	(11,918)	(11,630)	288	(17,748)	(17,748)	0
Control Total Deficit (excl. top ups)	**(4,363)**	**(4,363)**	**0**	**(31,641)**	**(31,641)**	**0**	**(53,456)**	**(53,456)**	**0**
Adjustments excl. from control total:									
National Top up	3,430	3,430	0	24,010	24,010	0	41,160	41,160	0
COVID Top up	933	933	0	6,531	6,531	0	11,196	11,196	0
Control Total Deficit (incl. top ups)	**(0)**	**(0)**	**0**	**(1,100)**	**(1,100)**	**0**	**(1,100)**	**(1,100)**	**0**
Donated income	124	9	(115)	124	134	10	491	491	0
Depreciation	(74)	(69)	5	(550)	(554)	(4)	(834)	(834)	0
Rounding	(48)	0	48	(25)	(51)	(26)	(52)	(52)	0
Reported	**2**	**(60)**	**(62)**	**(1,551)**	**(1,571)**	**(20)**	**(1,495)**	**(1,495)**	**0**

*The plan figures in month 8 have been adjusted to account for the YTD adjustment to correct the H2 plan.

Key message
For the month of November 2021, the position on a Control Total basis is breakeven, which is on plan. Small underspends shown in-month are offset by reduced clinical income due to unrecognised Accelerator programme activity.

FINANCIAL PERFORMANCE- OVERVIEW YTD

8. **Summary Year to Date**

Cumulative financial performance (April to November) on a Control Total basis is a deficit of £1.1m. This is consistent with the plan. Overspends on pay and non-pay related to delivery of additional elective activity, and wage awards, are now included in the H2 plan bringing the total to a breakeven position.

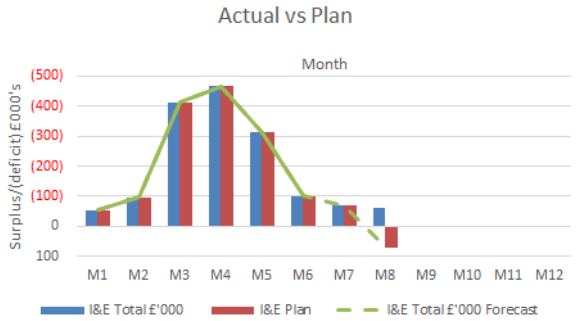
9. Clinical Income YTD
Clinical income shows a negative variance of £1.3m YTD, the Trust has recognised £7.6m related to ERF but has not recognised all the accelerator income. Further detail is included in Appendix 1.

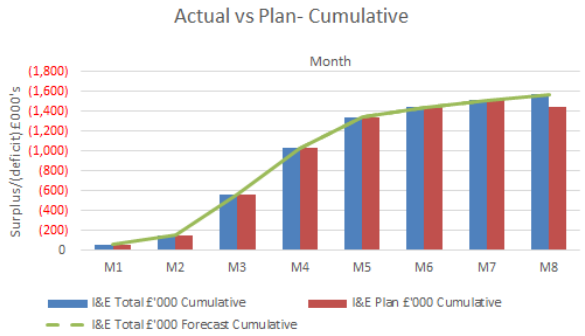
10. Other Income YTD
Other income is £0.6m above plan YTD due to receipt of additional education and training, research and development and maternity funding above planned levels.

11. Pay YTD
Pay is breakeven YTD. £3.5m of pay expenditure has been reported as a direct result of additional activity required to deliver elective recovery and the Trust has provided a further £1.4m for the anticipated cost of recovery. Further detail is included in Appendices 1 & 4.

12. Non-Pay YTD
There is a positive variance YTD of £0.4m. £2.4m of non-pay expenditure has been reported as a direct result of additional activity to deliver elective recovery. Further detail is included in Appendices 1 & 5.

13. Non-Operating Expenditure YTD
Non-operating expenditure is £0.2m under plan YTD due to reduced depreciation charges.





Key message
Up to November 2021, the position on a Control Total basis is a deficit of £1.1m. This is in line with the plan. Overspends on pay and non-pay relate to the delivery of additional clinical activity which is offset by additional income (ERF).

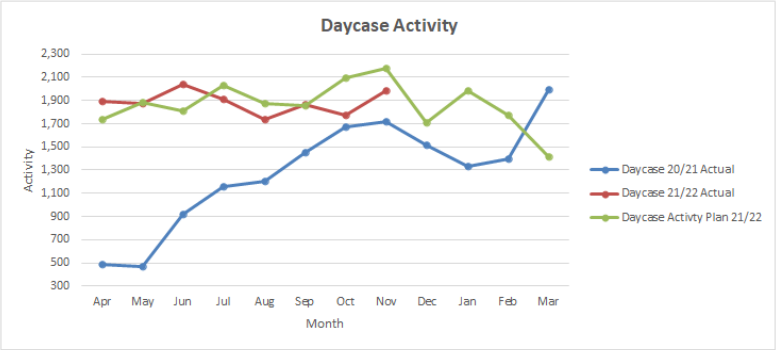
The Trust will continue to monitor operating costs to ensure expenditure incurred on additional activity is covered by ERF incentive payments.

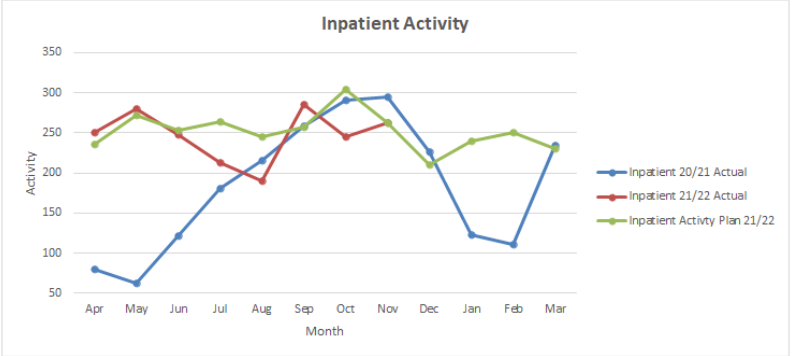
ACTIVITY PERFORMANCE & ERF

14. For the first half of the financial year activity in 2021/22 was to be measured against 2019/20 baseline, with expectations set by NHSE/I as a percentage of 2019/20 levels (adjusted for working days) Starting with 70% target in April rising by 5% increments each month, with the upper threshold set at 95%. Under this guidance the Trust developed its own recovery plan in line with activity requirements of the Accelerator programme, by which the Trust planned to meet 120% of the 2019/20 baseline by July. The Trust has revised the forecast delivery downwards from July onwards to consider performance YTD and known factors limiting activity over July and August. In addition, NHSE/I revised the policy baselines from July onwards (to 95%) in response to a robust activity recovery from the NHS.
15. During the second half of the financial year the ERF payment policy has been revised with payment (to systems) contingent on the proportion of 'clock-stop' activity (set at 89% of 2019/20).

16. <u>Activity vs Plan (as per CIVICA excluding accelerator target)</u>

Day case activity- Is below plan both in month and YTD. Although higher than October, operational pressures and A/L have impacted performance, this is likely to be impacted further by Covid in December.
Elective Inpatient Activity- Activity has increased slightly this month and is still below last year's activity however it is now in line with the 21/22 plan.
Outpatient Activity- Has increased in November compared to October. Actuals are just above plan.
Non-Elective Spells- While still at lower levels than the 19/20 baseline, the Trust is treating greater numbers of non-elective activity month-on-month.
A&E activity- Remains high in November, the Trust continues to experience sustained high levels of A&E attendances.





Key message
Month 8 has seen higher levels of activity from October. This is expected to reduce in December due to Covid and winter pressures.

17. ERF position summary

NHSE/I has introduced the Elective Recovery Fund (ERF) for 2021/22. For H2 this will be focussed on completed referral to treatment (RTT) pathway activity rather than total cost weighted activity which was used in H1. The thresholds for the scheme have been recalculated so that they are on a comparable basis to the 95% threshold for the ERF in Q2.

Where systems deliver completed RTT pathway activity above the 89% threshold, additional activity will be funded at 100% of tariff between 89% and 94%, and 120% of tariff over 94%.

It must be noted that any ERF incentive payment is calculated on overall system performance and the clearance of associated ERF gateway criteria. There is no guarantee MKUH (or any single organisation within the system) will receive funds if it over performs (but the aggregate system position is not achieved).

18. The Trust achieved £7.5m of ERF over the first six months of the year. This value was £4m lower than originally planned, £3.0m is due to the change in baselines and an additional £1m is due to unplanned theatre downtime and high uptake of staff annual leave during July and August. Due to uncertainty with the RTT figures for October no additional ERF income has been assumed this month.

19. In addition to the national ERF scheme, the Trust was selected as an 'accelerator site', this attracted additional funding of £3.0m to support the Trust to meet a target of 120% of 19/20 activity by July 2021. Income is recognised in-line with the additional expenditure in the upcoming months.

Key message

Although elective care activity increased in November compared to October, due to the change in calculating ERF, for prudency no additional income has been assumed this month. The YTD ERF value remains at £7.5m. This could increase following closure of the BLMK ERF position for November.

EFFICIENCY SAVINGS

20. As of November, the Trust has reported a breakeven position to plan, included within this position is £4.6m of efficiency target. The Trust has offset the planned efficiency target by managing the incremental cost of delivering additional activity (e.g., to support recovery) within the additional funding available.

21. For the second half of the financial year (October to March 2022) the Trust is increasing the focus on financial efficiency through the Better Value Brighter Outcomes programme. The Trust has identified £1.1m from schemes submitted to date.

Key message
YTD the Trust has delivered its £4.6m efficiency requirement to M8. This has been achieved through productivity savings against activity. Work is progressing through the Trust 'Better Values and Better Outcomes' programme to identify schemes in line with the efficiency target for Q4.

CAPITAL- OVERVIEW YTD

22. The YTD spend on capital (excluding donated assets and derecognised assets) is £8.26m, which is behind the Trust's capital plan (excluding the New Hospitals Programme (NHP)) by £2.53m. The strategic schemes are above plan due to schemes brought forward from prior year with no CDEL which are being offset by the timing of the costs for the Maple Centre (expected later in the year).

23. The Trust's has recently received approval for the second TIF bid relating to digital equipment (£1.92m), as well as Digital Diagnostics Capability funding for Pathology (£0.27m) and Imaging (£0.53m) and Digital workforce for echo cardiology £0.07m.

24. The Trust has received notification that it has been awarded £1.0m against its £1.8m bid for NHP funding for 21/22. The full breakdown of all funding and sources of application is shown in the table below.

	ICS Approved CDEL Allocation 2021/22		National CDEL Allocation 2021/22		
			Externally Funded		
Scheme Subcategory	**Internally Funded**	**Externally Funded Approved**	**Planned**	**Approved**	**Awaiting Approval**
	£m	£m	£m	£m	£m
Depreciation	13.6				
Self Funded	0.26				
PDC Funded					
Digital Diagnostic Equipment Replacement & Growth		0.15			
New Hospital Programme			28	0.98	
STP wave 4 (Maple Unit)			8.28	8.28	
Elective Recovery (TIF)				3.00	
Digital (TIF)				1.92	
Digital Diagnostics Capability - Pathology & Lims				0.27	
Digital Diagnostics Capability - Imaging				0.53	
Diagnostics Workforce - Echo cardiology				0.07	
Sub Total CDEL	**13.86**	**0.15**	**36.3**	**15.05**	**0.0**
CDEL Allocation Approved	**29.06**				**0.0**
Total Planned CDEL	**50.29**				

Key message
Capital expenditure is behind plan by £2.53m YTD, excluding NHP, which is due to the timing of costs for the Maple Centre. The Trust has been given approval for the TIF digital funding £1.92m, Digital diagnostics capability – Pathology £0.27m and Imaging £0.53m. The Trust has also received notification that it has been awarded £1.0m against its £1.8m bid for NHP funding for 21/22.

Capital Item	**YTD Plan up to end of Nov 21** £m	**Actual up to end of Nov 21** £m	**Variance YTD** £m	**Status**	**Comments** Status
CBIG Allocation	**3.44**	**1.29**	**-2.15**		Slightly below plan
Pre commitments					
Finance Leases	0.00	0.00	0.00		
Capitalised Staffing - IT and Estates	0.03	0.49	0.46		Above plan due timing of Cerner implementation
IT equipment	0.14	0.01	-0.13		Expenditure required in Q4 for license renewals
Cerner Phase C	0.13	0.21	0.08		Above plan due timing of Cerner implementation
LIMS (Pathology IT System)	0.00	0.05	0.05		Lims staffing costs not in orig plan
HR IT system	0.01	0.01	0.00		
Mammography Installation for 2 machines	0.04	0.25	0.21		Equipment costs in Q2, orig plan was Q4
Breast Unit Building Works	0.05	0.00	-0.05		BC going through approvals
Sub Total Pre-commitments	***0.40***	***1.03***	***0.63***		
Donated & Derecognised Assets (are excluded from CDEL)					
Baby Leo 3 incubators	0.08	0.08	0.00		Fully committed
Pathlake	0.43	0.00	-0.43		Expenditure not expected until Q4
COVID Donated assets	0.00	0.05	0.05		Not in the plan but no impact on capital spend
Derecognition of assets	0.00	-1.71	-1.71		Not in the plan but no impact on capital spend
Sub Total Donated & Derecognised Assets	***0.51***	***-1.59***	***-2.10***		
Strategic Schemes					
Staff Room Refurbishment	0.00	0.00	0.00		BC now approved
CT Scanner (prior year COVID funding)	0.05	0.00	-0.05		Part of TIF ERF Digital scheme
Endoscopy (prior year COVID funding)	0.02	0.00	-0.02		
Xray Interventional	0.11	0.00	-0.11		Part of TIF ERF Digital scheme
Angio Interventional	0.13	0.00	-0.13		Orders placed, long lead time for equipment
Other strategic schemes allocation	0.00	0.00	0.00		
Radiotherapy	*0.00*	0.00	0.00		Scheme supported in year
South Site Infrastructure	*0.00*	1.01	1.01		Monitoring the forecast
Bed replacement	*0.00*	0.00	0.00		BC approved procurement timing of order TBC
Sensyne	0.00	0.00	0.00		No confirmed CDEL
Prior year schemes not allocated CDEL					
Endoscopy Fit Out (Whitehouse)	0.00	0.00	0.00		No confirmed CDEL, BC outstanding
MRI installation	0.00	0.00	0.00		Not in capital plan but require CDEL
Flat roofs	0.00	0.00	0.00		Not in capital plan but require CDEL
HIP2 Infrastructure schemes	0.00	1.36	1.36		Not in capital plan but require CDEL
Sub Total Strategic Schemes	***0.31***	***2.37***	***2.06***		
Total ICS CDEL (excluding donated & derecog assets)	**3.64**	**2.85**	**-0.79**		
Other National Approved funding approved					
Maple Unit	6.92	5.18	-1.74		Fully committed
TIF (ERF Diagnostics)	0.00	0.00	0.00		Approval received in Dec
TIF (IT Digital)	0.00	0.00	0.00		Approval received in Dec
Digital Diagnostics - Pathology	0.00	0.00	0.00		Approval received in Dec
Digital Diagnostics - Imaging	0.00	0.00	0.00		Approval received in Dec
Diagnostics workforce - Echo Cardiology	0.00	0.00	0.00		Approval received in Dec
Total Capital (excluding NHP)	**10.56**	**8.03**	**-2.53**		Above CDEL allocation
New Hospital Programme (NHP)	7.84	0.23	-7.62		Approval received in Dec
Total Capital (including NHP)	**18.40**	**8.26**	**-10.14**		
Awaiting National Approval					
Unified Tech Fund					Awaiting approval for schemes
Total Capital (including NHP)	**18.40**	**8.26**	**-10.14**		Above CDEL allocation

CASH

25. Summary of Cash Flow

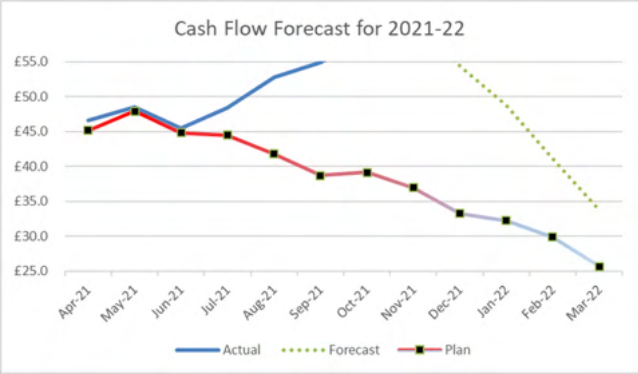
The cash balance at the end of November was £62.1m, this was £25.1m higher than the planned figure of £37m. This is an increase on last month's figure of £58.7m. See appendices 6-8 for the cashflow detail. The Trust is forecasting a year end cash balance of £33.8m (see opposite).

26. Cash arrangements 2021/22

The current cash funding arrangements for H2 are that the Trust is receiving monthly block payments as per its plan, plus any additional funding for high-cost drugs on a pass-through basis. The Trust received £2.5m ERF funding in September (for prior period performance).

27. Better Payment Practice

The Trust has fallen marginally below the national target of 95% of all bills paid within the target timeframe. Payment performance of NHS bills require improvement, an action plan is being developed. This metric will continue to be monitored in accordance with national guidance and best practice



Better payment practice code	Actual M8 YTD Number	Actual M8 YTD £'000	Actual M7 YTD Number	Actual M7 YTD £'000
Non NHS				
Total bills paid in the year	39,533	108,023	33,380	94,164
Total bills paid within target	37,285	103,119	31,514	89,885
Percentage of bills paid within target	**94.3%**	**95.5%**	**94.4%**	**95.5%**
NHS				
Total bills paid in the year	1,339	4,484	1,192	4,078
Total bills paid within target	1,050	2,663	936	2,378
Percentage of bills paid within target	**78.4%**	**59.4%**	**78.5%**	**58.3%**
Total				
Total bills paid in the year	**40,872**	**112,507**	**34,572**	**98,242**
Total bills paid within target	**38,335**	**105,782**	**32,450**	**92,262**
Percentage of bills paid within target	**93.8%**	**94.0%**	**93.9%**	**93.9%**

Key message

Cash is above plan by £25.1m, and the Trust has fallen marginally below the 95% target for BPPC when looking at the number of invoices paid.

BALANCE SHEET

28. Statement of Financial Position

The key movements include:

- Non-Current Assets have decreased from March 21 by £0.3m; this is driven by YTD depreciation.
- Current assets have increased by £8.8m, this is mainly due to the increase in cash £13.3m offset by a reduction in receivables (£4.5m).
- Current liabilities have increased by £7.3m, this is mainly due to the increase in Trade Payables £4.9m and Deferred Income £2.7m offset by decreases in Borrowings (£0.1m) and Provisions (£0.2m)
- There has been no change in Non-Current Liabilities in month.

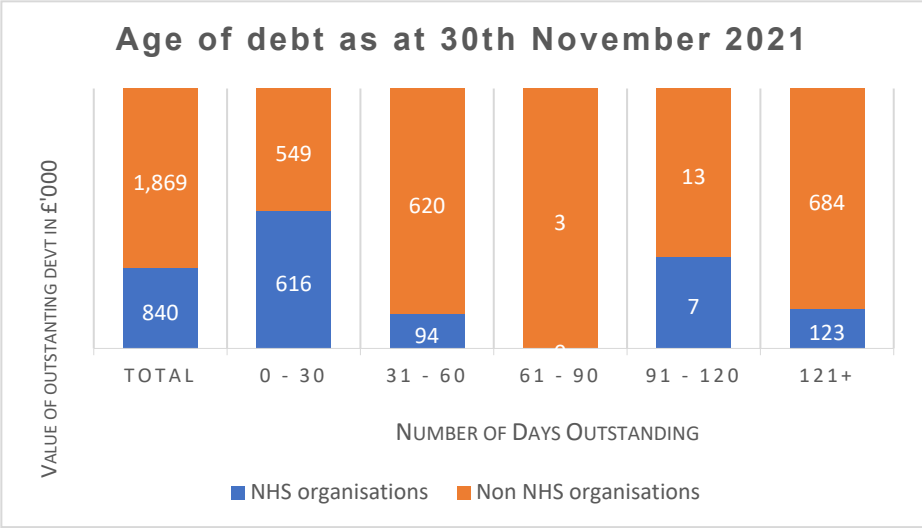
29. Aged debt

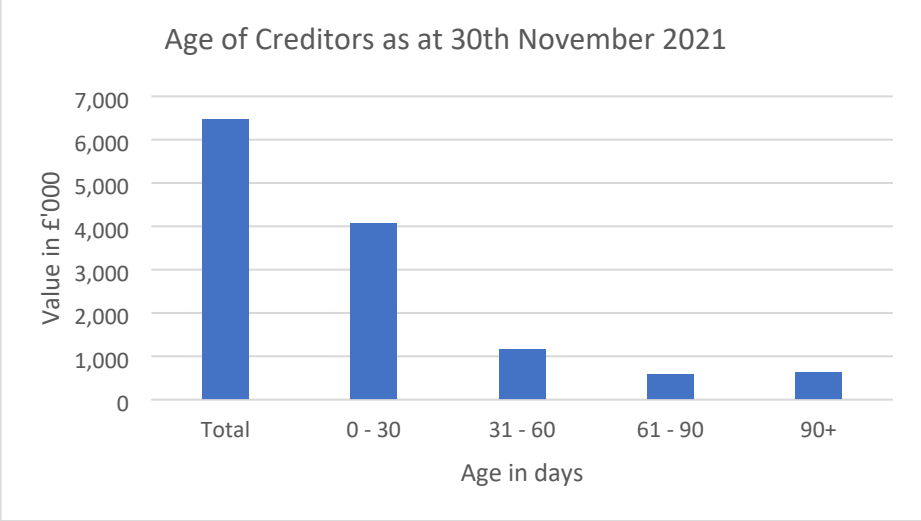
The debtors position as of 30th November is £2.7m, which is a decrease of £2.2m from the October position. Of this total £0.8m is over 121 days old.

The three largest NHS debtors are Bedford Hospital £0.4m for salary recharges, Central and NW London NHS Foundation Trust £0.1m for M5 non patient SLA recharge and Hertfordshire Community NHST £0.1m for the Vaccs Programme. The largest non-NHS debtors include £0.2m for overseas patients, £0.2m with Bedfordshire and Northamptonshire councils for sexual health, £0.7m with Buckinghamshire University for medical services placement.

30. Creditors

The creditor's position as of 30th November 21 is £6.5m, which is an increase of £0.9m from the October 21 position. Of this £2.4m is over 30 days, with £1.4m approved for payment.





Key message

No significant movements on the statement of financial position; debtors are similar to the prior month but there is an aged debtor of over 121 days of £1.2m that is being closely monitored

RECOMMENDATIONS TO BOARD

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

APPENDICIES

Appendix 1

Statement of Comprehensive Income
For the period ending 30th November 2021

	FY22	M8 CUMULATIVE			M8			PRIOR MONTH	
	Annual Budget	Budget	Actual	Variance	Budget	Actual	Variance	M7 Actual	Change
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME									
Outpatients	53,716	36,247	39,258	3,011	4,534	5,265	732	5,241 ▲	25
Elective admissions	26,165	18,274	16,985	(1,290)	2,394	2,201	(193)	2,199 ▲	1
Emergency admissions	77,583	52,598	49,526	(3,072)	6,425	6,611	186	6,535 ▲	77
Emergency adm's marginal rate (MRET)	0	0	0	0	0	0	0	0 ▲	0
Readmissions Penalty	0	0	0	0	0	0	0	0 ▲	0
A&E	16,398	11,229	11,502	274	1,429	1,396	(32)	1,438 ▼	(42)
Other Admissions	2,674	1,862	1,419	(443)	217	222	5	151 ▲	72
Maternity	21,670	14,656	14,652	(4)	1,781	1,523	(257)	1,765 ▼	(242)
Critical Care & Neonatal	7,001	4,469	4,726	257	629	738	109	454 ▲	284
Imaging	5,643	3,863	3,847	(16)	477	453	(25)	550 ▼	(98)
Direct access Pathology	4,818	3,312	3,053	(259)	403	427	23	391 ▲	35
Non Tariff Drugs and Devices (high cost/individual drugs)	18,900	12,627	14,679	2,052	1,584	1,913	329	1,856 ▲	57
Other (inc. home visits and best practice tariffs)	6,467	4,317	11,573	7,255	541	494	(46)	523 ▼	(29)
CQUINS	0	0	0	0	0	0	0	0 ▲	0
Contract Risk Provision - General challenge & CIP offset	0	0	0	0	0	0	0	0 ▲	0
National Block/Top up	56,279	29,322	27,251	(2,071)	8,438	2,278	(6,160)	2,870 ▼	(591)
MKCCG Block adj	0	0	0	0	0	0	0	0 ▲	0
Clinical Income	**297,314**	**192,775**	**198,470**	**5,695**	**28,851**	**23,522**	**(5,329)**	**23,973 ▼**	**(451)**
Non-Patient Income	19,051	12,467	13,330	863	1,877	1,799	(78)	1,884 ▼	(85)
PSF Income	0	0	(0)	(0)	0	0	0	0 ▲	0
Donations	491	124	134	10	124	9	(115)	0 ▲	9
Non-Patient Income	**19,542**	**12,591**	**13,464**	**873**	**2,001**	**1,808**	**(193)**	**1,884 ▼**	**(76)**
TOTAL INCOME	**316,856**	**205,366**	**211,934**	**6,568**	**30,852**	**25,330**	**(5,522)**	**25,857 ▼**	**(527)**
EXPENDITURE									
Pay - Substantive	(174,594)	(118,335)	(116,309)	2,025	(13,080)	(13,775)	(696)	(14,214) ▲	438
Pay - Bank	(16,422)	(9,093)	(11,554)	(2,461)	(2,778)	(1,586)	1,192	(1,588) ▲	1
Pay - Locum	(4,493)	(2,112)	(2,954)	(843)	(1,040)	(222)	818	(289) ▲	67
Pay - Agency	(7,373)	(4,341)	(5,536)	(1,194)	(975)	(700)	276	(630) ▼	(70)
Pay - Other	0	1,461	(529)	(1,991)	(1,098)	(62)	1,037	(78) ▲	17
Pay CIP	(389)	(115)	0	115	(139)	0	139	0 ▲	0
Vacancy Factor	0	16	0	(16)	(15)	0	15	0 ▲	0
Pay	**(203,271)**	**(132,519)**	**(136,883)**	**(4,364)**	**(19,125)**	**(16,345)**	**2,780**	**(16,798) ▲**	**453**
Non Pay	(77,545)	(49,279)	(49,707)	(428)	(8,250)	(5,909)	2,340	(5,720) ▼	(189)
Non Tariff Drugs (high cost/individual drugs)	(18,900)	(12,627)	(14,679)	(2,052)	(1,584)	(1,913)	(329)	(1,856) ▼	(57)
Non Pay	**(96,446)**	**(61,906)**	**(64,386)**	**(2,480)**	**(9,834)**	**(7,822)**	**2,011**	**(7,576) ▼**	**(246)**
TOTAL EXPENDITURE	**(299,717)**	**(194,425)**	**(201,269)**	**(6,845)**	**(28,959)**	**(24,167)**	**4,792**	**(24,374) ▲**	**207**
EARNINGS BEFORE INTEREST, TAXATION, DEPRECIATION AND AMORTISATION (EBITDA)	**17,139**	**10,941**	**10,664**	**(277)**	**1,893**	**1,163**	**(730)**	**1,483 ▼**	**(320)**
Interest Receivable	0	4	0	(4)	(3)	0	3	0 ▲	0
Interest Payable	(290)	(186)	(178)	8	(32)	(22)	10	(0) ▼	(22)
Depreciation, Impairments & Profit/Loss on Asset Disposal	(12,739)	(8,492)	(8,140)	352	(1,059)	(710)	349	(1,061) ▲	351
Donated Asset Depreciation	(834)	(550)	(554)	(4)	(74)	(69)	5	(71) ▲	1
Profit/Loss on Asset Disposal & Impairments	(48)	(48)	(48)	(0)	(48)	0	48	0 ▲	0
Unwinding of discounts	0	0	0	0	0	0	0	0 ▲	0
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**3,228**	**1,670**	**1,744**	**75**	**677**	**361**	**(316)**	**352 ▲**	**10**
Dividends Payable	(4,723)	(3,221)	(3,315)	(94)	(341)	(422)	(81)	(422) ▲	0
OPERATING SURPLUS/(DEFICIT) AFTER DIVIDENDS	**(1,495)**	**(1,551)**	**(1,571)**	**(19)**	**337**	**(60)**	**(397)**	**(70) ▲**	**10**

Whilst the in month and YTD figures are correct in this appendix, the phasing of the budget will be updated in month 9 to reflect the revised H2 plan.

Statement of Cash Flow
As of 30th November 2021

	Mth 8 £000	Mth 7 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	1,970	1,588	(132)
Operating (deficit)	**1,970**	**1,588**	**(132)**
Non-cash income and expense:			
Depreciation and amortisation	8,693	7,915	(1,131)
(Gain)/Loss on disposal	(48)	(48)	0
(Increase)/Decrease in Trade and Other Receivables	4,519	1,741	(625)
(Increase)/Decrease in Other Assets	0	0	0
(Increase)/Decrease in Inventories	(2)	(9)	1
Increase/(Decrease) in Trade and Other Payables	13,148	13,364	(4,767)
Increase/(Decrease) in Other Liabilities	2,637	496	1,134
Increase/(Decrease) in Provisions	(179)	(36)	4
NHS Charitable Funds	(134)	(124)	0
Other movements in operating cash flows	(3)	(4)	(1)
NET CASH GENERATED FROM OPERATIONS	**30,601**	**24,883**	**(5,517)**
Cash flows from investing activities			
Purchase of intangible assets	(1,382)	(1,468)	163
Purchase of Property, Plant and Equipment, Intangibles	(16,010)	(13,608)	918
Net cash generated (used in) investing activities	**(17,392)**	**(15,076)**	**1,081**
Cash flows from financing activities			
Public dividend capital received	2,717	2717	0
Capital element of finance lease rental payments	(134)	(117)	18
Interest element of finance lease	(178)	(156)	23
PDC Dividend paid	(2,412)	(2,412)	0
Receipt of cash donations to purchase capital assets	134	124	0
Net cash generated from/(used in) financing activities	**127**	**156**	**41**
Increase/(decrease) in cash and cash equivalents	**13,336**	**9,963**	(4,395)
Opening Cash and Cash equivalents	**48,765**	**48,765**	
Closing Cash and Cash equivalents	**62,101**	**58,728**	**(4,395)**

Statement of Financial Position as of 30th November 2021

	Audited Mar-21	Nov-21 YTD Actual	YTD Mvmt	% Variance
Assets Non-Current				
Tangible Assets	169.5	171.8	2.3	1.4%
Intangible Assets	22.0	19.4	(2.6)	(11.8%)
Other Assets	1.0	1.0	0.0	0.0%
Total Non Current Assets	**192.5**	**192.2**	**(0.3)**	**(0.2%)**
Assets Current				
Inventory	3.7	3.7	0.0	0.0%
NHS Receivables	7.3	5.2	(2.1)	(28.8%)
Other Receivables	12.5	10.1	(2.4)	(19.2%)
Cash	48.8	62.1	13.3	27.3%
Total Current Assets	**72.3**	**81.1**	**8.8**	**12.2%**
Liabilities Current				
Interest -bearing borrowings	(0.2)	(0.1)	0.1	(50.0%)
Deferred Income	(14.9)	(17.6)	(2.7)	18.1%
Provisions	(2.9)	(2.7)	0.2	(6.9%)
Trade & other Creditors (incl NHS)	(58.5)	(63.4)	(4.9)	8.4%
Total Current Liabilities	**(76.5)**	**(83.8)**	**(7.3)**	**9.5%**
Net current assets	**(4.2)**	**(2.7)**	**1.5**	**(35.7%)**
Liabilities Non-Current				
Long-term Interest bearing borrowings	(5.6)	(5.6)	0.0	0.0%
Provisions for liabilities and charges	(1.7)	(1.7)	0.0	0.0%
Total non-current liabilities	**(7.3)**	**(7.3)**	**0.0**	**0.0%**
Total Assets Employed	**181.0**	**182.2**	**1.2**	**0.7%**
Taxpayers Equity				
Public Dividend Capital (PDC)	259.9	262.6	2.7	1.0%
Revaluation Reserve	50.1	50.1	0.0	0.0%
Financial assets at FV through OCI reserve	0.2	0.2	0.0	0.0%
I&E Reserve	(129.2)	(130.7)	(1.5)	1.2%
Total Taxpayers Equity	**181.0**	**182.2**	**1.2**	**0.7%**

GLOSSARY OF TERMS

Abbreviation	Full name	Explanation
A/L	Annual Leave	Impact of staff annual leave
BAU	Business as usual	In the context of capital expenditure, this is the replacement of existing capital assets on a like for like basis.
BPP	Better payment practice	This requires all NHS Organisations to achieve a public sector payment standard for valid invoices to be paid within 30 days of their receipt or the receipt of the goods or services – the target for this is 95%
CBIG	Clinical Board Investment Group	Capital approval meeting overseeing small scale capital schemes including equipment replacement and building work.
CDEL	Capital Departmental Expenditure Limit	Trusts maximum amount of capital expenditure available to be spent for the current year set by Regional NHS team and reviewed every financial year.
CIP	Cost Improvement Programme	Scheme designed to improve efficiency or reduce expenditure
COVID	COVID-19	Costs associated with COVID-19 virus
E&T	Education & Training	
ERF	Elective Recovery Fund	Additional non recurrent funding linked to recovery
HCD	High Cost/Individual Drugs	
NHP	New Hospital Programme	National capital funding for major hospital redevelopments
PDC	Public Dividend Capital	A form of long-term government finance which was initially provided to NHS trusts when they were first formed to enable them to purchase the Trust's assets from the Secretary of State. Public dividend capital (PDC) represents the Department of Health's (DH's) equity interest in defined public assets across the NHS.
R&D	Research & Development	
YTD	Year to date	Cumulative costs for the year
Other frequently used abbreviations		
Accelerator	Accelerator Funding	Additional funding linked to recovery
Block	Block value	Block income value linked to 19/20 values
Top-up	Top up Funding	Additional block income linked to 19/20 values
Covid	COVID Funding	Additional block funding to cover incremental COIVD-19 expenditure
Maple Centre	Maple Centre	The initial project name for the Maple Centre was the Pathway Unit - a 23hr ambulatory care facility currently under construction

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: January 2022**
Report Title	**Hospital Charity 2020/21 Annual Report**	**Agenda Item: 13**
Lead Director	**Name: Terry Whittle**	**Title: Director of Finance**
Report Author	**Name: Thomas Crump**	**Title: Assistant Financial Accountant**

Key Highlights/ Summary	The Board to note the Hospital Charity's 2020/21 Annual Report and the Letter of Representation.			
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Noting** √	**For Review** ☐

Strategic Objectives Links	*N/A*
Board Assurance Framework (BAF)/ Risk Register Links	*N/A*

Report History	Charitable Funds Committee Audit Committee
Next Steps	Trust Board of Directors
Appendices/Attachments	i. Trustees Annual Report 2020-21 ii. Letter of Representation

Funds Held on Trust

Trustees Annual Report 2020-21

Introduction

This is the Annual Report of the Milton Keynes Hospital NHS Foundation Trust Charity. Administrative details regarding the management of the Charity are outlined below.

Charity Name (working name Milton Keynes Hospital Charity)	Milton Keynes Hospital NHS Foundation Trust Charity
Governing Document/Constitution	Statutory Instrument No. 2372, establishing the Trust from 1st April 1992
Charity Registration Number	1048297

The Charity has a corporate trustee: Milton Keynes University Hospital NHS Foundation Trust (The Trust). The directors of the Trust who served during the financial year were as follows:

	Professor J Harrison
	Mr J Blakesley
	Mr S Lloyd (Resigned January 2021)
	Ms K Jarman
	Ms A Davis
	Ms N Burns-Muir
	Ms E Livesley
	Mr A Blakeman
	Mr M Keech (Resigned November 2020)
	Dr I Reckless
	Ms H Smart
	Ms H Travis
	Mr J Clapman (Resigned June 2020)
	Ms D Petch
	Ms N Mcleod
	Ms S Aldridge (Interim Director of Finance November 2020- February 2021)
	Mr T Whittle
	Ms J Collier
	Mr J Lisle
	Dr L James
	Mr H Husain
	Professor J Tooley
Address of Registered Office	Milton Keynes University Hospital NHS Foundation Trust Standing Way, Eaglestone Milton Keynes MK6 5LD
Name and Address of Bankers	Royal Bank of Scotland 402 Lower Twelfth Street Central Milton Keynes MK9 3LF
Name and Address of Independent Examiners	Steve Robinson Mercer & Hole Chartered Accountant Silbury Court, 420 Silbury Boulevard Central Milton Keynes MK9 2AF
Name and Address of Solicitors	Foinette Quinn 123-131 Queensway, Bletchley Milton Keynes MK2 2DH

Charity Annual Report and Accounts
For the year ended 31 March 2021

Charity Objectives and Organisation

Milton Keynes Hospital Charity is the registered charity for Milton Keynes University Hospital NHS Foundation Trust. The charity raises funds for all wards and departments, although it will have fundraising priorities as determined by Trustees.

Thanks to its kind supporters, the charity makes a real difference to the experience of patients, their families and the staff who treat them – benefitting the community in and around Milton Keynes.

Fundraising enables wards and departments to go over and above what the NHS provides – always funding specific, tangible and intangible items such as:

- Comfort items for patients
- Pilots for new patient-care initiatives
- State of the art equipment
- Special advanced training for members of staff
- New welcoming, positive environments for everyone treated in our hospital.

Donors have options to support specific projects or wards or to contribute to a general hospital charitable fund.

The management of these funds is overseen by the Charitable Funds Committee, which reports into the Trust Board. Milton Keynes University Hospital NHS Foundation Trust acts as the sole corporate trustee of Milton Keynes Hospital Charity, in line with the Trust Board's Standing Orders, and this role is undertaken on its behalf by individual members of the Trust Board.

Each individual fund is managed on a day-to-day basis by three officers designated by the Chief Executive.

The Trust has a general policy of ensuring that income is spent as soon as practicable after receipt. Managers are instructed that unspent funds should not be allowed to accumulate without an agreed plan on how and when they will be used.

The Trustee confirms that it has complied with the duty included in section 4 of the Charities Act 2006 to have due regard to public benefit guidance provided by the Charity Commission when reviewing aims and objectives, when planning future activities and in setting the grant making policy for the year.

The charity carries out these objects by funding activities that benefit NHS patients of Milton Keynes University Hospital NHS Foundation Trust or the staff that deliver care to those patients. Primarily, these activities improve the health of patients and the general patient experience, but also activities that improve the skills of staff, improve working conditions and improve staff morale.

Review of the year

Due to Covid-19, this particular year was like no other. April 2020 onwards saw our events and fundraising activities cancelled for the foreseeable future as we entered Lockdown One. These did not pick up for the entirety of the financial year.

The charity's small fundraising team of three then took on the tasks of managing the gifts in kind and huge influx of extremely generous donations that came into the hospital from that point onwards.

The function of the fundraising team changed overnight from a mainly externally focussed team fundraising for patients and families, to one supporting staff within the hospital.

That said, our team continued to not only rise to the challenge of processing donations and supporting hospital staff at one of the most challenging points of their lives; but also fundraise for projects to support patients and families during the year, too.

Gifts in Kind

During the Pandemic the team has been the central point – collection and distribution – for thousands of gifts in kind that have been given to staff and patients.

Whilst making assessments on the use and value of these gifts, the team then made sure these kind donations were distributed as quickly and fairly as possible, meaning all teams, of all disciplines, received items of some kind.

During Lockdown Two, volunteers were drafted in to help cope with the volume of items coming through, mainly supporting with distribution. Following the setting up of an Amazon Wish List, we created care packs for staff, which were then boxed up by the team and distributed to wards. These care packs included items such as snacks, dry goods, hand creams, face packs, soft drinks, magazines, toiletries such as dry shampoo, deodorant and face wash and period products.

Types of items we collected and distributed included PPE (visors, scrubs, masks), hot meals, snacks and cold drinks for staff, toiletries and period products, puzzle books and other books and magazines, toys and equipment for young patients, puzzle books, twiddle muffs, socks, clothes and other items for patients on the wards.

Whilst it is difficult to obtain the exact value of some items, we estimate the total value of gifts donated to the hospital for the period April 2020 to March 2021 to be more than £136,000. More than 27,221 individual items were collected and distributed during the financial year.

Fundraising appeals and activities

Two appeals were successfully organised in 2020-21, for our Covid-19 support, mainly supporting staff, and to fundraise for BabyLeo incubators to be used in the trust's Neonatal Unit. Both were a success and between them raised almost £300,000.

At the end of March 2020, the charity team created a fundraising appeal to support mainly staff at Milton Keynes University Hospital. Our Covid-19 Emergency Appeal was launched in response to a huge influx of donations coming through to the charity. In just a month the appeal had received more than £100,000 in cash donations from individuals, groups and businesses wanting to support the NHS. Working in a far more agile

way than previously, the team quickly used funds to pay for items such as a staff hub, mobile phones to enable virtual visiting at the hospital and bespoke care packs for staff and patients including items such as snacks, socks and puzzle books.

The Covid-19 Emergency Appeal raised £190,000 in total and remaining monies have been allocated to a new permanent hub for staff, with 24-hour access and a garden, as well as a Meaningful Activities Co-ordinator role, to support older, vulnerable patients, including those with dementia, by working with patients at the beside to keep them alert and distracted during their stay.

In response to a request from the Women and Children's Division, in September 2020 we launched a BabyLeo Incubator Appeal for the Neonatal Unit. The appeal set out to raise £80,000 for new and high quality BabyLeos, which would replace current NHS-standard ones.

The BabyLeo Incubator appeal had us working across three income streams – with our major donors, community fundraisers and corporate supporters. We engaged with previous donors to the neonatal unit as well as using the appeal as an opportunity to recruit new donors to the cause – mainly through our Be Seen In Green event, which takes place each year. This way of working made sure we raised the amount needed to purchase three BabyLeo incubators in three months. We ended our financial year knowing the incubators were on order with an expected delivery date of June 2021.

Over the past year, we also continued to support the Milton Keynes Cancer Centre, committed to fundraising and spending funds on – amongst other items – the transformation of the cancer centre gardens and fundraising for additional furniture and electronic tablets for patients.

Financial review

The full financial reports and notes are reflected in pages 10 onwards. During 2020-21:

- Charitable income totals remained relatively the same as last year, with only a slight 3.5% decrease.
- During this financial year we saw a significant 43% decrease in community fundraising due to Covid-19 restrictions.
- However, donations from corporate fundraising increased by 53.7% over the same period.
- We also saw an increase in grants by an incredible 180%, mainly due to grants from NHS Charities Together for Covid-19 staff support.
- Expenditure in the year was £540k compared to £856k last year due to no major capital fundraising projects and a decrease in fundraising staff.
- The expenditure can be broken down into £144k fundraising staff costs, £35k governance costs (made up of £2k audit costs and £33k for administration) and activities in furtherance of charity's objectives which accounted for £361k.

The charity continues to hold a £300k cash investment portfolio with The Bank of Scotland. The investment is held in an Investment Money Market Account with a short call back period.

The charity holds no other assets other than cash resources that are held in the Trust bank accounts.

In keeping with the Charity Commission regulations and general accounting best practices, the financial statements for 2020-21 were reviewed by independent examiners, Mercer & Hole Chartered Accountants.

Governance

The charity does not employ any staff, but Milton Keynes University Hospital NHS Foundation Trust provides accounting and administration services.

Our charity has a corporate trustee, Milton Keynes University Hospital NHS Foundation Trust. The Trust Board of directors, which comprises 8 Non-Executive Directors (including Trust Chair) and 9 Executive Directors, represent the NHS Trust in this matter. The Trust Board, as corporate trustee, delegates responsibility to a board committee, the Charitable Funds Committee.

This Charitable Funds Committee meets at least four times a year and the chair of the committee reports to the Trust Board, as corporate trustee, following each meeting.

Charitable Funds Committee

Acting for the corporate trustee, the purpose of the Charitable Funds Committee is to:

- Ensure there are robust processes in place to manage resources and to ensure these processes are implemented.
- Monitor the disposition of resources to ensure funds held on Trust are used in a way which reflects donors' wishes and that funds are maximised.
- Promote greater awareness of our charity to encourage donations, particularly through demonstrating their impact on patient care.
- Proactively fundraise for Milton Keynes Hospital Charity to support charitable activities and purposes across our three great hospitals.

GDPR and Regulation

We have worked hard to meet our responsibilities under General Data Protection Regulations (GDPR). Supporters can see, via our privacy notice, what they can expect from us and how we collect and manage information about them. They are also invited to change the way we communicate with them at any time. Matters relating to GPDR compliance are reported to the Charitable Funds Committee as required.
We are registered with the Fundraising Regulator to demonstrate our commitment to our donors, supporters and charity management. Supporters have the right to know that they can trust us to be open and honest and that we will treat them and their data with care and respect. Our vision, mission and values are published on our website and explain what supporters can expect from us and what to do if they have any concerns.

No complaints were received regarding the charity or its fundraising practices in 2020-21.

Future plans

The corporate trustee has recently reviewed the objects of the charity and is confident that at present they are appropriate but will continue to keep them under regular review.

In the latter part of the 2020-21 financial year, the charity was developing a three-year fundraising strategy to support fundraising and mitigate any loss of income post-Covid. As part of this strategy some of our priorities in year one include:

- Exploring the potential of digital fundraising, revising our website and looking at how we can better engage with supporters online, digitally and through social media
- Getting to know our individual donors more, developing a journey for each and every supporter and making them feel valued through a more structured individual giving programme
- Knowing that 67% of our donors are grateful patients or relatives, looking at how we can better promote the charity and charitable giving within the hospital, through branding as well as better engagement with staff.

Impact – measuring our success

Everything we do at the charity enhances the hospital experience for patient, visitors and staff, so it is right that these groups of people will be a key measure of how successful a project has been. On a project-by-project basis we will use the most appropriate medium to actively seek their feedback before, during and after the project - whether in written format, conversation, photographs or video.

In addition to user feedback, the success of projects will also be measured by receiving positive answers to the questions; "Does it provide the expected good value for money" and "Was the project completed within the agreed timescales and with the minimum of disruption to the smooth running of the ward or department". Yes, impact is about the direct benefit to patients, families and staff – but we must also factor in these questions to measure the overall effectiveness, too.

Some of the items we have funded over the past year include:

- Funding the fitting out and furnishing of rooms in the cancer centre bays and offices; funding special items of equipment including ECG machines and special reclining chairs for use throughout the centre.
- Variable height cots for use on the neonatal unit – especially helpful for mums who have had a c-section and struggle to bend down.
- Supporting our ICU staff with furniture and fittings in their new staff room.
- Playmobil and other play equipment for the children's wards.
- Recliner chairs for a parent needing to stay overnight on the children's wards.
- Staff hubs for members of staff to take time out in during first wave of the Pandemic.
- Mobile phones to support virtual visiting as visiting restrictions came into place during Covid-19.
- A special newspaper service for patients, to help keep them entertained on the ward.
- Portable radios and distraction items for patients.
- The curation and management of almost 400 pieces of artwork around the hospital, which benefits patients, visitors and staff; making the hospital environment less intimidating.
- Funding the maintenance of four courtyard gardens within the hospital, helping to manage these calm and relaxing spaces where patients, families and staff can take some time out.
- Making one of our courtyard gardens accessible to dementia patients, so they can spend time outside of the ward and enjoy the peace a beautiful garden brings.
- Funding the transformation of all three gardens in and around the cancer centre.
- Dying Matters packs for our palliative care team, as well as other end of life materials to give to families.
- Coaching and training for cancer specialists on having difficult conversations with patients and families.
- A bladder scanner for use by our surgery team.
- Recliner chairs for use on the Stroke Ward.
- Cost of room hire so that cancer patients can participate in groups such as the 'Beyond the C' choir and Look Good Feel Better sessions.

- Funding a special online staff wellbeing event called "Event in the Tent" to support and promote better health and wellbeing for #teamMKUH
- Working with local companies, MK Dons and the community in providing gifts to those in hospital over Christmas.

We're proud of what we've achieved over this past financial year and could not have achieved any of this without the generosity – in time as well as money – of our donors, volunteers and supporters, so thank you.

Relationships with Other Organisations

As an NHS Charity, the Board of Trustees are the same as the Trust Board at Milton Keynes University Hospital NHS Foundation Trust.

Risk Statement

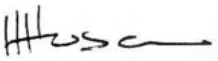
The Trustees have identified that placing short term Money Market Investments with highly rated Banking Institutions minimises any risk of loss. All investments placed are monitored for their performance quarterly and reported through the Charitable Funds Committee.

Remuneration

Neither the Trustees nor any persons connected with them received any remuneration for their work for the charity.

Financial Review

By order of the Trustees

Signed:  Date: 02 November 2021

Name: Haider Husain Trustee

Signed:  Date: 02 November 2021

Name: Terry Whittle Trustee

FINANCIAL STATEMENTS for 2020-21

The accounts of the funds held by Milton Keynes University Hospital NHS Foundation Trust Charity

FOREWORD

These financial statements for the year ended 31 March 2021 have been prepared by the Trustees in accordance with Section 132 of the Charities Act 2011 and comply with the Statement of Recommended Practice (SORP), Accounting and Reporting by Charities issued in 2019 by the Charity Commissioner for England and Wales.

The Financial Statements have been prepared under FRS 102.

STATUTORY BACKGROUND

The Trustees have been appointed under s11 of the NHS and Community Care Act 1990.

The Milton Keynes University Hospital NHS Foundation Trust charitable funds held on trust are registered with the Charity Commission and include funds in respect of Milton Keynes University Hospital.

MAIN PURPOSE OF THE FUNDS HELD ON TRUST

The main purpose of the charitable funds held on trust is to apply income for any charitable purpose relating to the NHS wholly or mainly for the services provided by Milton Keynes University Hospital NHS Foundation Trust.

Statement of trustees' responsibilities

The Trustees are responsible for:

- Ensuring that proper accounting records are maintained for the charity - disclosing with reasonable accuracy at any time the financial position of the funds held on trust to enable them to ensure that the accounts comply with requirements of the Charities Act 2011 and directions issued by the Secretary of State in respect of the management of Foundation Trusts;
- Establishing and monitoring a system of internal controls and checks to mitigate risk exposure for the funds managed; and
- Establishing arrangements for the prevention and detection of fraud and corruption.

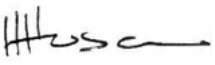
The Trustees are required under the Charities Act 2011 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, and the Charities Commission direct that these accounts give a true and fair view of the financial position of the funds held on trust, in accordance with the Charities Act 2011. In preparing those accounts, the trustees are required to:

- Apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- Make judgements and estimates which are reasonable and prudent,
- State whether applicable accounting standards have been followed. Material departures should be disclosed and explained as part of the notes to the accounts.
- Present financial statements for publication in line with the requirements and standards set by the Charity Commission.

The Financial Statements have been prepared on a going concern basis, as the Trustees believe that the charity is able to discharge its liabilities and commitments as they fall due in the foreseeable future

The Trustees confirm that they have met the responsibilities set out above and complied with the requirements for preparing the financial statements. The financial statements set out on pages 10 to 21 below have been compiled from and are in accordance with the financial records maintained by the Trustees. These financial records are open to view by any stakeholders seeking to review such details at the charity's registered offices listed above.

By Order of the Trustees

Signed: 

Trustee Date: 02 November 2021

Signed:  Date: 02 November 2021

Trustee

Independent Examiner's Report to the Trustees of Milton Keynes University Hospital NHS Foundation Trust Charity

I report to the charity trustees on my examination of the accounts of the charity for the year ended 31 March 2021 which are set out on pages 1 to 21.

Responsibilities and basis of report

As the charity's trustees you are responsible for the preparation of the accounts in accordance with the requirements of the Charities Act 2011 ('the Act').

I report in respect of my examination of the charity's accounts carried out under section 145 of the Act and in carrying out my examination I have followed all the applicable Directions given by the Charity Commission under section 145(5)(b) of the Act.

Independent examiner's statement

Since the charity's gross income exceeded £250,000 your examiner must be a member of a body listed in section 145 of the Act. I confirm that I am qualified to undertake the examination because I am a member of ICAEW, which is one of the listed bodies.

I have completed my examination. I confirm that no material matters have come to my attention in connection with the examination giving me cause to believe that in any material respect:

1. accounting records were not kept in respect of the charity as required by section 130 of the Act; or
2. the accounts do not accord with those records; or
3. the accounts do not comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give a 'true and fair view' which is not a matter considered as part of an independent examination.

I have no concerns and have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

Steve Robinson FCA
Mercer & Hole Chartered Accountants
Silbury Court
420 Silbury Boulevard
Central Milton Keynes
MK9 2AF

8 November 2021

Statement of Financial Activities for the year ended 31 March 2021

	Note	Unrestricted Funds	Restricted Funds	2020-21 Total Funds	Unrestricted Funds	Restricted Funds	2019-20 Total Funds
		£000	£000	£000	£000	£000	£000
Incoming resources	2						
Donations, Legacies and similar resources							
Donations	2.1	460	0	**460**	127	267	394
Legacies	2.1	10	0	**10**	36	43	79
Grants receivable:	2.1						
From other NHS bodies		0	0	**0**	0	0	0
Other grants receivable		200	0	**200**	0	71	71
Total Donations and Legacies		670	0	**670**	163	381	**544**
Operating Activities							
Investment income	2.2	0	0	**0**	1	1	2
Other incoming resources	2.3	7	0	**7**	2	7	8
Total incoming resources		**678**	**0**	**678**	**165**	**389**	**554**
Resources expended							
Costs of generating funds	4.1	(144)	0	**(145)**	(44)	(209)	(253)
Charitable expenditure							
Activities in furtherance of charity's objectives	3.1	(361)	0	**(361)**	(100)	(476)	(576)
Governance Costs	3.2	(35)	0	**(35)**	(17)	(11)	(28)
Total resources expanded		**(540)**	**0**	**(540)**	**(160)**	**(696)**	**(856)**
Net (outgoing)/incoming resources before Transfers		138	0	**138**	4	(307)	(303)
Gross transfer between funds		0	0	**0**	0	0	0
Transfer between restricted and unrestricted funds		2	(2)	**0**	0	0	0
Net (outgoing)/incoming resources		**140**	**(2)**	**138**	**4**	**(307)**	**(303)**
Net movement in funds	5	**140**	**(2)**	**138**	**4**	**(307)**	**(303)**
Fund balances brought forward at 31 March 2020		321	2	**323**	317	310	**627**
Fund balances carried forward at 31 March 2021		**461**	**0**	**461**	**321**	**2**	**323**

Note 2.1 includes £136k of donations in kind which were gifts received by the charity, which were all distributed by the end of the financial year.

Note 3.1 includes the £136k worth of gifts that were distributed by the charity.

Balance Sheet as at 31 March 2021

Balance Sheet as at 31 March 2021

	Notes	Unrestricted Funds £000	Restricted Funds £000	**Total at 31 March 2021 £000**	**Total at 31 March 2020 £000**
Fixed Assets					
Investments	6.2	300	0	**300**	**300**
Total Fixed Assets		**300**	**0**	**300**	**300**
Current Assets					
Debtors	7.1	0	0	**0**	**0**
Cash at bank and in hand		176	0	**176**	**81**
Total Current Assets		**176**	**0**	**176**	**81**
Creditors: Amounts falling due within one year	8.1	15	0	**15**	**58**
Net Current Assets/(Liabilities)		**161**	**0**	**161**	**23**
Total Assets less Current Liabilities		**461**	**0**	**461**	**323**
Total Net Assets		**461**	**0**	**461**	**323**
Funds of the Charity					
Income Funds:					
Restricted	9.1	0	0	**0**	**2**
Unrestricted	9.2	461	0	**461**	**321**
Total Funds		**461**	**0**	**461**	**323**

Cashflow for the year ended 31 March 2021

Statement of Cashflow		2021 Total £000	2020 Total £000
Net cash used in operating activities	12	**95**	**(298)**
Cash flows from investing activities:			
Dividends, interest and rents from investments	2.2	0	2
Net Cash provided by investing activities		**0**	**2**
Changes in cash and cash equivalent in the reported period		**95**	**(296)**
Cash and Cash equivalents at the beginning of the period		**81**	**377**
Cash and Cash equivalents at the end of the period		**176**	**81**

NOTES TO FINANCIAL STATEMENTS

1. Accounting Policies

1.1 Accounting Convention

The accounts (financial statements) have been prepared under the historical cost convention with items recognised at cost or transaction value unless otherwise stated in the relevant note(s) to these accounts. The financial statements have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued in October 2019 and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and the Charities Act 2011. The Financial Statements have been prepared under FRS 102.

1.2 Income

a) All income is included in full on the Statement of Financial Activities as soon as the following three factors are met:

i. entitlement - arises when a particular resource is receivable or the charity's right becomes legally enforceable
ii. probable – it is more likely than not that the economic benefits associated with the transaction or gift will flow to the charity
iii. measurement - when the monetary value of the incoming resources can be measured with sufficient reliability

b) Legacies
Legacies are accounted for as income once the receipt of the legacy becomes normally probable. This will be once confirmation has been received from the representatives of the estates that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled.

1.3 Expenditure

The funds held on trust accounts are prepared in accordance with the accruals concept. All expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party.

a) **Cost of generating funds**:

The cost of generating funds are the costs associated with generating income for the funds held on trust. This will include the costs associated with generating voluntary income, fundraising and managing investments.

b) **Grants payable**

Grants payable are payments, made to third parties (including NHS bodies) in the furtherance of the funds held on trust's charitable objectives to relieve those who are sick. They are accounted for on an accruals basis where the conditions for their

payment have been met or where a third party has a reasonable expectation that they will receive the grant. This includes grants paid to NHS bodies.

c) **Governance costs**

These are accounted for on an accruals basis and are recharges of appropriate proportions of the following costs from Milton Keynes University Hospital NHS Foundation Trust and include the costs of governance arrangements which relate the general running of the Charity, for example Management and Audit Fees.

d) **Activities in furtherance of charity's objectives**

These are accounted for on an accruals basis and are recharges of appropriate proportions of the following costs from Milton Keynes University Hospital NHS Foundation Trust and includes fundraising and publicity, patient welfare, staff welfare, research, contribution to trust capital and other.

1.4 Structure of funds

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund. Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment funds. Other funds are classified as unrestricted funds. Funds which are not legally restricted but which the Trustees have chosen to earmark for set purposes are classified funds. The major funds held within these categories are disclosed on notes 9.1 to 9.3.

1.5 Investment Fixed Assets

Investment fixed assets are shown at market value.

a) There are no property assets held by the trust in respect of the Charitable Funds.
b) Quoted Stocks and shares are included in the balance sheet at mid-market price excluding Dividend
c) Other investment fixed assets are included at Trustees' best estimate of market value.

1.6 Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later).

1.7 Reserves

A Reserves Policy is in place to support the holding of funds within the Charity Accounts in order to monitor proposed expenditure against future objectives that have been set. The policy is reviewed on an annual basis by the Trust's Charitable Funds Committee.

2. Analysis of Income

Analysis of incoming resources	**2**					
			Unrestricted Funds	Restricted Funds	**Total 2021 Funds**	Total 2020 Funds
			£000	£000	£000	£000
Donations, Legacies and similar resources	**2.1**	Donations	324	0	**324**	394
		Legacies	10	0	**11**	79
		Grants receivable	200	0	**200**	71
		Donations In Kind	136	0	**136**	0
			671	**0**	**671**	**544**
Investment income	**2.2**	Investment Income	0	0	**0**	2
			0	**0**	**0**	**2**
Other Incoming resources	**2.3**	Other	7	0	**7**	8
			7	**0**	**7**	**8**
		Total Incoming resources from charitable activities	**678**	**0**	**678**	**554**

Other incoming resources includes other sources of income that are not donations, legacies, grants or investment income, including income from fundraising events.

3. Analysis of Expenditure

			Unrestricted Funds	Restricted Funds	**Total 2021 Funds**	Total 2020 Funds
Resources Expended - Other	**3.1**	Other:	£000	£000	**£000**	£000
		Patients welfare and amenities	143	0	**143**	**99**
		Staff welfare and amenities	69	0	**69**	**0**
		Contributions to Trust's Capital	0	0	**0**	**476**
		Miscellaneous	13	0	**13**	**1**
		Gift in Kind	136	0	**136**	**0**
			361	**0**	**361**	**576**

			Unrestricted Funds	Restricted Funds	**Total 2021 Funds**	**Total 2020 Funds**
Analysis of Governance Costs	**3.2**					
			£000	£000	**£000**	**£000**
		Independent Examiners Fees	2	0	**2**	**2**
		Management/Admin Fee	33	0	**33**	**26**
			35	**0**	**35**	**28**

4. Analysis of total expenditure

Analysis of Total Resources Expended 4.1	Costs of Generating Funds	Costs of Activities for Charitable Objectives	Governance Costs	**Total 2021**	Total 2020
	£000	£000	£000	**£000**	£000
Staff	144	0	0	**144**	153
Auditors remuneration:					
Audit fee	0	0	2	**2**	2
Bought-in services from NHS	0	0	20	**20**	15
Other	0	361	13	**374**	686
	144	361	35	**540**	856

Analysis of staff costs **4.2**

The Charitable Fund does not directly employ staff but incurred expenses relating to the Fundraising Manager, and two Fundraising Assistants` of £144k (2019-20 £153k). The decrease in staff costs for 2020-21 is due to the fundraising team only having two fundraising assistants for the second half of the year rather than three.

Pension Contributions for Senior employees **4.3**

No pension costs were charged to the charity during the year.

5. Net movement in funds

	Unrestricted Funds	Restricted Funds	**Total 2021 Funds**	Total 2020 Funds
	£000	£000	**£000**	£000
Net movement in funds for the year	138	0	**138**	(303)
for future activities	138	0	**138**	(303)

6. Analysis of Fixed Asset Investments

			2021	2020
Analysis of Fixed Asset Investments	**6.1**	Fixed Asset Investments:	**£000**	£000
		Market value at 31 March	**300**	300
		Market value at 31 March	**300**	300

			Held in UK	2021 Total	2020 Total
	6.2	Market value at 31 March :			
		All Investments are held in the UK.	£000	**£000**	£000
		Cash held as part of the investment portfolio	300	**300**	300
			300	**300**	**300**

			Held in UK	2020-21	2019-20
Analysis of gross income from investments	**6.3**	Total gross income			
			£000	**£000**	£000
		Investments in a Common Deposit Fund or Common Investment Fund	0	**0**	2
			0	**0**	**2**

7 Analysis of Debtors

			31 March 2021	31 March 2020
Analysis of Debtors	**7.1**	Amounts falling due within one year:	**£000**	£000
		Trade debtors	**0**	0
		Total debtors falling due within one year	**0**	0
	7.2	Amounts falling due over one year:		
		Other debtors	**0**	0
		Total debtors falling due after more than one year	**0**	0
		Total debtors	**0**	0

8 Analysis of Creditors

			31 March 2021	31 March 2020
Analysis of Creditors	**8.1**	Amounts falling due within one year:	**£000**	£000
		Trade creditors	**15**	58
		Amounts due to subsidiary and associated undertakings	**0**	0
		Other creditors	**0**	0
			0	0
		Total creditors falling due within one year	**15**	58
	8.2	Amounts falling due after more than one year:		
		Other creditors	**0**	0
		Total creditors falling due after more than one year	**0**	0
		Total creditors	**15**	58

9 Analysis of funds

9.1 Restricted Funds

	Balance 31 March 2020	Incoming	Resources Expended	Transfers	Gains and Losses	**Balance 31 March 2021**
	£000	£000	£000	£000	£000	**£000**
Material funds						
Cancer Centre Appeal	2	0	0	(2)	0	**0**
Total	**2**	**0**	**0**	**(2)**	**0**	**0**

Comparative year	Balance 31 March 2019	Incoming	Resources Expended	Transfers	Gains and Losses	**Balance 31 March 2020**
	£000	£000	£000	£000	£000	**£000**
Material funds						
Cancer Centre Appeal	310	390	(698)	0	0	**2**
Total	**310**	**390**	**(698)**	**0**	**0**	**2**

9.2 Unrestricted Funds

	Balance 31 March 2020	Incoming	Resources Expended	Transfers	Gains and Losses	**Balance 31 March 2021**
	£000	£000	£000	£000	£000	**£000**
Total	**321**	**678**	**540**	**2**	**0**	**461**

Comparative year	Balance 31 March 2019	Incoming	Resources Expended	Transfers	Gains and Losses	**Balance 31 March 2020**
	£000	£000	£000	£000	£000	**£000**
Total	**317**	**171**	**(166)**	**0**	**0**	**321**

Greater than £15k

Details of		**Name of fund**	**Amount**
			£'000
Unrestricted funds greater than £15k	**A**	General Fund	**126**
	B	Little Lives Fund	**106**
	C	MK Cancer Services	**71**
	D	Staff Welfare Fund	**61**
	E	Baby Bereavement Fund	**17**

A transfer of £2k was made from restricted funds to unrestricted funds due to the Cancer Centre Appeal being closed down, the £2k was transferred from the Cancer Centre Appeal (restricted) to the MK Cancer Services Fund (unrestricted).

10 Trustees and connected persons

The Trustees did not receive any remuneration or expenses in the year.

11 Related party transactions

Name, nature of connection, description of activities undertaken and details of any qualifications expressed by their auditors	2020-21 Turnover of Connected Organisation £000	2020-21 Net Profit/ Loss for the Connected Organisation £000	2019-20 Turnover of Connected Organisation £000	2019-20 Net Profit/ Loss for the Connected Organisation £000
Milton Keynes Hospital NHS Foundation Trust	310,121	393	282,045	(5,124)

Milton Keynes University Hospital is the host Trust and Corporate Trustee of the charity, providing administrative support to the charity, and is its sole beneficiary.

During the year the charity incurred expenditure of £164k (2019-20: £680k) with the host trust. At the balance sheet date, there was a debtor balance of £0k (2019-20: £0k) and a creditor balance due to the host trust of £14k (2019-20: £57k).

12 Reconciliation of net movement in funds to net cash flow from operating activities.

	2021 £'000	2020 £'000
Net movement in funds	138	(303)
Deduct interest income shown in investing activities	0	(2)
Decrease/ (increase) in debtors	0	2
Decrease/ (increase) in creditors	43	8
Net cash used in operating activities	**95**	**(298)**

Milton Keynes Hospital NHS Foundation Trust
Milton Keynes Hospital
Standing Way
Eaglestone
Milton Keynes
MK6 5LD

Mercer & Hole
Silbury Court
420 Silbury Boulevard
Central Milton Keynes
MK9 2AF

Dear Sirs

Milton Keynes Hospital NHS Foundation Trust

The following representations are made on the basis of enquiries of management and staff with relevant knowledge and experience such as we consider necessary in connection with your independent examination of the charity's financial statements for the year ended 31 March 2021. These enquiries have included inspection of supporting documentation where appropriate. All representations are made to the best of our knowledge and belief.

General

1 We acknowledge that the work performed by you is substantially less in scope than an audit performed in accordance with International Standards on Auditing (UK) and that you do not express an audit opinion.

2 We confirm that the charity was entitled to exemption under section 144 of the Charities Act 2011 the requirement to have its financial statements for the financial year ended 31 March 2021 audited.

3 We have fulfilled our responsibilities as trustees as set out in the terms of your engagement letter dated 26 June 2018, under the Charities Act 2011 for preparing financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice), for being satisfied that they give a true and fair view and for making accurate representations to you.

4 All the transactions undertaken by the charity have been properly reflected and recorded in the accounting records.

5 All the accounting records have been made available to you for the purpose of your independent examination. We have provided you with unrestricted access to all appropriate persons within the charity, and with all other records and related information requested, including minutes of all management and trustee meetings and correspondence with The Charity Commission.

6 The financial statements are free of material misstatements, including omissions.

7 The effects of uncorrected misstatements are immaterial both individually and in total.

Assets and liabilities

8 The charity has satisfactory title to all assets and there are no liens or encumbrances on the charity's assets, except for those that are disclosed in the notes to the financial statements.

9 All actual liabilities, contingent liabilities and guarantees given to third parties have been recorded or disclosed as appropriate.

10 We have no plans or intentions that may materially alter the carrying value and where relevant the fair value measurements or classification of assets and liabilities reflected in the financial statements.

Accounting estimates

11 Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

Legal claims

12 We have disclosed to you all claims in connection with litigation that have been, or are expected to be, received and such matters, as appropriate, have been properly accounted for, and disclosed in, the financial statements.

Laws and regulations

13 We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.

Related parties

14 Related party relationships and transactions have been appropriately accounted for and disclosed in the financial statements. We have disclosed to you all relevant information concerning such relationships and transactions and are not aware of any other matters which require disclosure in order to comply with legislative and accounting standards requirements.

Subsequent events

15 All events subsequent to the date of the financial statements which require adjustment or disclosure have been properly accounted for and disclosed.

Going concern

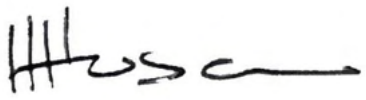
16 We believe that the charity's financial statements should be prepared on a going concern basis on the grounds that current and future sources of funding or support will be more than adequate for the charity's needs. We have considered a period of twelve months from the date of approval of the financial statements. We believe that no further disclosures relating to the charity's ability to continue as a going concern need to be made in the financial statements.

Grants and donations

17 All grants, donations and other income, the receipt of which is subject to specific terms or conditions, have been notified to you. There have been no breaches of terms or conditions in the application of such income.

18 We confirm that the treatment of general appeals funds as unrestricted is correct and compliant with the donor wishes. We accept responsibility for ensuring that funds are used as the donor intended

Yours faithfully



Haider Husain, Non-Executive Director & Chair of the Charitable Funds Committee

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Signed on behalf of the board of trustees

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Trust Board	Date 13 January 2022
Report title:	Antimicrobial Stewardship Annual Report	Agenda item: 13
Lead directors **Report author Sponsor(s)**	Ian Reckless Dr Prithwi Chakrobarty	Medical Director Consultant Microbiologist
FoI status:	Public document	

Report summary	The 2020/21 Annual Report for Anti-microbial Stewardship is attached.			
Purpose *(tick one box only)*	**Information**	**Approval** ☐	**To note** x	**Decision**
Recommendation	The Board is asked to note the contents of the report			

Strategic objectives links	1. Improve Patient Safety 3. Improve Clinical Effectiveness
CQC outcome/ regulation links	This report relates to CQC: Regulation 12 – Safe care & treatment

Report history	The Annual Report was previously received at Quality & Clinical Risk Committee in December 2021

Antimicrobial Stewardship Annual Report: 2020-21

Meeting title	Quality Board	**Date: Dec 2021**
Lead Director	**Ian Reckless**	
Author	**Prithwiraj Chakrabarti**	

Report summary				
Purpose *(tick one box only)*	Y **Information**	**Approval**	**To note**	**Decision**
Recommendation				
Strategic objectives links	1. Improve Patient Safety and clinical outcome 2. Deliver Key Targets			
Board Assurance Framework links	Antimicrobial Stewardship Group Infection Prevention & Control Committee			
CQC outcome/ regulation links	1. Outcome 4/regulation 9 2. Outcome 16/regulation 10 3. Outcome 13/regulation 9			
Identified risks and risk management actions	For information			
Resource implications	Nil			
Legal implications including equality and diversity assessment	Healthcare Act –code of practice criteria Criteria 3- Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance. Also includes, criteria 1,5,6,7,8,9,and 10.			

Executive summary

This report summarizes the key performance indicators and all the major activities performed by antimicrobial stewardship (AMS) team between April 2020 and March 2021. During this period, AMS team focussed on activities to monitor AM prescribing and curb the challenges on antibiotic use over the pandemic. There were three AMS meeting conducted during this period due to COVID constrains, sickness and short staffing. The AMS ward rounds were continued throughout the COVID period to support AM prescribing. Procalcitonin based individualised AMS project has been implemented in the trust and is now running for more than one year. PCT based AM prescribing has been found to be effective in critical care particularly for COVID patients. MKUH has completed the ARK (Antimicrobial Review Kit) study during this period and the key messages were already embedded in the practice. The AM e-learning pack for mandatory training has been updated. The new microguide app has been launched for trust wide AM guidance. The microbiology lab has validated MALDI-TOF which is functioning to its capacity to reduce turnaround time to identify significant isolates and therefore helping in early intervention. The laboratory has been working 24x7 since Nov 2020 which is an immense improvement to overcome the barriers of processing blood culture and significant samples during out of hours. During this period, the laboratory was also inspected by UKAS first time in November and achieved UKAS accreditation for the serology section. Overall, the improvement in the TAT of significant samples and total quality of microbiology reporting will have a long-term positive impact on AMS.

AM usage has gone up throughout the country during COVID pandemic. PHE data showed spike of AM use since the beginning of pandemic. MKUH showed a similar pattern but overall rate of AM consumption in MKUH remained lower than national average. MKUH reduced significant carbapenem use during the last year compared to national average. The total antibiotic use was reduced as well but it was likely due to less number of admissions during pandemic. The total use of carbapenem, piperacillin-tazobactam and co-amoxyclav were lower than previous year. MKUH needs to improve on using WHO access category drugs. The *C.difficile* infection rates had slightly gone up following national trend, but the number of cases remained low in comparison to the national average and neighbouring trust.

Introduction

The Antimicrobial Stewardship (AMS) team drives, supports and monitors the AMS activity at MKUH. Currently, the AMS team consists of a Consultant Microbiologist (1 PA activity) and two Antimicrobial Pharmacists (part-time), however the AM pharmacist posts are vacant since April 2021. The AMS team reports to the Antimicrobial Stewardship Group (AMSG) members, which meet 5-6 times per year and meetings, are chaired by the Medical Director. AMSG consists of clinicians, nurses, pharmacists and managers from different disciplines. AMSG regularly discuss and review various AMS activities along the national and local AMS targets, review and approve policies and proposals for changes and sets overall governance on AMS activity at MKUH. However due to COVID constraints only 3 AMS meetings took place during April 2020 to March 2021. The main goal of AMS activity at MKUH is focussed on reduction of unnecessary AM consumption by rationalising AM usage. Irresponsible antimicrobial prescription is the main driver of AM resistance locally, nationally as well as globally. Institutional AM prescribing practice depends on clinician's knowledge, attitude and perception towards AM prescribing behaviour. Therefore, institutional governance on AM usage plays a key role in changing AM prescribing behaviour among clinicians.

The key AMS activities during April, 2020- March, 2021 are summarised below.

1. AMS ward round

AMS ward rounds were continued twice a week with the aim of providing regular AM governance, proactive decision making and improving AM prescribing behaviours. During COVID pandemic, general use of antibiotics went up due to standard prescription of antibiotics among COVID patients. AMS round was focussed on rationalising the duration of broad-spectrum AM (Piperacillin-Tazobactam, Meropenem, quinolones and co-amoxiclav) for both COVID and non-COVID patients. Our aim was to prevent the rise of meropenem during pandemic which has direct impact on AM resistance.

2. Procalcitonin based individual AM stewardship

Procalcitonin (PCT) is a marker for bacterial sepsis and low PCT value can be a useful guide to stop or switch antibiotics early. PCT based AMS guidance has been updated locally and implemented throughout MKUH in May 2020. PCT audit was conducted to demonstrate the value of the QIP at MKUH. A research project has been finished (HRA- IRAS 295166) involving junior doctors and a manuscript has been submitted for publication. The research showed significant decrease in AM consumption among COVID positive patients in ICU if PCT is done within first 48 hrs of ICU admission.

3. Microbiology laboratory upliftment

Microbiology lab took the responsibility of timely COVID testing and reporting to allow the patient flow and maintain the standard of care. The laboratory showed good resilience to absorb the work with appropriate support from management. We achieved our goal of at least 100 onsite testing facilities in Jan 2021. The Lab underwent a complete remodeling of working pattern with the introduction of 24x7 work model with some additional resources. MALDI-TOF was introduced in Aug 2020, and it has been made functioning since December 2020 supporting identification and reporting of significant isolates. The lab has successfully cleared the UKAS inspection in December 2020 and achieved accreditation for serology section. Overall the 24 x7 service and MAL-TOF had improved the TAT and quality of reporting of significant samples which has helped early management of difficult infections and appropriate antimicrobial prescriptions.

4. AM policy update

The Trust's AM policy needs to be continually reviewed and updated in response to local and national requirements. The current MKUH AM policy is available via the Trust intranet and Microguide app. AMS team has been working with respective clinical teams and divisions to upgrade local policies and we have updated further 5 policies until March 2021.

Antibiotic policy updates	Update date	Comment
COVID-19 AM policy	May 2020	As per NICE guide 1st May 2020
PCT based individualised AM stewardship	June 2020	At the time of introduction of PCT
Orthopaedic pre-op guidance	Mar 2021	Reviewed the guidance following an audit for compliance
Neonatal AM Policy	Apr 2020	As per requirement
Gentamicin policy	Mar 2021	Reviewed as per AE audit action

5. Antimicrobial e-learning update for Trust's mandatory training

AM e-learning for Trust's mandatory AM training was due for update (last update was in 2017). The update has been completed and the latest version is live for AMS mandatory training. Thanks to Jane Plant and Linda Potter for helping.

6. Rx guide to Microguide AM app

The Microguide app has now replaced the Rx guidance for AM app at MKUH. The transfer of data was completed in March 2021, and the app was made live since then.

7. Teaching

COVID pandemic has impacted on teaching and training. AMS round provides a good opportunity for spot teaching. AMS team involved in few formal teaching sessions sharing learning and experience within nurses, junior doctors, medical students, and grand rounds (5-6 sessions delivered in 2020-21). There were also 3 sponsored teaching sessions organised during AM awareness week.

8. ARK study

AMS team participated in ARK (Antibiotic review kit) study in 2019 with an aim to improve AM review within first 72hr of prescribing. The study involved three interventions. These included short e-learning training package for all doctors and pharmacists, asking the prescribing doctor to document probable/possible/confirmed infection when prescribing an antibiotic and giving out patient information leaflets to inform patients about the need for AMS. The second intervention has been adopted in e-care. The study helped spreading awareness of regular antibiotic review in the participating medical wards. The final part study data submission has been completed in Oct 2020 and it's officially closed now.

9. AMS audits/QI projects/Research

PCT based QI Projected has been completed in Oct 2020 and all actions completed. AMS team participated in COVID research since April 2020, which has led to a publication in 2021.

Using Machine Learning Algorithms to Develop a Clinical Decision-Making Tool for COVID-19 Inpatients - PubMed (nih.gov)

10. AMS week

AMS team celebrated the World Antimicrobial Awareness Week between 18-24th Nov 2020 with variety of activities including AM Quiz and educational sessions. The quiz involved an inter-ward competition to promote participation and increase awareness and over 100 entries were received with ward 1 being crowned the winners. There were three sponsored teaching sessions on AM prescription and difficult to treat infections by national and international speakers.

11. AMR CQUIN

NHSI launched two new AM resistance CQUIN in the year 2019-20 (link below)

Part 1- AM prescribing for lower UTI in older people

Part 2- Antibiotic prophylaxis for elective colorectal surgery

https://www.england.nhs.uk/wp-content/uploads/2020/08/FINAL_20191023_CQUIN_FAQs_1920_v11.pdf

MKUH submitted data in 2019-20. The result produced baseline value on AM prescribing in UTI treatment. However, there were inconsistencies in the collection of data among trusts and therefore majority of trusts couldn't submit comparable data. The CQUIN was not further followed up by PHE due to COVID pandemic. However, in MKUH, we continued disseminating NICE guidance based UTI management to the clinical team and nurses via various forum. The recommendations had been incorporated in the new AM e-learning for mandatory training.

The part-2 of the CQUIN had been completed and MKUH submitted data for all 4 quarters in 2019-20. There was 84% compliance with the current policy for surgical prophylaxis. Further audit has been planned to monitor its sustainability.

CQUIN 2020-21 also commented on antifungal stewardship. AMS team has produced a plan for antifungal stewardship activity at MKUH based on baseline data collection, diagnostic stewardship, and regular review of broad-spectrum antifungals in the AM stewardship round.

12. Action plans 2019-20- Progress report

	Action Plan 2019-20	Comment
1.	PCT based AM stewardship	Completed. Further audit is recommended
2.	AE gentamicin prescription audit action plan	Completed. E-care pop-up to be done in Sep and further audit recommended
3.	Nebulised Gent for Bronchiectatic patients	Not achieved due to COVID pressure & staffing issue
4.	Moving Rx guideline to Microguide app	Completed, need further pharmacy support for updates
5.	Improvement of Laboratory reporting time and quality	MALDI-TOF installed, Lab 24 x7 work, on call with Swindon implemented. UKAS accreditation done.

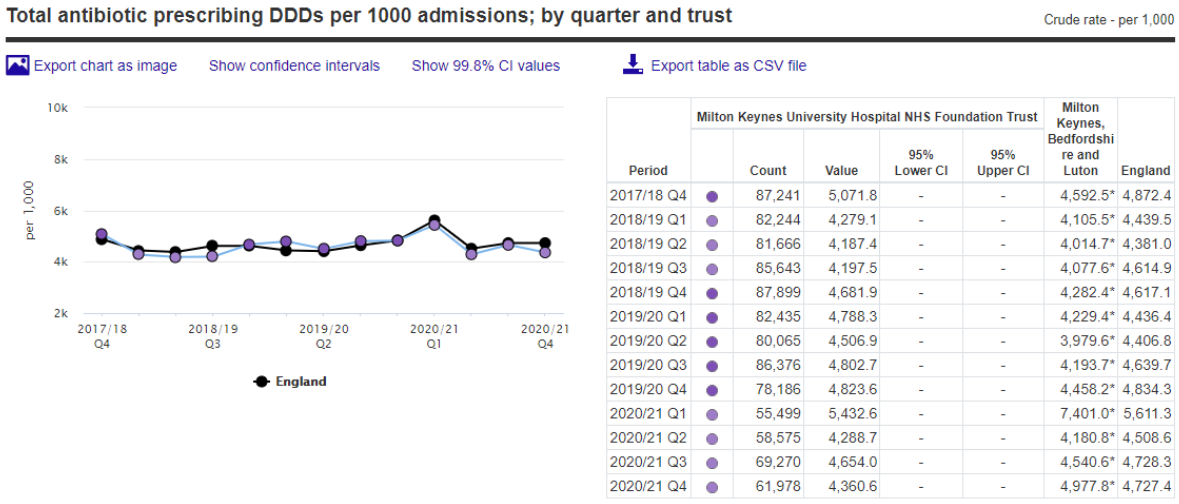
AMS performance data

PHE regularly publishes data on AMS performance of each NHS trust and the data is available on public domain. The performance standard is comparable with national average and other NHS trusts. The PHE data related to AM performance focusses on primarily two parameters.

1. Total AM consumption (DDD-defined daily dose) per 1000 total admissions
2. Total Carbapenem consumption (DDD) per 1000 total admissions

The full performance report for MKUH can be found on the following website

https://fingertips.phe.org.uk/profile/amr-local-indicators



Total antibiotic prescribing DDDs per 1000 admissions; by quarter and trust

Crude rate - per 1,000

Export chart as image | Show confidence intervals | Show 99.8% CI values

Export table as CSV file

Period		Milton Keynes University Hospital NHS Foundation Trust Count	Value	95% Lower CI	95% Upper CI	Milton Keynes, Bedfordshire and Luton	England
2017/18 Q4		87,241	5,071.8	-	-	4,592.5*	4,872.4
2018/19 Q1		82,244	4,279.1	-	-	4,105.5*	4,439.5
2018/19 Q2		81,666	4,187.4	-	-	4,014.7*	4,381.0
2018/19 Q3		85,643	4,197.5	-	-	4,077.6*	4,614.9
2018/19 Q4		87,899	4,681.9	-	-	4,282.4*	4,617.1
2019/20 Q1		82,435	4,788.3	-	-	4,229.4*	4,436.4
2019/20 Q2		80,065	4,506.9	-	-	3,979.6*	4,406.8
2019/20 Q3		86,376	4,802.7	-	-	4,193.7*	4,639.7
2019/20 Q4		78,186	4,823.6	-	-	4,458.2*	4,834.3
2020/21 Q1		55,499	5,432.6	-	-	7,401.0*	5,611.3
2020/21 Q2		58,575	4,288.7	-	-	4,180.8*	4,508.6
2020/21 Q3		69,270	4,654.0	-	-	4,540.6*	4,728.3
2020/21 Q4		61,978	4,360.6	-	-	4,977.8*	4,727.4

Fig1 PHE data showing AM consumption rate per 1000 admissions at MKUH in 2020-21 has been below the national average. The sharp rise of antibiotic consumption rate during Q1 was due to COVID pandemic which reflected with a national surge, as almost 90% of COVID patients received antibiotics.

https://fingertips.phe.org.uk/profile/amr-local-indicators

Total systemic antibiotic consumption

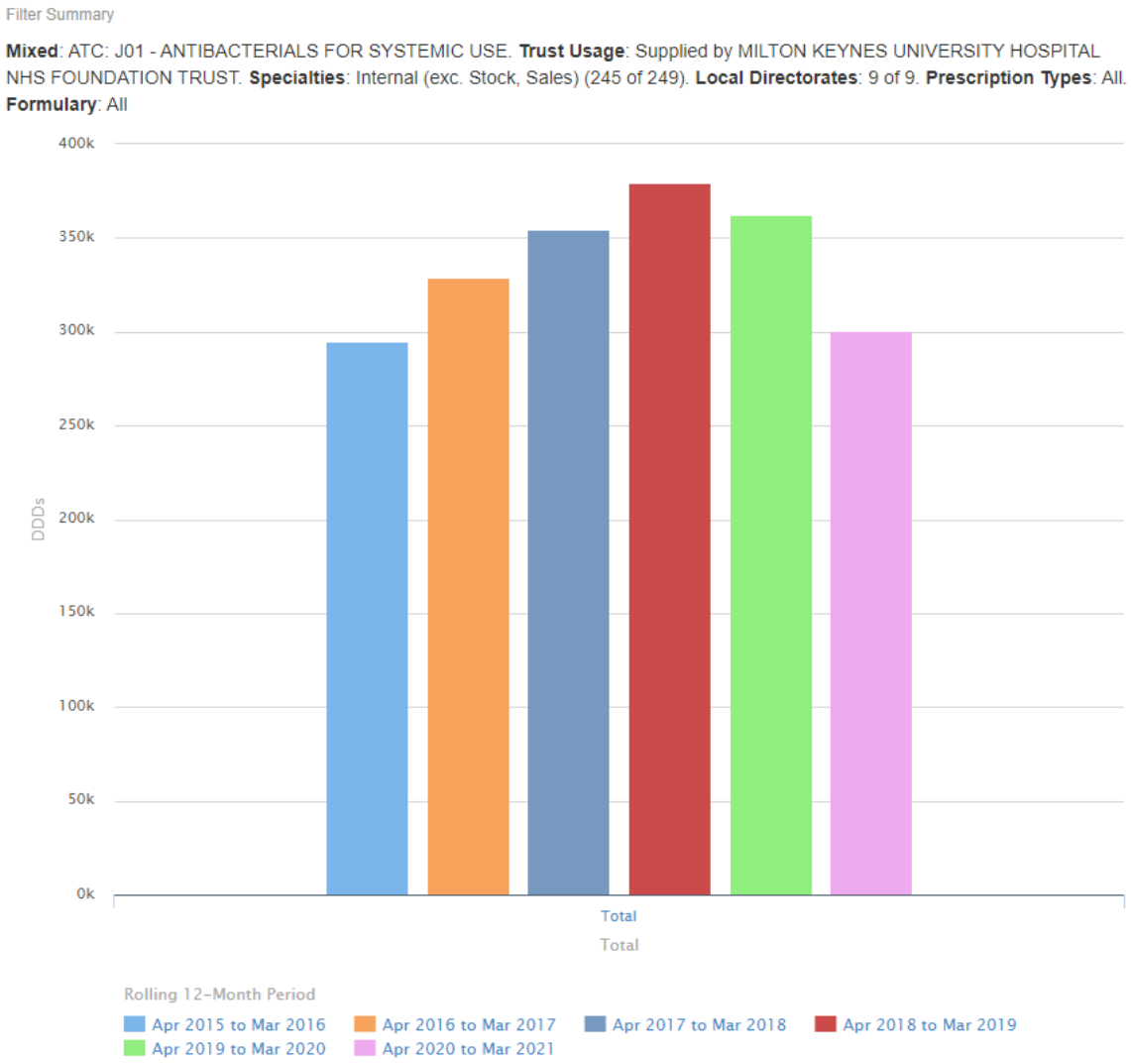
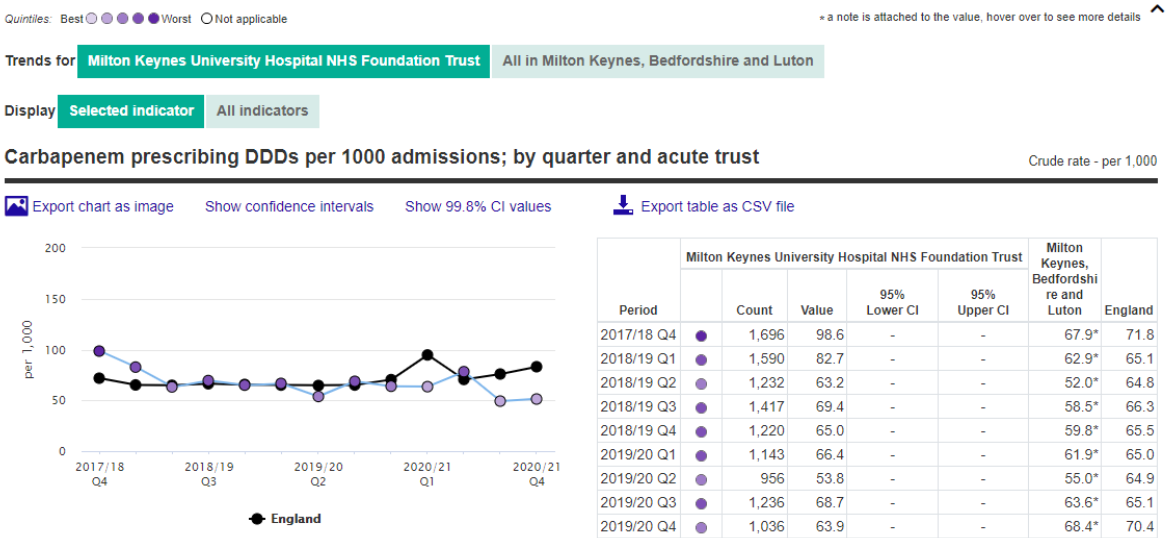


Fig 2. Historic data from Rx information showed that there was a gradual rise of total DDDs (total systemic antibiotic consumption) at MKUH since 2015, which was reversed in 2019-20 and continued in 2020-21. However, the sharp fall in 2020-21 was likely due to reduced total admission during COVID pandemic. Despite the total consumption plummeted during COVID period, the rate of antibiotic use (DDD/1000 admissions) went up as shown in Fig 1.

Carbapenem prescription at MKUH

Carbapenems are the broadest spectrum antibiotics. Our AMS activity is mostly focussed on appropriate prescription and duration of carbapenem use in the trust. Meropenem and ertapenem are the two carbapenems used in MKUH. Carbapenem resistance is rapidly rising nationally and internationally, and mostly due to increase use/duration of carbapenems for difficult infections. The following figures (fig 3 and 4) showed the trend of carbapenem use in MKUH.



Period		Milton Keynes University Hospital NHS Foundation Trust Count	Value	95% Lower CI	95% Upper CI	Milton Keynes, Bedfordshire and Luton	England
2017/18 Q4		1,696	98.6	-	-	67.9*	71.8
2018/19 Q1		1,590	82.7	-	-	62.9*	65.1
2018/19 Q2		1,232	63.2	-	-	52.0*	64.8
2018/19 Q3		1,417	69.4	-	-	58.5*	66.3
2018/19 Q4		1,220	65.0	-	-	59.8*	65.5
2019/20 Q1		1,143	66.4	-	-	61.9*	65.0
2019/20 Q2		956	53.8	-	-	55.0*	64.9
2019/20 Q3		1,236	68.7	-	-	63.6*	65.1
2019/20 Q4		1,036	63.9	-	-	68.4*	70.4
2020/21 Q1		648	63.5	-	-	114.0*	94.7
2020/21 Q2		1,068	78.2	-	-	76.4*	70.6
2020/21 Q3		733	49.3	-	-	64.8*	76.0
2020/21 Q4		732	51.5	-	-	84.8*	83.1

Source: DDDs were provided by RxInfo © 2019 to support NHS England CQUINs. Prescribing rates were calculated using HES admissions data provided by NHS Digital.

Fig3. PHE data showed MKUH carbapenem use has been continued to be below national average. In Q2 there was a spike of carbapenem use which is attributed to the peak of pandemic and surge of antibiotic use. However, we introduced procalcitonin guided antibiotic treatment which helped to reduce the use of carbapenems particularly in COVID patients.

https://fingertips.phe.org.uk/profile/amr-local-indicators

Total Carbapenem consumption in MKUH

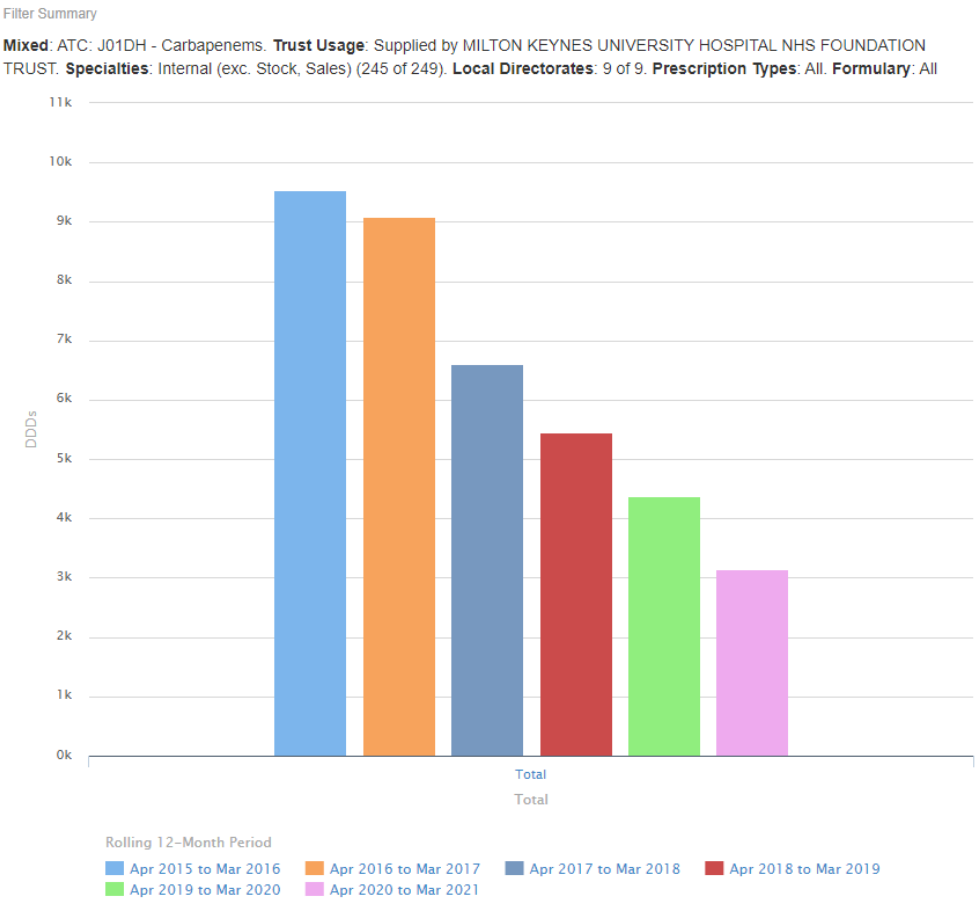
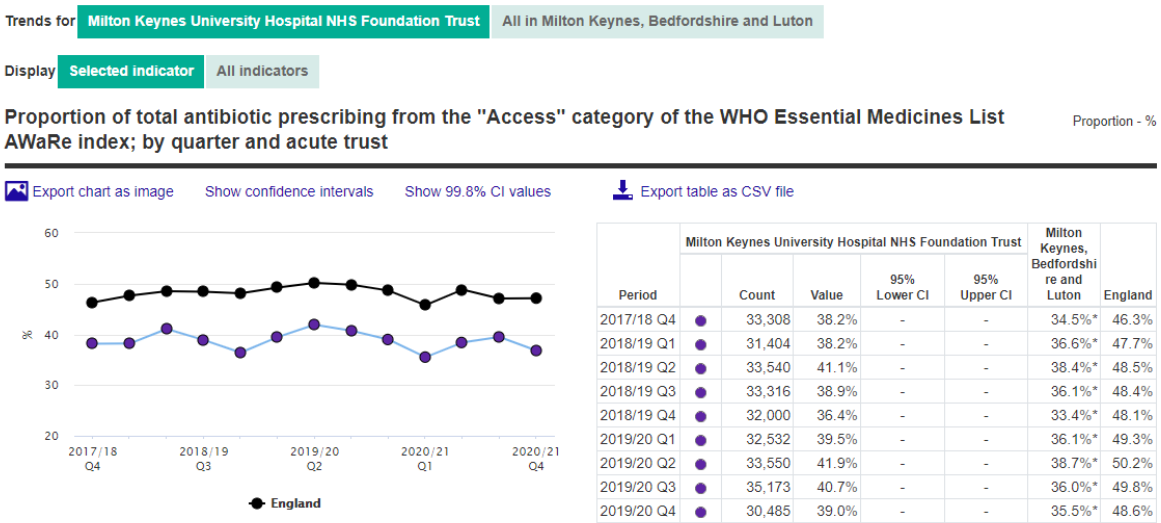


Fig 4. Refine data showed meropenem use at MKUH. There is a significant stepwise reduction of meropenem over the years. The lowest use of carbapenems was in 2020-21, this was likely due to reduced number of total admissions. However, we focussed on minimizing carbapenem use among COVID patients during pandemic.

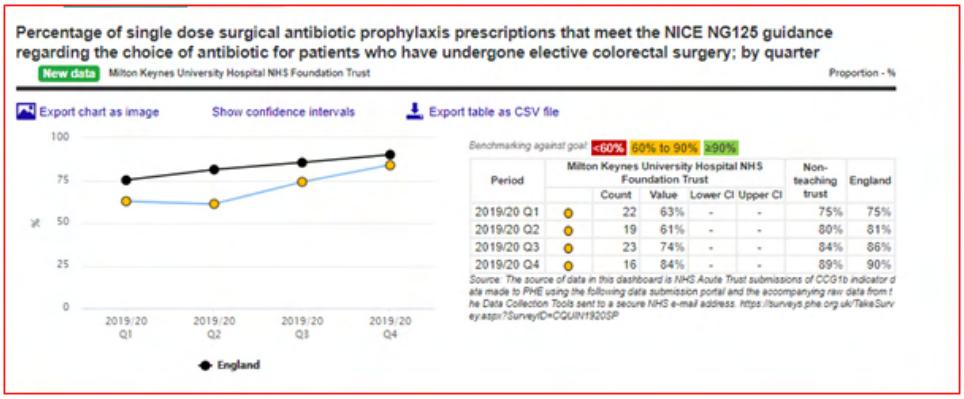
Use of WHO access category (narrower spectrum) antibiotics in MKUH



Period		Milton Keynes University Hospital NHS Foundation Trust Count	Value	95% Lower CI	95% Upper CI	Milton Keynes, Bedfordshire and Luton	England
2017/18 Q4	●	33,308	38.2%	-	-	34.5%*	46.3%
2018/19 Q1	●	31,404	38.2%	-	-	36.6%*	47.7%
2018/19 Q2	●	33,540	41.1%	-	-	38.4%*	48.5%
2018/19 Q3	●	33,316	38.9%	-	-	36.1%*	48.4%
2018/19 Q4	●	32,000	36.4%	-	-	33.4%*	48.1%
2019/20 Q1	●	32,532	39.5%	-	-	36.1%*	49.3%
2019/20 Q2	●	33,550	41.9%	-	-	38.7%*	50.2%
2019/20 Q3	●	35,173	40.7%	-	-	36.0%*	49.8%
2019/20 Q4	●	30,485	39.0%	-	-	35.5%*	48.6%
2020/21 Q1	●	19,712	35.5%	-	-	28.9%*	45.8%
2020/21 Q2	●	22,491	38.4%	-	-	34.2%*	48.8%
2020/21 Q3	●	27,356	39.5%	-	-	32.7%*	47.1%
2020/21 Q4	●	22,816	36.8%	-	-	28.4%*	47.1%

Source: DDDs were provided by RxInfo © 2019 to support NHS England CQUINs.

Fig 4. PHE data shows that MKUH needs to improve on using of WHO access category medicine. WHO access category indicates narrower spectrum antibiotics. MKUH use co-amoxy-clav for sepsis, UTI and chest infections, therefore co-amoxyclav remains the most common choice and used widely. Unfortunately, co-amoxyclav doesn't come under WHO access category. Moving from co-amoxyclav to amoxicillin in certain infections can improve the parameter. The change from co-amoxy/gent/metro to amox/gent/metro in prophylaxis for colorectal surgery was a significant step taken in 2019-20 to promote use of narrower spectrum antibiotics at MKUH.



Period	Milton Keynes University Hospital NHS Foundation Trust Count	Value	Lower CI	Upper CI	Non-teaching trust	England
2019/20 Q1	22	63%	-	-	75%	75%
2019/20 Q2	19	61%	-	-	80%	81%
2019/20 Q3	23	74%	-	-	84%	86%
2019/20 Q4	16	84%	-	-	89%	90%

Source: The source of data in this dashboard is NHS Acute Trust submissions of CCG1b indicator d ata made to PHE using the following data submission portal and the accompanying raw data from t he Data Collection Tools sent to a secure NHS e-mail address. https://surveys.phe.org.uk/TakeSurv ey.aspx?SurveyID=CQUIN1920SP

Fig 5 PHE data shows MKUH improved to 84% on Antibiotic prophylaxis for elective colorectal surgery (CQUIN-part-2). We still need to work on to keep it high at 90%. Further audit is required to demonstrate sustainability.

https://fingertips.phe.org.uk/profile/amr-local-indicators

Piperacillin-Tazobactam (Tazocin)

PT remains the most valuable 2nd line antibiotic for majority of infections. High use of PT is the main driver of spread of ESBL in many countries including UK. Rise of PT use has been linked with rise of carbapenem use in many hospitals. AMS round focuses on appropriate use and duration of PT in MKUH.

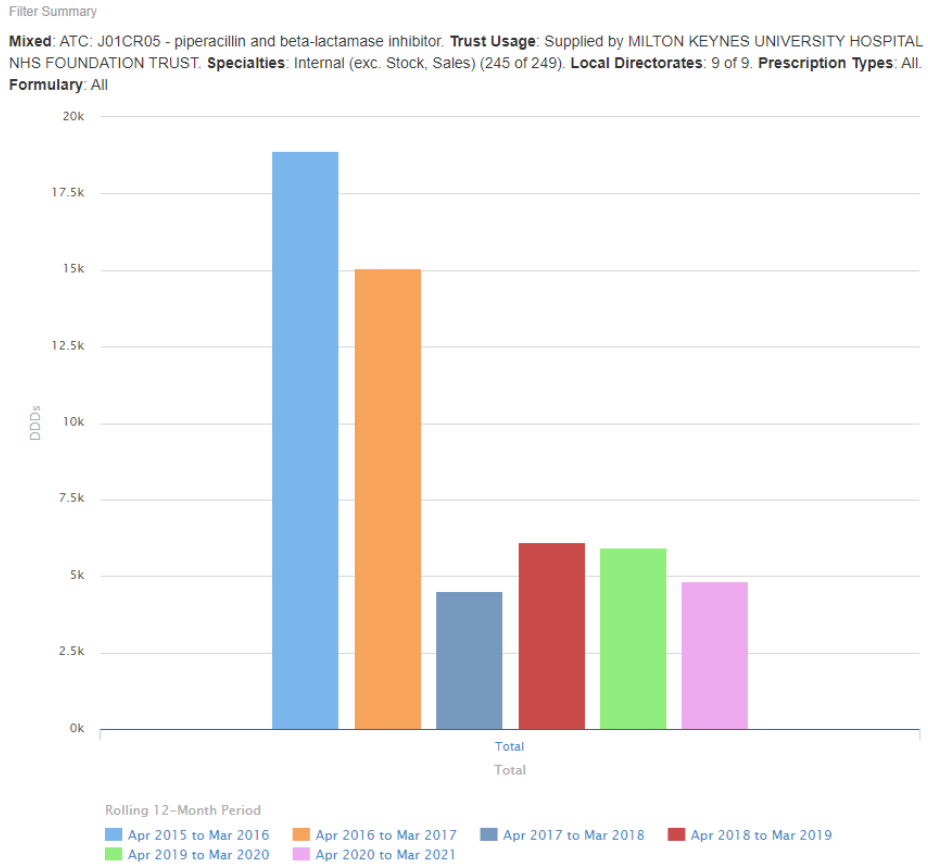


Fig 6. Refine data showed Piperacillin-Tazobactam (Tazocin) use at MKUH. The big dip in 2017-18 was likely due to a stock shortage of Tazocin that prompted a change of empiric antibiotic choice from Piperacillin-Tazobactam to co-amoxiclav and gentamicin. Tazocin consumption have come down since 2018-19, however the drop in 2020-21 may be due to a smaller number of hospital admission. We are keen to continue PT as a 2nd line to reduce the antibiotic pressure on development of resistance.

Co-amoxyclav use in MKUH

MKUH uses co-amoxyclav as a primary antibiotic of choice for the majority of infections. Despite rising gram-negative resistance to co-amoxiclav, the combined gentamicin and co-amoxyclav provide good cover for the majority of infections in local population. AMS round focuses particularly on the regular review and duration of co-amoxyclav in MKUH.

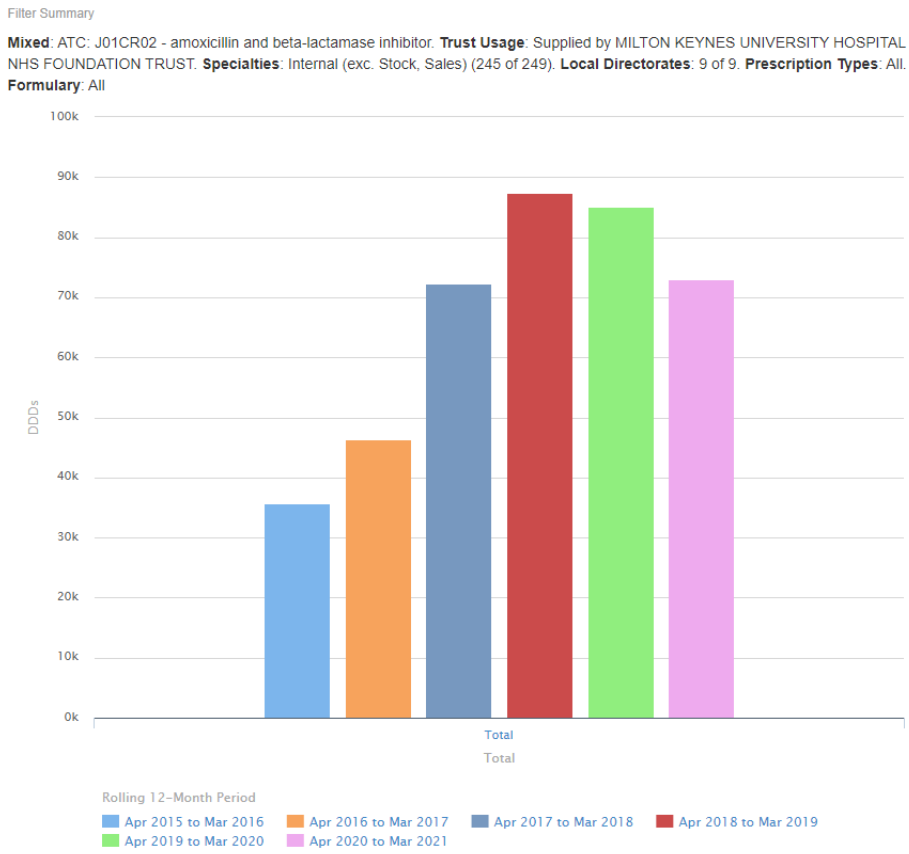
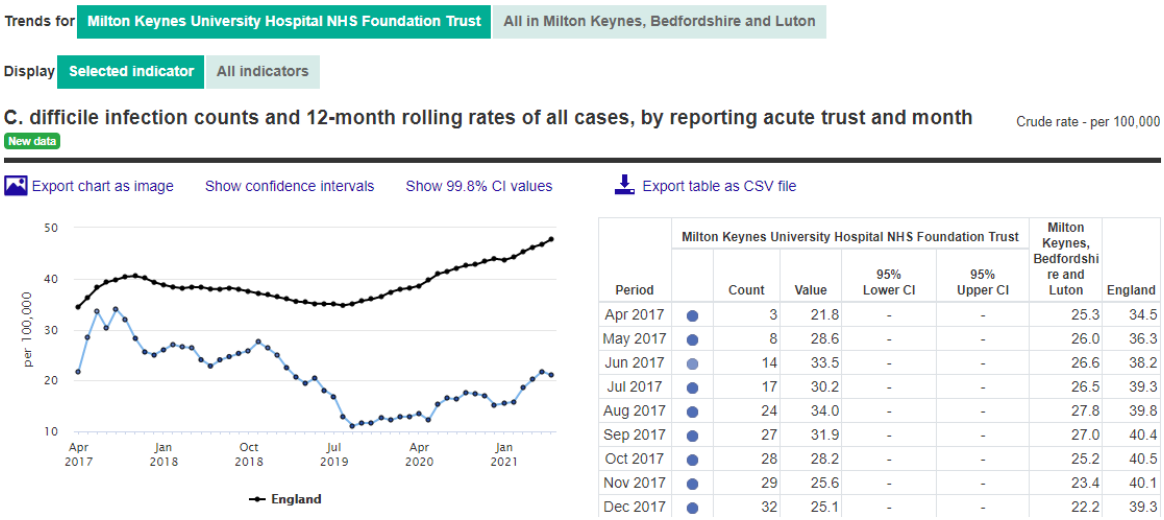


Fig7. Refine data showed Amoxicillin-clavulanic acid (co-amoxyclav) use at MKUH. The total co-amoxiclav use has gone down since 2018-19. However, the drop in 2020-21 may be due to less number of admissions.

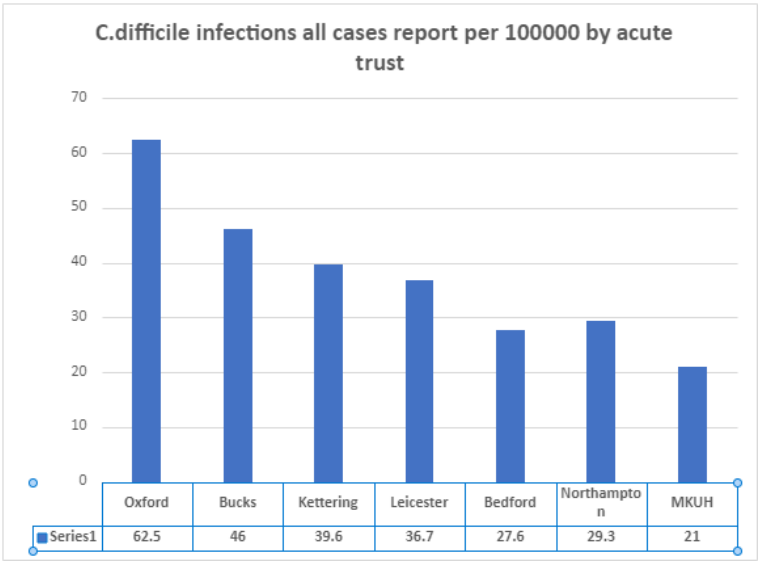
C.difficile infection trend

The Clostridium difficile infection is an indicator of antibiotic practice, presumably high infection rates are associated with inappropriate antibiotic prescriptions. MKUH reported much lower number of C.difficile infections in comparison to national averages.



Period		Milton Keynes University Hospital NHS Foundation Trust Count	Value	95% Lower CI	95% Upper CI	Milton Keynes, Bedfordshire and Luton	England
Apr 2017		3	21.8	-	-	25.3	34.5
May 2017		8	28.6	-	-	26.0	36.3
Jun 2017		14	33.5	-	-	26.6	38.2
Jul 2017		17	30.2	-	-	26.5	39.3
Aug 2017		24	34.0	-	-	27.8	39.8
Sep 2017		27	31.9	-	-	27.0	40.4
Oct 2017		28	28.2	-	-	25.2	40.5
Nov 2017		29	25.6	-	-	23.4	40.1
Dec 2017		32	25.1	-	-	22.2	39.3

Fig 8: Trend of C. difficile infections reported by MKUH. The number of C.difficile infection has gone up nationally due to rise of antibiotic consumption rate during COVID pandemic. Similar trend has been noticed in MKUH but the infection numbers are significantly below national average. Interesting MKUH *C.difficile* infection rate is significantly lower than other neighbouring trusts.



Data collected from: https://fingertips.phe.org.uk/profile/amr-local-indicators

AM stewardship is a continuous process of governance and improving prescribing behaviour of the clinicians focussing on rationalising and targeted AM use to improve clinical care and reduce harm to the patients. The year 2020-2021 was a challenging year for AM stewardship due to the COVID-19 pandemic and our inexperience to treat the new viral infection. The rate of total and broad-spectrum antibiotic consumption had increased throughout this year due to the ongoing pandemic. This was reflected nationally and globally which is likely to impact on AM resistance in future. The ongoing pandemic, the huge backlog in NHS, increasing complicated infections and winter pressure could potentially increase the antibiotic use in 2021-22. We are determined to support the stewardship activity focussing on specific areas which are at risk of AM overuse.

Following areas have been identified as focus for 2021-22

We have already started observing several complicated infections growing in various wards including haemto-oncology, respiratory, elderly care and surgical units. As the hospital is getting busier and the number of bed-occupancy rises, these areas along with COVID wards are at risk of high AM consumption. Senior clinicians need to be proactive to support AM stewardship and take ownership of AM prescribing practice in their clinical areas. This awareness may have been interrupted by the pandemic wave but can be reiterated again through regular teaching, audits, research, and AM Stewardship meeting.

1. **Antifungal stewardship plan**

   In 2021-22, AMS team will produce baseline data on antifungal use in MKUH and produce some tools to monitor the use of broad-spectrum antifungals in the trust.

2. **Recruitment of AM Pharmacists**

   AMS team lost both the AM pharmacists early this year. This has weakened the AMS team and slowed down some activities. We need to fulfil those posts asap to avoid any long-term impact on the AMS activities.

3. **Gentamicin usage audit**

   A pharmacy led local audit highlighted that gentamicin dosing remained variable in the trust. Some action plans have already been put in place to address the issue and further audits need to be done to mitigate the risk.

4. **Improvement of Laboratory reporting time and quality of service**

   Microbiology department is continuously working on various laboratory improvements to enhance the quality of infection service. MALDI-TOF has already been found to be effective in reducing TAT of

significant results. Microbiology 24 x7 service has improved the blood culture processing time and availability of critical results earlier.

a. Network collaboration for Microbiology IT integration

The microbiology department is involved in harmonisation of work between the network trusts to develop the new network wide IT system. This system will enable intra-network sample processing and result transfer more efficiently and reduce TAT.

b. Microbiology UKAS scope enhancement and full laboratory accreditation

UKAS accreditation is mandatory for a modern microbiology laboratory as it provides the necessary framework for quality assured service. The serology section has already got accreditation. The department is keen to enhance the scope further this year to apply for accreditation of the whole laboratory.

c. Microbiology junior doctor post approval and recruitment

The approval of business case for a junior microbiologist was supportive and highly commendable. This post mitigates the risk of contingency of service in microbiology and AM stewardship. A junior support will help the department to grow microbiologist-led diagnostic stewardship in the trust which will help reducing unnecessary investigations and in-patient stay as well as save waiting time for referrals.

Conclusion

During 2020 (Apr)-21 (Mar), MKUH has seen a number of improvements in the AMS services being provided by our AMS team which had impacted AMS performance. COVID-19 was a huge challenge at the beginning of the year but the lab and AMS team showed good resilience to get over the hard time. The introduction of PCT based individualised AM stewardship, proactive AM support, AMS rounds, improved microbiology service, have supported to keep antimicrobial consumption rate below national average, specifically for carbapenem usage. However, the ongoing pandemic and winter pressure along with staff shortage may put significant challenges in the year ahead.

References

1. **UK 5-year action plan for antimicrobial resistance 2019 to 2024.** https://www.gov.uk/government/publications/uk-5-year-action-plan-for-antimicrobial-resistance-2019-to-2024
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3. **PHE patient safety alert.** https://www.england.nhs.uk/wp-content/uploads/2015/08/psa-amr-stewardship-prog.pdf
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5. **Antibiotic Review Kit-A research program aiming to safely reduce antibiotic use in hospitals.** http://www.arkstudy.ox.ac.uk/
6. **World Antibiotic awareness week, 18-22 November.** https://www.england.nhs.uk/2019/10/world-antibiotic-awareness-week-18-22-november/
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8. **COVID-19 rapid guideline: antibiotic for pneumonia in adults in hospitals** COVID-19 rapid guideline: antibiotics for pneumonia in adults in hospital | Guidance | NICE
9. British Thoracic Society Guideline for bronchiectasis in adults, 2018. https://thorax.bmj.com/content/74/Suppl_1/1

Meeting Title	**Board of Directors**	**Date: January 2022**
Report Title	**Enhancing Board Oversight: A New Approach To Non-Executive Director Champion Roles**	**Agenda Item: 15**
Lead Director	**Name: Kate Jarman**	**Title: Director of Corporate Affairs**
Report Author	**Name: Kwame Mensa-Bonsu**	**Title: Trust Secretary**

Key Highlights/ Summary	*N/A*			
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** [x]	**For Noting** ☐	**For Review** ☐

Strategic Objectives Links	*N/A*
Board Assurance Framework (BAF)/ Risk Register Links	*N/A*

Report History	*N/A*
Next Steps	*Review Board Committee Terms of References and Workplans*
Appendices/Attachments	• Appendix 1 - Report • Appendix 2 – NHSI/E Guideline: Enhancing board oversight. A new approach to non-executive director champion roles

Appendix 1

Enhancing Board Oversight:

A New Approach to Non-Executive Director Champion Roles

1. Introduction

In December 2021, NHSE/I published a new guideline which was developed in conjunction with several stakeholders, including the Care Quality Commission, recommending a new and enhanced approach to ensuring Board oversight of important strategic issues. The guideline was developed due to the growing recognition that non-executive directors' (NEDs) limited availability prevented them from effectively championing the increasing number of issues which they were being asked to champion.

To effectively utilise the limited availability of the NEDs, the guideline recommended a limited number of areas for NEDS to 'champion' and drive change, while highlighting the issues which would be best managed through the Board Committees structure. (Please see below).

If the Trust Board agrees with the recommendations as listed below, and approves the implementation of the various actions, the Terms of References of the Board Committees will be revised and updated as appropriate.

It needs to be noted that this new enhanced approach does not affect or have any impact on the senior independent director role which is required by the Foundation Trust Corporate Governance Code.

2. Summary of Recommendations (For Foundation Trusts)

For Foundation Trusts, **four NED champion roles should be retained**, and these are:

A. Maternity Board Safety Champion
B. Wellbeing Guardian
C. Freedom to Speak-Up Guardian (FTSU)
D. Doctors' Disciplinary

Other areas where NEDs were previously champions, should be covered through Committees. These are as follows:

Area	**Responsible Committee**	**Commentary**	**Additional Requirements**
Dementia	Quality and Clinical Risk Committee		
Inpatient falls	Quality and Clinical Risk Committee	Note link with Dementia **(Appendix 2)**	
Palliative and End of Life Care	Quality and Clinical Risk Committee		
Resuscitation	Quality and Clinical Risk Committee		
Learning from Deaths	Quality and Clinical Risk Committee		

Area	Responsible Committee	Commentary	Additional Requirements
Health and Safety	Quality and Clinical Risk Committee and Workforce and Development Assurance Committee	This is a change from current reporting through the Audit Committee	
Safeguarding			All Trust Board members should have Level 1 core competencies in safeguarding and must know the common presenting features of abuse and neglect and the context in which it presents to healthcare staff. All Trust Board members should understand the statutory role of the Board in safeguarding including partnership arrangements, policies, risks and performance indicators, staff roles and responsibilities in safeguarding. All Trust Boards should understand the expectations of regulatory bodies in safeguarding.

In addition to the above, the guideline makes the following recommendations:

Guideline Recommendation	**Trust Recommendation for the Board**
A NED may be appointed as the safety and risk champion	All NEDs take an active interest in safety and risk. All Committee chairs champion these agendas through their Committees. The Chair of the Audit Committee has a particular interest in, and role in supporting, risk management processes.
A NED may be appointed as the champion for children and young people	It is recommended that this is a special interest role, rather than a formal champion role, and NEDs are invited to express an interest in this area.
The Trust Board should undertake annual cyber awareness training sessions	This is part of the annual Board plan.
Security Management (Violence and Aggression) The Trust Board may wish to ensure the following: i. That the Trust has committed to develop a 'violence prevention and reduction strategy' and this commitment has been endorsed by the Trust Board, ensuring the strategy is monitored and reviewed regularly – 'regularly' to be decided by the Board. ii. Inequality and disparity in the experience of any staff groups, including those with protected characteristics, has been addressed and clearly referenced in an equality impact assessment, which has been made available to all stakeholders.	

iii. A senior management review is undertaken twice a year and as required or requested, to evaluate and assess the Violence Prevention and Reduction Programme, the findings of which are shared with the Board	
A NED may be appointed as the emergency preparedness champion	It is recommended that this role continues

3. Conclusion

The Board is asked to review the recommendations and approve the actions for implementation. (Please see **Appendix 2** for the NHSE/I Guideline)

Classification: Official

Publication approval reference: PAR994

Enhancing board oversight

A new approach to non-executive director champion roles

Version 1, December 2021

Contents

1. Summary

1.1 Introduction

This guidance sets out a new approach to ensuring board oversight of important issues by discharging the activities and responsibilities previously held by some non-executive director (NED) champion roles, through committee structures. It also describes which roles should be retained and provides further sources of information on each issue. For the purposes of this guidance the term NED champion includes ‘named NEDs’ and ‘NED leads’.

There are a range of issues which at various times have required additional board level focus to respond to and learn from high-profile failings in care or leadership. This has resulted in several reviews and reports establishing a requirement for trust boards to designate NED champions for specific issues to deliver change. This has led to an increasing number of roles spanning quality, finance and workforce.

The number of NED champion roles started to make it difficult for trusts to discharge them all effectively, particularly with a limited number of NEDs, and many do not have a role description, making it difficult to measure their impact on delivering change. Some roles have also been in place for over a decade without review.

Working with stakeholders, we have reviewed the issues the roles were originally established to address, to consider the most effective means of making progress now. There are a small number that are statutory requirements and some that still require an individual to drive change or fulfil a functional role. In these instances, the principle of the unitary trust board – with joint responsibility and decision making – remains. However, there are many issues where we now consider progress will be best made through existing trust committees rather than through individual NED champion roles.

This new approach will help enhance board oversight for these issues, by ensuring they are embedded in governance arrangements and assurance process, and through providing an audit trail of discussions and actions identified by committees. The risk of false assurance among chairs and directors who are not designated ‘champions’ will also be reduced, as oversight of transformational change to

improve care and responsibility to constructively challenge on all issues using Appreciative Inquiry approaches, will rest with the whole committee and not just an individual. By reducing the risk of individual NEDs becoming too involved in operational detail, this approach may also help maintain their independence – something that NEDs are uniquely positioned to bring to a board.

1.2 Status of guidance

This new approach is recommended but not mandatory. If trusts consider NED champion roles an effective tool to provide assurance to their board on specific issues, then they have the flexibility to retain or implement that approach.

1.3 Co-developing the approach

The new approach has been co-developed with a working group of trust chairs and we have also held a series of workshops with a range of providers. This enabled us to identify current roles and test alternative approaches to enhancing board oversight of important issues. We have engaged with national policy teams on the issues requiring oversight at board level that have associated NED champion roles. Further detail on each issue is provided in annexes 1 and 2.

We have engaged with the Care Quality Commission (CQC) throughout the development of this approach. While there is a shared understanding that strong leadership and board oversight is critical for the provision of high-quality care, the governance arrangements that individual trusts use to achieve this is expected to vary according to local circumstances and priorities. CQC inspectors will be looking for evidence of strong leadership and governance, with effective oversight of important issues. Trusts will be expected to demonstrate how they provide this, including with reference to this guidance where appropriate.

1.4 New recommended approach

For each issue, we identified the original review or report that recommended the establishment of a NED champion role and worked with the relevant national policy team to consider the current status of the role and the best way of responding to the issue at this point in time. In many cases, it was agreed that board oversight would be enhanced through a change from NED champion roles to committee discharge. It was also noted that the new approach should sit alongside other effective governance tools such as walkarounds, for example.

The table below sets out the NED champion roles that were in scope for this review and their status under the new approach.

Roles to be retained				
Maternity board safety champion	Wellbeing guardian	Freedom to speak up	Doctors disciplinary	Security management
Roles to transition to new approach				
Hip fracture, falls and dementia	Learning from deaths	Safety and risk	Palliative and end of life care	Health and safety
Children and young people	Resuscitation	Cybersecurity	Emergency preparedness	Safeguarding
Counter fraud	Procurement	Security management-violence and aggression		

It should be noted that the table above includes those issues for which a report or review has suggested a NED champion role should be established and does not include all important issues that trusts should have oversight of.

2. Implementation and support

To support the effective implementation of this new approach we recommend that trusts take the following steps:

2.1 Review current roles

Trusts should undertake a review to identify a list of their current NED champion roles. Annex 1 outlines roles that are statutory roles or that continue to require an individual to discharge those responsibilities. These roles should be retained. All other roles should be embedded in governance arrangements and aligned to committee structures where possible.

2.2 Align remaining roles to committee structures

Where we have recommended that issues are now discharged through a committee, we have grouped these issues by 'theme' to align with committee structures commonly used by trusts. However, this is not prescriptive, and trusts will want to align issues with the committee that they believe is the best fit and is aligned with their current governance arrangements.

Understandably some complex issues may fall under the remit of more than one committee structure – in these cases trust boards may wish to adopt a joint approach to ensure appropriate assurance.

2.3 Outline reporting structures

It will be up to trusts to decide how committees should report back on their assurance activities to the board, whether that is through existing reporting mechanisms or by establishing new periodic updates on issues that were previously the responsibility of a NED champion. Company secretaries may wish to ensure these issues are included on board/committee forward plans.

2.4 Update terms of reference

As trusts review their governance arrangements, they will want to ensure that committee terms of reference reflect any new responsibilities and respective reporting requirements because of these changes. Committee chairs and members

may wish to consider actions needed to discharge the roles effectively, such as regular engagement with an executive lead, background reading, visiting services and attending seminars or training as available and appropriate to the trust.

2.5 Ongoing support

While some trusts may already be working with similar arrangements, it is recognised that effective implementation may require cultural and behavioural shifts. To support implementation, it would be useful to receive trusts' feedback on where the proposed approach has worked well, to identify examples of best practice. We (NHS England and NHS Improvement) can then support in disseminating successful case studies and lessons learned with other trusts.

Existing platforms such as the NHS Providers Company Secretaries Network, existing care groups and regional forums will be used to share those learnings and collect feedback.

This guidance will be kept under review and updated as necessary.

Please send feedback and best practice examples to nhsi.providerpolicyengagement@nhs.net.

Annex 1: Retained NED champion roles

We have identified five NED champion roles which at this point should be retained. These are maternity board safety champion, wellbeing guardian, freedom to speak up guardian (FTSU), doctors disciplinary and security management. These should be retained because they are either a statutory requirement, the function requires a named individual to discharge or because we consider having an individual NED to be the most effective way of delivering the changes that are needed. This section provides further detail on these roles and additional sources of information are set out in the Resources section.

1. Maternity board safety champion

Applies to	All trusts providing maternity services
Type of role	Assurance
Legal basis	Recommended
Role description	Maternity NED role descriptor

In response to the Morecambe Bay Investigation (2015), this role was established through Safer Maternity Care 2016, which stated that “Senior trust managers will want to ensure unfettered communication from ‘floor-to-board’ by appointing a board level maternity champion”. The role is in line with recommendations from the Ockenden Review (2020) and while not a statutory requirement, for trusts providing maternity services having a named NED maternity board safety champion is recommended.

The champion should act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal), service users, local maternity system (LMS) leads, the regional chief midwife and lead obstetrician and the trust board to understand, communicate and champion learning, challenges and successes.

The named champion could be the chair of the quality and safety committee and the requirements of the role could be discharged through the appropriate committee provided trusts ensure that the clinical director and director of midwifery are integral

to these committee meetings. NEDs should use appreciative inquiry approaches and the Maternity Self-Assessment Tool to provide assurance to the board that the best quality maternity care is being provided by their trust. Trusts may also wish to note that the NSR maternity incentive scheme safety actions refer to the maternity board safety champion role under Safety Action 9.

Along with other recommendations contained in the Ockenden Review, this role will be reviewed nationally in 2-3 years' time to gauge its effectiveness.

2. Wellbeing guardian

Applies to	All trusts
Type of role	Assurance
Legal basis	Recommended
Role description	Guardian community website and role description

This role originated as an overarching recommendation from the Health Education England 'Pearson Report' (NHS Staff and Learners' Mental Wellbeing Commission 2019) and was adopted in policy through the 'We are the NHS People Plan for 2020-21 – action for us all'. The NED should challenge their trust to adopt a compassionate approach that prioritises the health and wellbeing of its staff and considers this in every decision.

The role should help embed a more preventative approach, which tackles inequalities. As this becomes routine practice for the board, the requirement for the wellbeing guardian to fulfil this role is expected to reduce over time. The Guardian community website provides an overview of the role and a range of supporting materials.

3. FTSU NED champion

Applies to	All trusts
Type of role	Functional
Legal basis	Recommended
Role description	FTSU supplementary information

The Robert Francis Freedom to Speak Up Report (2015) sought to develop a more supportive and transparent environment where staff are encouraged to speak up about patient care and safety issues. In line with the review, it is recommended that all NHS trusts should have this functional FTSU guardian role so that staff have a clear pathway and an independent and impartial point of contact to raise their concerns in the organisation.

The role of the NED champion is separate from that of the guardian. The NED champion should support the guardian by acting as an independent voice and board level champion for those who raise concerns. The NED should work closely with the FTSU guardian and, like them, could act as a conduit through which information is shared between staff and the board (p.146, Francis FTSU report).

All NEDs should be expected to provide challenge alongside the FTSU guardian to the executive team on areas specific to raising concerns and the culture in the organisation. When an issue is raised that is not being addressed, they should ask why. A full description of NED responsibilities can be found in the FTSU supplementary information.

4. Doctors disciplinary NED champion/independent member

Applies to	All trusts (advisory for foundation trusts)
Type of role	Functional
Legal basis	Statutory
Role description	None

Under the 2003 Maintaining High Professional Standards in the modern NHS: A Framework for the Initial Handling of Concerns about Doctors and Dentists in the NHS and the associated Directions on Disciplinary Procedures 2005 there is a requirement for chairs to designate a NED member as “the designated member” to oversee each case to ensure momentum is maintained. There is no specific requirement that this is the same NED for each case. The framework was issued to NHS foundation trusts as advice only.

5. Security management NED champion

Applies to	All trusts, excluding NHS foundation trusts
Type of role	Assurance
Legal basis	Statutory
Role description	None

Under the Directions to NHS Bodies on Security Management Measures 2004 there is a statutory requirement for NHS bodies to designate a NED or non-officer member to promote security management work at board level. Security management covers a wide remit including counter fraud, violence and aggression and also security management of assets and estates. Strategic oversight of counter fraud now rests with the Counter Fraud Authority and violence/aggression is overseen by NHS England and NHS Improvement.

While promotion of security management in its broadest sense should be discharged through the designated NED, relevant committees may wish to oversee specific functions related to counter fraud and violence/aggression. We have included further guidance on these two functions in Annex 2. Boards should make their own local arrangements for the strategic oversight of security of assets and estates.

Annex 2: Issues that can be overseen through committee structures

This section covers those issues which reports or reviews previously suggested should be overseen by a NED champion, but which we now consider are best overseen through committee structures. Trusts should use their discretion to determine the relevance of each issue to their trust. It should be noted that there will be many other important issues not included in this guidance that trusts should also have oversight of.

For the purposes of this guidance the issues are grouped into ‘themes’ aligned to committee structures commonly used by trusts. However, each trust will need to determine whether each issue is relevant to their trust and how best they should be allocated to their committee structures, especially since some issues will cut across several committees. These issues and themes are summarised in table format under the resources section.

Quality and Safety Committee

1. Hip fractures, falls and dementia

All trusts and health boards should have a director with responsibility for falls and the ‘National Audit of Inpatient Falls Audit (NAIF) Report 2020’ recommends a patient safety group which is overseen by a member of the executive and non-executive team. This could be fulfilled by an executive rather than a NED, provided there is committee and board oversight of safety, prevention and risk management and use of data to gauge the effectiveness of practice.

Hip fractures and other serious harms resulting from inpatient falls can be linked to dementia. The board should consider the benefits of joint oversight and strategic planning across both agendas and implement where appropriate. Sufficient senior level support to enable systemic change is needed, including effecting change in partner external organisations and allocating resources as needed.

The Quality Committee may wish to ensure that the executive lead for dementia attends the Quality Committee and, in acute trusts, that they also attend the Dementia Steering Group, reporting issues into the Quality Committee. The NAIF audit has produced a useful information guide for healthcare champions which could be accessed to support this work.

2. Palliative and end of life care

The Ambitions for Palliative and End of Life Care National Framework 2021-26 set out six key ambitions for the improvement of Palliative and End of Life Care (PEoLC). Improving quality is one of the three strategic priorities of the national NHS England and NHS Improvement PEoLC programme, including high quality PEoLC, for all, irrespective of condition or diagnosis.

The impact of executive leadership on improving the quality of PEoLC is a theme that has been identified by the NHSE PEoLC team during visits to trusts. Having a NED as part of the PEoLC Executive committee, led to significant support at the Board and a focus on PEoLC. Board level oversight for PEoLC can be well supported through the Quality Committee, with reporting into the Board. The work of the Quality Committee might include:

- attendance of a NED from the Quality Committee at the PEoLC Executive Committee
- ensuring the board is aware of standards of care in PEoLC
- reviving PEoLC complaints to see where improvements could be made.

3. Resuscitation

Health Service Circular Series Number: HSC 2000/028 (Sept 2000) stipulates that chief executives of all NHS trusts should give a NED designated responsibility on behalf of the trust board for ensuring that a resuscitation policy is agreed, implemented, and regularly reviewed within the clinical governance framework.

This has been referred to more recently in the May 2020 Resuscitation Council Quality Standards in relation to acute, mental health and community trusts. The Quality Committee may wish to discharge this role, rather than an individual NED, and include this on the committee workplan, ensuring sign-off from the board.

4. Learning from deaths

Executive and non-executive directors have a key role in ensuring their provider is learning from issues such as incidents and complaints and identifying opportunities for improvement in healthcare identified through reviewing or investigating deaths. All NEDs play a crucial role in constructively challenging the executives to satisfy themselves that clinical quality controls and risk management systems are robust and defensible.

In particular, they should familiarise themselves with the care provided to individuals with learning disabilities and those with mental health needs and should encourage meaningful engagement with bereaved families/carers. The Quality Committee in particular should understand the Learning from Deaths review process, champion quality improvement that leads to actions that improve patient safety, and assure published information on the organisation's approach, achievements and challenges. Implementing the Learning from Deaths Framework: Key requirements for trust boards includes some useful questions that NEDs may wish to ask in relation to these responsibilities.

5. Health and safety

Strong leadership at board level and a strong safety culture, combined with NED scrutiny, are essential. Health and safety should be viewed in its broadest sense to include patient safety, employee safety, public safety and system leadership. As such the remit will cut across committees including Quality, Workforce/People and Planning (estates). All committees need to help ensure their organisation gets the right direction and leadership on health and safety matters through performing a scrutinising role – ensuring the integrity of processes to support boards facing significant health and safety risks.

Committee members should have a sound understanding of the risks, the systems in place for managing them, an appreciation of the causes of any failures and an understanding of the legal responsibilities of employers and individual directors for ensuring the health and safety of workers and others affected by work activities. They should be familiar with the trust's health and safety policy – which should be an integral part of the organisation's culture, values and standards – and assure themselves that this is being followed.

6. Safeguarding

Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff suggests that boards should consider the appointment of a NED to ensure the organisation discharges its safeguarding responsibilities appropriately and to act as a champion for children and young people.

This role could be discharged through a committee but in ensuring appropriate scrutiny of their trust's safeguarding performance, all board members should have Level 1 core competencies in safeguarding and must know the common presenting features of abuse and neglect and the context in which it presents to healthcare staff. In addition, board members should understand the statutory role of the board in safeguarding including partnership arrangements, policies, risks and performance indicators; staff roles and responsibilities in safeguarding; and the expectations of regulatory bodies in safeguarding.

The CQC Trust-Level Well Led Framework does not reference a safeguarding NED; rather it notes that the inspection team should speak to the/any senior member of the organisation with safeguarding responsibility.

7. Safety and risk

The Trust-Level Well-Led Inspection Framework refers to interviewing a sample of NEDs with the NED for safety and risk being a priority. This is not intended to imply that a specific NED champion role should be in place. Moreover, it refers generally to a NED that would have suitable oversight of these areas such as the chair of Quality and/or Audit committees as examples.

CQC have endorsed the new approach recommended in this guidance. However, should trusts wish to do so, then allocating the role to an individual NED as one tool for ensuring strong leadership and governance is acceptable practice.

8. Lead for children and young people

The Core Service Inspection Framework for Children and Young People (CYP) refers to an interview with the 'NED on the board with responsibility for CYP'. This is not intended to imply that a specific NED lead role should be in place. Moreover, it refers generally to a NED that would have suitable oversight of this area, such as the chair of quality for example. CQC have endorsed the new approach recommended in this guidance. However, should trusts wish to do so, then

allocating the role to an individual NED as one tool for ensuring strong leadership and governance is acceptable practice.

Audit and Risk Committee

9. Counter fraud

The role of fraud champion is one that is suited to a senior manager who is directly employed by the trust. This could also be an executive but is not intended to be a NED role. The 2004 Counter Fraud Directions included a requirement for NHS trusts to designate a NED to undertake specific responsibility for counter fraud. However, these were revoked by the 2017 Directions on Counter Fraud, so there is no longer a statutory requirement to designate a NED champion for counter fraud.

NHS funded services are required to provide the NHS Counter Fraud Authority (NHSCFA) details of their performance annually against the Government Functional Standard 013: Counter Fraud and NHSCFA ask that the audit committee chair (usually a NED) signs off the trust's submissions. The audit committee chair (and members) may also wish to review the local counter fraud specialist's (LCFS) final reports and consider any necessary improvements to controls, along with any recommendations contained within reports following NHSCFA's engagement through its quality assurance programme.

10. Emergency preparedness

The NHSE Emergency Preparedness, Resilience and Response (EPRR) Framework sets out the responsibilities of the accountable emergency officer (AEO), who is expected to be a board level director with executive authority and responsibility for ensuring that the organisation complies with legal and policy requirements.

The Framework suggests that a NED or other appropriate board member should support the AEO and endorse assurance to the board that the organisation is complying with legal and policy requirements. This will include assurance that the organisation has allocated sufficient experienced and qualified resource to EPRR.

The independence that NEDs bring is essential to being able to hold the AEO to account, but responsibility for EPRR sits with the whole board and all NEDs should assure themselves that requirements are being met. EPRR should be included on

appropriate committee forward plans and EPRR board reports, including EPRR annual assurance, should be taken to the board at least annually.

Given the synergies between the agenda for EPRR and other important issues such as security management and health and safety, triangulation between these areas through the Board and committees will be essential.

Finance, Performance and Planning Committee

11. Procurement

Procurement should be seen by the board as a value-adding function. The Finance, Performance and Planning Committee should help raise awareness of commercial matters at board and director levels and facilitate discussions that identify benefits to procurement activity and strategic development. The committee would need to understand the scope of procurement, the priorities (at national and at integrated care system level) and the challenges of delivering change. The Audit Committee should regularly review procurement.

Our Procurement Target Operating Model (PTOM) programme team is seeking ambassadors who can advocate and raise the profile of procurement at a local level. This role can also be carried out by an executive, provided there is committee and board oversight. NEDs should collectively provide assurance via these committees to the board that their trust is viewing procurement as a priority, engaging with the PTOM programme and aligning their procurement activity with national activity.

12. Cyber security

Board leadership is seen as essential to the success of this agenda so trusts may decide it is more appropriate for this function to be discharged by the board than a committee. NEDs should provide check and challenge, ensuring information governance has been considered in all decisions and that this can be evidenced.

Each trust should have a senior information risk owner (SIRO), who would usually be an executive, although trusts can appoint a NED to this role should they wish to do so. The SIRO should ensure on behalf of the board that the 10 minimum cyber-security standards are followed throughout their organisation.

The board/committee should regularly review cyber security risks, ensuring appropriate mitigation, and that regular maintenance of critical systems and equipment takes place, while minimising impact on clinical services during system downtime. This should include the following:

- Removal of unsupported systems from trust networks.
- Timely patching of systems and prompt action on high severity Alerts when they are issued.
- Ensuring robust and immutable backups are in place.

It is also recommended that boards undertake annual cyber awareness training, in addition to the mandatory and statutory information governance training that individual board members are required to complete.

Workforce/People Committee

13. Security management – violence and aggression

As set out in 'We are the NHS People Plan for 2020-21 – action for us all' and the NHS Violence Prevention and Reduction Standard 2020, the board may wish to ensure the following:

- The trust has committed to develop a violence prevention and reduction strategy and this commitment has been endorsed by the board, which is underpinned by relevant legislation (set out in the Violence Prevention and Reduction Standard 2020), ensuring the strategy is monitored and reviewed regularly – 'regularly' to be decided by the board.

- Inequality and disparity in the experience of any staff groups, including those with protected characteristics, has been addressed and clearly referenced in an equality impact assessment, which has been made available to all stakeholders.

- A senior management review is undertaken twice a year and as required or requested, to evaluate and assess the Violence Prevention and Reduction Programme, the findings of which are shared with the board.

The Workforce/People Committee may wish to align this with wider wellbeing work being undertaken by the committee, particularly in relation to wellbeing support after violence.

Resources

Summary of roles by suggested committee and further sources of information

The following is a list of further reading that NEDs and other board members may find useful in developing their knowledge and understanding of the issues highlighted in this document.

Role	Links to further reading
General	
Maternity board safety	• Morecambe Bay Investigation (2015) • Ockenden Review (2020) • NSR Maternity Incentive Scheme Safety Actions • Maternity and Neonatal Safety Champions Toolkit • Transforming Perinatal Safety Resource Pack • NHS England and NHS Improvement Maternity Safety Resources • Safer Maternity Care 2016
Wellbeing guardian	• Guardian Community website and role description • Health Education England 'Pearson Report' (NHS Staff and Learners' Mental Wellbeing Commission 2019)
Freedom to speak up	• Report template – NHS England and NHS Improvement website (england.nhs.uk) • Robert Francis Freedom to Speak Up report • FTSU supplementary information • FTSU Guidance and self-review tool
Doctors disciplinary	• Directions on Disciplinary Procedures 2005 • Maintaining High Professional Standards in the modern NHS
Security management	• Directions to NHS Bodies on Security Management Measures 2004

Role	Links to further reading
Quality and Safety Committee	
Hip fracture, falls and dementia	• Patient Information Resource National Audit of Inpatient Falls- Guide for Healthcare Champions • National Audit of Inpatient Falls (NAIF) 2020 Annual Report | RCP London • NICE Guidance - Falls in Older People: Assessing Risk and Prevention • Dementia Care Pathway- Full implementation guidance • Dementia wellbeing in the COVID pandemic • NHS England Dementia: Good Personalised Care and Support Planning Information for primary care providers and commissioners - Guidance
Palliative and end of life care	• Ambitions for Palliative and End of Life Care: a national framework for local action 2021-2026 • "What NHS England is doing to improve end of life care", NHS England and NHS Improvement webpage • "Resources on End of Life Care", NHS England and NHS Improvement webpage
Resuscitation	• Quality Standards: Acute Care, Resuscitation Council UK
Learning from deaths	• https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf
Safety and risk	• Inspection Framework – trust-wide well led, CQC
Lead for children and young people	• Inspection framework – NHS Hospitals services for children and young people, CQC
Safeguarding	• Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff
Health and safety	• "Leading Health and Safety at Work", HSE webpage • FAQs: Leading health and safety at work, HSE webpage • Leading health and safety at work: Actions for directors, board members, business owners and organisations of all sizes- Guidance, HSE

Role	Links to further reading
Audit and Risk Committee	
Counter fraud	• Refer to service condition 24 of the NHS standard contract: 2021/22 NHS Standard Contract, NHS England and NHS Improvement • "Information for Fraud Champions", Fraud Prevention, NHS Counter Fraud Authority webpage
Emergency preparedness	• NHS England and NHS Improvement Emergency Preparedness, Resilience and Response Framework – Guidance
Finance, Performance and Planning Committee	
Procurement	• NHS Procurement: Raising Our Game – Best Practice Guidance
Cyber security	• 2017/18 Data Security and Protection Requirements- Guidance • Data Security and Protection Toolkit, NHS Digital • The Minimum Cyber Security Standard- Guidance, Cabinet Office • Lessons learned review of the WannaCry Ransomware Cyber Attack – Independent report
Workforce/People Committee	
Security management - violence and aggression	• Violence prevention and reduction standard

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This publication can be made available in a number of other formats on request.

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: January 2022**
Report Title	**Declarations of Interests – 2021/22**	**Agenda Item: 15**
Lead Director	**Name: Kate Jarman**	**Title: Director of Corporate Affairs**
Report Author	**Name: Kwame Mensa-Bonsu**	**Title: Trust Secretary**

Key Highlights/ Summary	Compared to 2020/21, there were significant improvements in the numbers of Consultants and staff above Band 8A who submitted their declarations of interests in 2021/22.			
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Noting** √	**For Review** ☐

Strategic Objectives Links	*N/A*
Board Assurance Framework (BAF)/ Risk Register Links	*N/A*

Report History	*N/A*
Next Steps	*N/A*
Appendices/Attachments	a. A summary of Trust Board members' current register of interests for 2021/22 (**Appendix 1**). b. A summary of the register of interests of decision-making staff for 2021/22 (**Appendix 2**). c. A summary of the Hospitality and Gifts register for 2021/21 (**Appendix 3**).

DECLARATIONS OF INTERESTS REPORT

1. Introduction

The purpose of the report is to provide the Audit Committee with an update on the returns submitted for 2021/22.

2. Background

In line with the Trust's Conflicts of Interest, Hospitality, Gifts, Donations and Sponsorship Policy, all 'decision making staff' (defined as AfC band 8A and above, staff involved in contracting and procurement, and all consultant medical staff), Non-Executive Directors and members of the Council of Governors were asked in October 2021 to submit their declarations of interests for 2021/22.

For this declarations exercise, an online solution was introduced with a particular focus on improving the rate of returns for the Trust's Consultants and to ensure the improvement is sustained, steps will be taken to keep improving the solution's questionnaire.

3. Update on 2021/22 Returns

For 2021/22, 158 (80%) out of the 198 Trust Consultants submitted their declarations of interests by the deadline date of 05 November 2021. 11 of the 158 Consultants provided details of their other interests, while the rest provided 'nil' returns as their submissions. It must be noted this was a significant improvement on the 39 (22%) out of the 178 Trust Consultants who participated in the 2020/21 exercise.

148 (74%) out of 201 staff above Band 8A submitted their declarations in 2021/22, from the 73 (36%) who submitted their declarations for the 2020/21 exercise. This was also a significant improvement which can be attributed to the online solution implemented in 2021/22.

19 of the 23 Trust's Procurement Staff submitted their 2021/22 declarations, from the 18 who provided their submissions in 2020/21. This will become a particular area of focus to ensure that a 100% of the staff provide their declarations and that the register of interests for the area is regularly updated.

4. Plans for 2023

The Trust Secretariat will, among other steps, work towards supporting staff to provide better details and to also increase the number of staff submitting their declarations by improving the online solution.

The Conflict of Interest, Hospitality, Gifts, Donations and Sponsorship Policy will also be revised to support actions being undertaken to ensure Procurement Staff submit their declarations of interests and also to ensure that all staff are better informed on how to report offers of gifts and hospitality, whether accepted or not.

5. Recommendation

The Committee is asked to:

- **Note** the report and the appended registers.

NHS
Milton Keynes University Hospital
NHS Foundation Trust

APPENDIX 1: BOARD OF DIRECTORS – DECLARATIONS OF INTERESTS 2021/22

Director	Role	Do you, your spouse, partner of family member hold or have any of the following: • A directorship of a company? • Any interest or position in any firm, company, business or organisation (including charitable or voluntary) which does or might have a trading or commercial relationship with the Foundation Trust? • Any interest in an organisation providing health and social care to the NHS?	Do you or your spouse, partner or family member have a position of authority in a charity or voluntary organisation in the field of health and social care?	Do you, your spouse, partner or family member have any connection with an organisation, entity or company considering entering into a financial arrangement with the Foundation Trust, including but not limited to lenders or banks?	Dates during which the interests were held	Action taken to manage any potential conflict *[Board and Committee agendas are proactively and continuously scrutinised to ensure that Board members are not exposed to potential conflicts and at every Board and Committee meeting, members are asked to declare any conflicts that they may have]*
Ian Reckless	Medical Director	Yes – ADMK (wholly owned subsidiary of MKUH NHS Foundation Trust) Spouse is an NHS doctor working at hospitals in the region	No	No	July 2019 to date	

Joe Harrison	Chief Executive Officer	Yes – Programme Director for Joining Up Care Programme (with NHSX) Member of Lantum's Customer Advisory Board Vice Chair, University of Buckingham Council Member – National Association of Primary Care Member of TenX Advisory Board Member of NHS Employers Policy Board Trustee of NHS Confederation Vice-Chair of NHS Employers Policy Board Keele University Lecturer Advisor to Alphasights Advistor to M3 Global Research Advisor to Silverlight Advisor to Stepcare	No	No	July 2019 to date	

		Spouse is the Prime Minister's Expert Advisor for NHS Transformation and Social Care. Ruth Harrison – Director at Durrow Limited.				
Dr Luke James	Non-Executive Director	Yes – Striatum Consulting Limited Medical Director for Bupa Global and UK Insurance – part of the Market Unit which includes Bupa Clinics Bupa Care homes and Bupa Dental businesses. However, Luke is not involved in executive or commercial aspects of these Director / Board Member of Bupa Trustees Limited	No	No	April 2020 to date	
Terry Whittle	Director of Finance	Yes - Spouse is a Divisional Manager at West Herts NHS Trust	No	No	March 2021 to date	
John Blakesley	Deputy CEO	Yes – Director of ADMK Limited, wholly owned subsidiary of the Trust	No	No	July 2019 to date	

Danielle Petch	Director of Workforce	Yes – Company Secretary, S4 Software Solutions Limited Husband is Management Director, S4 Software Solutions Limited	No	No		
Andrew Blakeman	Non-Executive Director	Yes – Director of Stryde International Ltd, a subsidiary of BP PLC	No	No		
Haider Husain	Non-Executive Director	Yes- Director & CEO of Paracat Ltd Director & COO of Healthinnova Limited British Standards Institute (BSI) Committee member – Healthcare Organisation Management Associate Non-Executive Director, Medicines and Healthcare products Regulatory Agency Board	No	No	Feb 2018 to date March 2019 to date Apr 2019 to date September 2020	

Kate Jarman	Director of Corporate Affairs	Yes – Faculty Member of the Good Governance Institute Board Member – Milton Keynes Urgent Care Centre Member of the Labour Party Member of Women's Equality Party	No	No	Nov 2020 to date	
Professor James Tooley	Non-Executive Director	Yes – Director – The Education Partnership (UK) Ltd Director – Apollo Buckingham Health Science Campus (ABHSC) Ltd Director – University of Buckingham Medical School of the North (UBMSN), Crewe University			2000 to present 2020 to Present 2020 to present	
Alison Davis	Hospital Chair	Yes – Non-Executive Director of Impact MH CIC			To date	
Jacqueline Collier	Director of Transformation & Partnerships	Yes – Husband is a partner in PA Consulting.			To date	
Helen Smart	Non-Executive	Nil				

	Director					
Nicky Burns-Muir	Director of Patient Care and Chief Nurse	Nil				
Heidi Travis	Non-Executive Director	Nil				
Emma Livesley	Director of Operations	Nil				
Nicky McLeod	Non-Executive Director	Nil				

APPENDIX 2: REGISTER OF INTERESTS OF DECISION-MAKING STAFF

Milton Keynes University Hospital NHS Foundation Trust

Position within, or relationship with, the Trust	Description of interest (including for indirect interests, details of the relationship with the person who has the interest)	Financial year interest this declaration relates to	Additional comments including on any mitigating actions undertaken
Consultant	Director of medical company	2021/22	None
Consultant	Employed by South Central Ambulance Service NHS Foundation Trust Honorary Consultant at Oxford University Hospitals NHS Foundation trust, Council member at the Royal College of Anaesthetists Trustee of the Royal College of Anaesthetists Independent sector anaesthetic work at the Saxon hospital in Milton Keynes	2021/22	
Consultant	Have private practice at Saxon clinic		
Consultant	Future Director Newmedica Northampton	Jan 2022 onwards	None
Consultant	I am a Trust employee but within that employment/role work also for Willen Hospice (Consultant/Medical Lead) and University of Buckingham (as Cancer Care Block Lead/Honorary Senior Lecturer).	2021-2022	Both associations are part of my role as a Trust employee.
Consultant	I am an honorary guest speaker (paid) for Daiichi Sankyo UK Ltd but this does not effect my prescribing activity.	2021-2022	Lipid talk arranged by Daiichi Sankyo UK Ltd. I do this outside my NHS working hours.

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Milton Keynes University Hospital NHS Foundation Trust

Position within, or relationship with, the Trust	Description of interest (including for indirect interests, details of the relationship with the person who has the interest)	Financial year interest this declaration relates to	Additional comments including on any mitigating actions undertaken
Consultant	I have a private gastroenterological practice as outlined in my approved job plan for 21-22; this is clearly timetabled and is separate in all aspects (clinically and financially) from my NHS practice at MKUH.	2021-22	My private practice secretarial work is undertaken by an MKUH secretary, in her own time and utilising non-NHS equipment/storage etc. This has been confirmed by the core clinical managerial team.
Consultant	I have no conflict of interest that I am aware of in relation to my employment at Milton Keynes University Hospital. I have received payment for consultancy services in relation to the design of clinical trials in Sjogren's syndrome (related to my longstanding research interest in this area at the University of Birmingham/University Hospitals Birmingham. In the past 36 months I have consulted for Abbvie, Astra Zeneca, Galapagos and Novartis in this area only.	2019-2021	nil required

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Milton Keynes University Hospital NHS Foundation Trust

Position within, or relationship with, the Trust	Description of interest (including for indirect interests, details of the relationship with the person who has the interest)	Financial year interest this declaration relates to	Additional comments including on any mitigating actions undertaken
Consultant	Payment for additional work above Service Level Agreement carried out at AIRS Clinic at Whaddon Medical Centre	2020-2021	AIRS (Assessment and Investigation of Respiratory Symptoms) is a cooperative and joint project between the Hospital and Community to improve care for Respiratory patients and reduce non-elective admissions. This has been led by the CCG, and harnesses community resources under the leadership of a MKUH Consultant, to benefit patients, primary care and the Acute trust, improving patient care, reducing waiting times and costs of care.
Consultant	Advisor for Royal College of Physician. Private practice at BMI Saxon clinic.	2021	N/A
Consultant	Private Practice and membership of surgical LLP	2021	Withdrawn from any discussions and continue not to be involved in negotiations
Senior Manager	Board director of Milton Keynes Urgent Care Service CIC		I am the representative for MKUH who has a 40% shareholding in this CIC and has 2 Board representatives.
Senior Manager	Committee member of the British and Irish Orthoptic Society “Leads of the Orthoptic Profession” (LOOP) group.	2021 - 2022	Should not cause a conflict of interest as this role is to assist and support orthoptic heads across the country through best practice
Manager	Director of Limited Company	2021/22	Does not do business with the Trust

APPENDIX 2: REGISTER OF INTERESTS OF DECISION-MAKING STAFF

Milton Keynes University Hospital NHS Foundation Trust

Position within, or relationship with, the Trust	Description of interest (including for indirect interests, details of the relationship with the person who has the interest)	Financial year interest this declaration relates to	Additional comments including on any mitigating actions undertaken
Senior Manager	I am a Trustee of Willen Hospice (formal name - The Hospice of Our Lady and St John), Willen Village, Milton Keynes.	2021-2022.	I had told the MKUH Directors of Workforce and of Corporate Affairs about this appointment to make sure the Trust understood my role at the Hospice, and my intention to recuse myself from any related discussions, that might involve financial and contracting items. In addition, I have made a similar declaration at Willen Hospice.
Senior Manager	some private practice work	2021	manager aware and agreed
Senior Manager	Some shares from an old employee share scheme with an old employer - Compass Group (a current service provider main entrance retail and supplier - Steamplicity)	2021/22	Retail Contract managed by Estates. Ensure all contractual dealings with the supplier are managed by Procurement.
Manager	Visiting lecturer for Univ of Hertfordshire	Not discussed	Request from Apprenticeship provider for Applied Biomedical Science degree
Manager	Voluntary trusteeship	2020/21	Managing any potential conflict of interest with funders etc, discussions with line manager

APPENDIX 3

Milton Keynes University Hospital NHS Foundation Trust

2021/22 Hospitality Register and Declaration of Gifts and Hospitality

DATE VISIT/GIFT ETC	DESCRIPTION OF HOSPITALITY/GIFT RECEIVED INCLUDING LOCATION IF RELEVENT	SUPPLIER OR DONATOR OF THE GIFT/HOSPITALITY, NAME OF COMPANY AND BUSINESS ACTIVITY	TITLE OF MEMBER OF STAFF RECEIVING THE HOSPITALITY OR GIFT	VALUE OF HOSPITALITY OR GIFT
18-21 July 2021	Sponsorship for attendance to Virtual HIV/AIDS Meeting in July 2021 as Consultant IV Physician	ViiV Pharmaceuticals	Consultant	£400.00
27-30 October 2021	Attended European AIDS Clinical Society Meeting	Gilead Sciences	Consultant	£750.00
November 2021	Sponsorship to cover the cost of the European Respiratory Society annual meeting enrolment fee (held virtually)	Glaxo Smith Kline	Consultant	Not provided

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	Trust Board	**Date:** 13 January 2022
Report Title	Risk Report	**Agenda Item: 16**
Lead Director	**Name:** Kate Jarman	**Title:** Director of Corporate Affairs
Report Author	**Name:** Paul Ewers	**Title:** Risk Manager

Key Highlights/ Summary	*The report includes all significant risks across all Risk Registers (where the Current Risk Rating is graded as 15 or above), as of 5th January 2022.*			
Recommendation *(Tick the relevant box(es))*	**For Information** √	**For Approval** ☐	**For Noting** ☐	**For Review** ☐

Strategic Objectives Links	*Objective 1: Keeping you safe in our hospital* *Objective 2: Improving your experience of care* *Objective 3: Ensuring you get the most effective treatment* *Objective 4: Giving you access to timely care* *Objective 7: Spending money well on the care you receive* *Objective 8: Employ the best people to care for you* *Objective 10: Innovating and investing in the future of your hospital*
Board Assurance Framework (BAF)/ Risk Register Links	*Compliance Paper*

Report History	*The Risk Report is an ongoing agenda item*
Next Steps	*N/A*
Appendices/Attachments	*Significant Risk Register – as of 5th January 2022* *Corporate Risk Register – as of 5th January 2022*

Risk Report

1. INTRODUCTION

This report shows the profile of significant risks across the Trust.

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

2. RISK PROFILE – Significant Risk Register

- There are a total of 44 significant risks identified on Risk Registers across the Trust, and of these risks, 20 are overdue their review dates. The 20 overdue risks have been escalated for corporate review.

- There were 3 new significant risks added during December 2021.

  a. ***RSK-305*** *- If there is insufficient strategic capital funding available, then the Trust will be unable to invest in the site to maintain pace with the growth of the Milton Keynes population's demand for hospital services*
  b. ***RSK-306*** *- There is a national shortage of BD vacuum biopsy needles due capacity constraints at their sterilisation facility.*
  c. ***RSK-310*** *- The rate of incident reporting within Maternity has decreased significantly in the last 3 months. The average incident reporting a month up to August was 132 incidents a month. In September there were 96, October 82 and when Radar went live the incident reporting decreased to 53 incidents.*

- There are 4 risks showing on Radar as controlled. This is where current risk scores for the risks are the same as their target risk scores. The controlled risks are listed below:

  a. ***RSK-112*** *- Lack of capacity for appropriate management of CT and MRI within KPI and DM01 timescales.*
  b. ***RSK-125*** *- Trust ability to maintain patient care and clinical services, or loss of staff to support clinical and non-clinical services due to high levels of absence, or a loss of national stockpile in PPE or medical devices (ventilators) resulting in the Trust not receiving deliveries to preserve the safety of patients and staff*
  c. ***RSK-113*** *- The 10yr old mammography machine in BS2 could fail due to its age. The increased amount of unplanned downtime this year is consistent with aging equipment.*
  d. ***RSK-114*** *- The risk is that the paediatric team cannot provide a full dietetic service to children and young people in the Milton Keynes area*

- There are 4 risks that have been identified as uncontrolled. These are therefore recorded as significant risks with no controls in place to reduce the risk. These risks will be reviewed with the relevant risk owners to identify whether there are controls in place and if not, discuss what controls need to be developed. These uncontrolled

risks are listed below:

a. ***RSK-247*** *- The wait times for ventilated babies and children requiring transfer to a tertiary centre are increasing due to increasing pressures across the system. This has resulted in the children's physiotherapy and on call team being asked to assess and treat ventilated children. The physiotherapists do not currently have the training and competencies to complete this.*
b. ***RSK-139*** *- IF there is no dedicated Obstetric Theatres and Theatre Team THEN Maternity do not have a guaranteed emergency theatre available 24hrs a day*
c. ***RSK-306*** *- There is a national shortage of BD vacuum biopsy needles due capacity constraints at their sterilisation facility.*
d. ***RSK-310*** *- The rate of incident reporting within Maternity has decreased significantly in the last 3 months. The average incident reporting a month up to August was 132 incidents a month. In September there were 96, October 82 and when Radar went live the incident reporting decreased to 53 incidents.*

3. CORPORATE RISK REGISTER

Work on developing a Corporate Risk Register (CRR) continues to be progressed. Attached as **Appendix 2** is the CRR approved by the Risk and Compliance Board on 21st December 2021.

4. CONCLUSION

The Trust Secretary and the Risk Manager are working to ensure that the Trust's Risk Framework is 'live' and always reflective of the state of the hospital. As such they are taking steps, including meetings with Executive Directors, to review the Trust's Risk Registers and Risk Strategy, and to enhance the Risk management processes in the Trust. As part of this work, the risk reports will be restructured to enhance the assurance they provide.

5. RECOMMENDATION

The Board is asked to review and discuss this paper.

6. APPENDICES

Appendix 1 - Significant Risk Register as of 5th January 2022.
Appendix 2 - Corporate Risk Register as of 5th January 2022.

7. DEFINITIONS:

Significant Risks: Any risk where the Current risk score (the level of risk now) is graded 15 or above.
Current Risk: This is the level of risk posed at the time of the risk's last review.
Target Risk: Recognising that there is always an element of risk and that (depending on the risk) the lowest level of risk is not always the optimum (e.g. cost vs benefit), this is the level of risk that the Trust is willing to accept/tolerate.
Controlled Risk: This is where the current risk score is the same as the Target risk score. Risks should only be recorded as controlled where the risk has been managed down to an acceptable level in line with the Trust's risk appetite statement in the risk strategy.
Uncontrolled Risk: This is where the risk does not have any controls recorded. This means that, whilst the risk has been identified, there are currently no controls in place to mitigate/manage the risk.
Risk Appetite: The amount of risk the Trust is willing to take in pursuit of its objectives

Significant Risk Register

Report Date: **05-Jan-2022**

Status Legend:
NotApplicable
Compliant
Planned
Pending
Overdue

Risk Score Legend:	
	Un scored
1 - 3	Low
4 - 7	Moderate
8 - 12	Significant
13 - 25	High

Reference	Created on	Owner	Category	Description	Impact of risk	Scope	Region	Location	Last review	Next review	Status	Original score	Current score	Target	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-035	28-Sep-2021	Helen Chadwick	Operational	If there is a high turnover of staff due to: work pressure, not having the opportunity to work at the top of their licence, lack of capacity for development, lack of capacity for supervision / support. Also difficulty in recruiting particularly to 8a posts.	Leading to: 1. increased length of stay due to TTO delay 2. increase in prescribing errors not corrected 3. increase in dispensing errors 4. increase in missed doses	Organisation			09-Dec-2021	28-Sep-2021	Overdue	20	20	6	Actively recruiting, listening events with staff, implementing 1-1 system to support staff, reviewing work activities of 8a's and above to identify what could		Not Applicable	Treat	Gaps in controls: Use of senior staff to support not viable long term - 28/5/21 This action has resulted in further
RSK-079	14-Oct-2021	Celia Hyem-Smith	Operational	IF there are increased referral rates, a lack of space to deliver treatment, an inability to deliver timely treatment (rehab/maternity), and a lack of administrative resources	LEADING TO patient's not receiving timely treatment/intervention, patient's becoming unconditioned, continual pressure to provide appointments, a reduced patient outcomes and unnecessary waiting time for appointments.	Region	Therapies		20-Dec-2021	30-Nov-2021	Overdue	20	20	8	Approval given for locum support until the end of November 2021,Virtual clinic appointments have been introduced as part of the treatment		Not Applicable	Treat	Risk added to Risk Register following approval at Therapies governance meeting
RSK-088	15-Oct-2021	Zuzanna Gawlowski	Operational	Overcrowding and insufficient space in the Neonatal Unit, exacerbated by need for social distancing due to COVID-19. The milk kitchen was condemned due to this.	Without the increase in cot numbers and corresponding cot spacing we will be unable to meet patient needs or network requirements. We will now also be unable to meet PHE recommendations for social distancing	Region	Paediatric Services		20-Dec-2021	18-Jan-2022	Planned	25	20	9	Business Case for Refurnishing Milk Kitchen and Sluice	1. Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards(15-Oct-2021),2. Parents asked to leave	Not Applicable	Treat	
RSK-100	25-Oct-2021	Melissa Davis	Operational	Avoiding Term Admissions into Neonatal Units (ATAIN) is a programme of work initiated under patient safety to identify reasons for admission to the neonatal unit at term and the proportion of admissions which are avoidable vs those which are unavoidable . ATAIN is	Maternity/ Neonatal services -Staff/ patients/Trust. Staff, patients, Trust reputation.	Region	Women's Health		20-Dec-2021	18-Jan-2022	Planned	20	20	4		1.ATAIN meetings still taking place when possible/ quorate.(25-Oct-2021),Completing Datix retrospectively(25-Oct-2021),Shadowing opportunities at	Not Applicable	Treat	The risk has been increased due to 2 meetings being cancelled, 2 meetings falling on bank holidays over the Xmas period and
RSK-112	28-Oct-2021	Paula Robinson	Operational	Lack of capacity for appropriate management of CT and MRI within KPI and DM01 timescales	Financial due to missed targets Reputation due to long waiting times Reputation and financial due to increased infection rates Staff leaving due to poor working conditions.	Region	Diagnostic & Screening		10-Dec-2021	29-Jun-2021	Overdue	20	20	20		Extended working hours and days, some scans sent off site to manage demand. Reduced appointment times to optimise service.	Not Applicable	Not Applicable	
RSK-125	04-Nov-2021	Adam Biggs	Operational	IF there is a surge of COVID-19 patients impacting on Trust ability to maintain patient care and clinical services, or loss of staff to support clinical and non-clinical services due to high levels of absence, or a loss of national stockpile in PPE or medical devices	LEADING TO Loss of clinical and non-clinical services, risk to patient care, risk to staff wellbeing and financial impacts	Organisation			09-Dec-2021	07-Feb-2022	Planned	25	20	20		COVID-19 operational and contingency plans in place(04-Nov-2021),PPE logged daily covering delivery and current stock(04-Nov-2021)	Not Applicable	Not Applicable	Trust follows national guidance on all responding mechanisms covering COVID-19 alongside its Category one
RSK-126	04-Nov-2021	Zuzanna Gawlowski	Operational	IF cot spacing in the Neonatal Unit does not comply with BAPM guidance or the latest PHE guidance for COVID-19 (the Unit is seeking to increase both total cot spacing and cot numbers by 4 HDU/ITU cots in line with Network 5 year projections of acuity and	LEADING TO an inability to meet patient needs or network requirements. We will now also be unable to meet PHE recommendations for social distancing This may result in a removal of Level 2 status if we continue to have insufficient space to adequately fulfil	Organisation			20-Dec-2021	18-Jan-2022	Planned	25	20	9	Business Case for Refurnishing Milk Kitchen and Sluice	Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards(04-Nov-2021),Parents asked to leave	Not Applicable	Treat	Risk transferred from Datix to Radar
RSK-128	04-Nov-2021	Emma Livesley	Operational	IF there is an inability to identify/review in a timely manner any cases where there may be immediate system or process learning., or there is an inability to complete an incident report in a timely manner	LEADING TO a negative impact on the provision of Maternity / Neonatal Services, a negative impact on patient care and a negative impact on the Trust's reputation	Region	Women's Health		14-Dec-2021	18-Jan-2022	Planned	20	20	4		ATAIN meetings still taking place when possible/quorate(04-Nov-2021),Completing incident report retrospectively(04-Nov-2021),Weekly ATAIN meetings to review current	Not Applicable	Not Applicable	advised by KS and LR to link this risk with ATAIN risk 100
RSK-131	04-Nov-2021	Deborah Noble	Hazard / Health & Safety	IF the demand for CT and MRI increases and there is continued requirement to reduce scan turnaround times THEN there will be a delay in patient management, an	LEADING TO financial targets being missed, negative impact on reputation due to long waiting times Reputation, and financial due to increased infection rates, and staff leaving due to poor working conditions.	Region	Diagnostic & Screening		10-Dec-2021	29-Jun-2021	Overdue	20	20	4		Extended working hours and days(04-Nov-2021),Some scans sent off site to manage demand(04-Nov-2021),Reduced appointment times to optimise service(04-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-144	10-Nov-2021	Melissa Davis	Operational	Antenatal and Newborn Screening Service: Screening co-ordinator is unavailable due to long term absence and there are currently no internal staff available with knowledge and experience to undertake the Screening Co-ordinator role.	Inability to provide a full time antenatal and newborn screening service which is a requirement of PHE and the National screening standards.	Region	Women's Health		15-Dec-2021	18-Jan-2022	Planned	20	20	3		There is currently one Band 6 bank midwife with previous experience of screening and fetal medicine who can provide part time cover to support the service.(10-Nov-2021),There is an	Not Applicable	Not Applicable	risk reviewed with KS and LR, Traget score amended to 3- Advised P Ewers that risk was not visible on WH RRegister.
RSK-199	16-Nov-2021	Melissa Davis	Operational	eCare CTG issue: CTG documentation tool within eCare is not based on a human factors principles Parameters within the CTG documentation tool on eCare do not match the parameters within the local	Negative impact on fetal morbidity and mortality resulting from a delay in recognition or escalation of an evolving clinical picture of which one element is the fetal monitoring	Region	Women's Health		16-Dec-2021	18-Jan-2022	Planned	20	20	6		Re-introduction of sticker as CTG documentation tool alongside the entry onto eCare(16-Nov-2021),Increase of registrar presence within maternity setting. Increase in	Not Applicable	Treat	Category amended to organisational as incorrect
RSK-001	06-Sep-2021	Tina Worth	Hazard / Health & Safety	IF all known incidents, accidents and near misses are not reported; THEN the Trust will be unable to robustly investigate all incidents and near-misses within the required timescales;	LEADING TO an inability to learn from incidents, accidents and near-misses, an inability to stop potentially preventable incidents occurring, potential failure to comply with Duty of Candour legislation requiring the Trust to report all known incidents	Organisation			21-Dec-2021	30-Mar-2022	Planned	20	16	12		Incident Reporting Policy(06-Sep-2021),Incident Reporting Mandatory/Induction Training(06-Sep-2021),Incident Reporting Training Guide and adhoc training as	Low	Treat	Risk reviewed & remains current. Note reduction in incident reporting rate with roll out of Radar. Review in 3 months
RSK-016	22-Sep-2021	Simon Nicholson	Operational	Lack of flow in the organisation leading to unsafe environment for patient care causing increased waits within the ED and inability to meet Emergency Access Targets - Overcrowding within the ED department and or significant number of patients with a high	Unsafe environment for patients and staff due to bed space capacity, ambulance queues, missed trust targets and overcrowding into ED/radiology corridors creating H+S hazard and continued pressure, leading to poor patient care/treatment and delays in	Region	Emergency Department		10-Dec-2021	28-Oct-2021	Overdue	25	16	9	EPIC consultant in place to aid flow within department and speed up decision making (22-Sep-2021),Recruitment drive for more nurses/HCA's and consultants		Not Applicable	Tolerate	Rehman, Raja - Clinical Governance Lead (Internal/Specialty/HaemOnc) 09/09/2021 10:22:08
RSK-027	23-Sep-2021	Lucy Matthews	Operational	Staffing risk for epilepsy service. Consultant lead on extended leave and no epilepsy specialist nurse in post. Follow-ups, responding to queries and First Seizure-	The team may be unable to meet the standard (NICE CG137) of reviewing all First Fit patients within 14 days. Epilepsy follow-up appointments will be delayed.	Region	Specialty Medicine		10-Dec-2021	22-Sep-2021	Overdue	16	16	6	GAPS: Nurses ANP vacancy,GAPS: Wait list 630+	Agency locum in post temporarily, and are actively recruiting for a further NHS locum.(23-Sep-2021),Substantive neurology consultants are seeing patients ad	Not Applicable	Treat	Ohadekwe, Ms Edith - Operations Manager - Specialist Medicine 20/07/2021 13:19:10 7/7/2021 Medicine

Significant Risk Register

Reference	Created on	Owner	Category	Description	Impact of risk	Scope	Region	Location	Last review	Next review	Status	Original score	Current score	Target	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-030	23-Sep-2021	Francesca Csordas	Operational	We had 2 lithotripsy handles that broke and were replaced like for like, pre 2016 Information For Use (IFU's) was not considered mandatory and therefore could be reprocessed by HSDU. The new handles (post 2016) require FUI's but the one provided by Olympus	Patients with large stones will not be able to have them manually crushed during ERCP procedure, this may mean patient remain compromised by stones blocking the common bile duct, a repeat / further procedure elsewhere or surgery resulting increased	Region	Specialty Medicine		10-Dec-2021	21-Oct-2021	Overdue	16	16	8	Risk potentially to be resolved because of a local SOP in place which is currently in Draft. (23-Sep-2021)		Not Applicable	Treat	Rehman, Raja - Clinical Governance Lead (Internal/Specialty/HaemOnc) 21/09/2021 10:39:05
RSK-048	01-Oct-2021	Jane Adderley	Hazard / Health & Safety	Psychological wellbeing of staff on the Intensive Care Unit is at risk due to managing complex patients and families specifically following extraordinary circumstances such as the Pandemic, sudden death, and distressing situations with relatives.	All staff may have an inability to function at their designated role in a high stress situation. Increased risk of ill health, fatigue, anxiety and post traumatic stress disorder (PTSD symptoms)leading to potential increase in sickness.	Region	Anaesthetics & Theatres		03-Jan-2022	28-Feb-2022	Planned	20	16	8	Access to external psychological support. (03-Jan-2022)	Clear leadership and team support. Staff health and well-being initiatives. Individual stress risk assessments for staff.(01-Oct-2021)	Not Applicable	Treat	Business case for substantive psychologist in ICU is with ADO surgery for review.
RSK-080	15-Oct-2021	Andrew James	Compliance	There is a risk to head injury patients not being appropriately cared for as they are not being treated in accordance with NICE guidance (CG176: Head injury: assessment and early management, updated September 2019)	- Potential reduction in patient safety - T&O surgeons and nursing teams may be unaware of how to care for patients with moderate to severe head injuries especially patient who are anticoagulated. - Clinicians may have to wait for an opinion from the	Region	Musculoskeletal		09-Dec-2021	31-Jan-2022	Planned	12	16	8	1, 2 & 3. Preventive controls - On going discussions with Senior Medical Team - CSU Lead to escalate via trauma network	1, 2 c& 3. mitigating controls - Policy for management of head injuries has been developed - Awaiting appointment of head injury liaison Nurse	Not Applicable	Treat	Risk reviewed at T&O CIG meeting. Team are still concerned that they are receiving inappropriate referrals for head injury
RSK-093	22-Oct-2021	Elizabeth Pryke	Operational	The dietetics department (Core clinical)in paediatrics are unable to assess and advise new patients and review existing patients in a timely manner. This is subsequently impacting on patients nutritional status and longer term dietary management on what is a	If the paediatric dietetics team continue to provide a service with insufficient capacity THEN patient care and patient safety will be at risk LEADING TO vulnerable children becoming nutritionally compromised.	Region	Therapies		10-Dec-2021	01-Dec-2021	Overdue	16	16	12		1. Dietetic manager has been given approval to source a band 6 experienced locum paediatric dietitian to provide cover.(22-Oct-2021),2. As a back up plan,a band 5	Not Applicable	Not Applicable	
RSK-113	28-Oct-2021	Deborah Noble	Operational	The 10yr old mammography machine in BS2 could fail due to its age. The increased amount of unplanned downtime this year is consistent with aging equipment.	Failure of the machine would lead to a loss of service capacity for the 2ww clinics and NHSBSP programme which give have a detrimental effect on Trust metrics.	Region	Diagnostic & Screening		10-Dec-2021	01-Aug-2021	Overdue	16	16	16		Comprehensive service contract All faults reported immediately to external contractor / physicist for support. Robust QA systemin process to	Not Applicable	Not Applicable	
RSK-127	04-Nov-2021	Karan Hotchkin	Financial	IF the Trust does not have a sufficient capital expenditure limit (CDEL) then the Trust will not be able to complete the level of planned capital investment	LEADING TO Insufficient capital expenditure limit to accommodate the Trusts investment.	Organisation			10-Dec-2021	07-Jan-2022	Pending	20	16	10		The Trust is introducing enhanced in-year capital spend monitoring to proactively manage in-year underspends across other capital schemes.(04-Nov-2021),Where	High	Treat	Risk transferred from Datix to Radar
RSK-132	04-Nov-2021	Julie Orr	Operational	IF there are a lack of Discharge Coordinators (Registered Nurses B6 level) due to vacancies and sudden long term sickness, with an additional Discharge Coordinator due to have major surgery leading to additional long term sickness	LEADING TO Increased length of stay (LOS) for complex discharges, leading to a potential for an increase in hospital acquired infections, de-conditioning Potential to affect the stranded and super stranded patient numbers and a failure achieve	Organisation			09-Dec-2021	30-Nov-2019	Overdue	20	16	9		Covering a small number of shifts with former Discharge Coordinator carrying out bank shifts, when available(04-Nov-2021),Recruited in to one vacancy and interviewing in to	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-134	04-Nov-2021	Karan Hotchkin	Financial	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability	LEADING TO an impact of H2 funding streams being worked through, reductions in non-NHS income streams as a direct result of COVID-19, Impaired operating productivity leading to costs for extended working days and/or outsourcing and potential for	Organisation			10-Dec-2021	07-Jan-2022	Pending	20	16	8		Cost and volume contracts replaced with block contracts (set nationally) for clinical income(04-Nov-2021),Top-up payments available where COVID-19 leads to additional costs over and	High	Treat	Risk transferred from Datix
RSK-135	04-Nov-2021	Jill Beech	Operational	IF the Pathology LIMS system is no longer sufficient for the needs of the department, due to being outdated with a limited time remaining on its contract THEN the system is at risk of failure, virus infiltration	LEADING TO the Pathology service being halted and contingency plans would have to be implemented. Sensitive information could lost or security of the information could be breached.	Region	Diagnostic & Screening		10-Dec-2021	09-Jan-2022	Pending	16	16	4	High Level Design Completed	Systems manager regularly liaises with Clinysis to rectify IT failures(04-Nov-2021),Meetings with S4 to establish joint procurement take place periodically(04-Nov-	Not Applicable	Not Applicable	Currently coming to an end of the High Level Design meetings. Due to delays the planned end date has now been delayed until Jan/Feb
RSK-136	04-Nov-2021	Deborah Noble	Operational	IF the Mammography machine in BS2 were to fail THEN there could be delays in the machine being fixed due to reduced availability of older parts. Due to its age, there is an increased risk of vulnerability to cyber	LEADING TO a loss of service capacity for the 2ww clinics and NHSBSP programme, which give have a detrimental effect to patients and on Trust performance metrics	Region	Diagnostic & Screening		10-Dec-2021	01-Aug-2021	Overdue	16	16	3		Comprehensive service contract(04-Nov-2021),All faults reported immediately to external contractor / physicist for support(04-Nov-2021),Robust QA systemin process to	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-138	04-Nov-2021	Jamie Stamp	Hazard / Health & Safety	IF the trust is not providing suitable accommodation for the dietetic team THEN the trust is failing in its statutory legal duty under the Health & Safety at Work etc. Act 1974,	LEADAING TO physical and mental wellbeing concerns in relation to staff welfare with potential for sickness absence and potential litigation claims; Multiple breaches of statutory and regulatory duties leading to interest from the Health & Safety Executive;	Region	Therapies		10-Dec-2021	22-Nov-2021	Overdue	16	16	6	Resolve short term issues - drinking water / flooring / window latches / changing facilities / secure path,Upkeep of the portacabin including drinking	Due to the number of staff within the area, increased number of staff are having to work from home (rota basis), however as all the team see inpatients this is limited.(04-Nov-	Not Applicable	Not Applicable	Risk transferred to Radar
RSK-305	06-Dec-2021	Karan Hotchkin	Financial	If there is insufficient strategic capital funding available	then the Trust will be unable to invest in the site to maintain pace with the growth of the Milton Keynes population's demand for hospital services	Organisation			09-Dec-2021	07-Jan-2022	Pending	16	16	9	The trust has a process to target investment of available capital finance to manage risk and safety across the hospital		Medium	Treat	Risk was approved by Finance and Investment committee on 30/12/2021
RSK-025	22-Sep-2021	Elizabeth Winter	Operational	Vacancies of Band 5 and senior nursing skill mix 247. -1. All wards are experiencing some issues with nurse staffing levels and skill mix	This may impact on Patient Safety, staff wellbeing, the number of complaints received and incidents e.g pressure ulcers reported. There is a significant cost risk incurred in relation to using agency staff leading to increased pressure on Trust finances. Datix incidents	Region	Internal Medicine		10-Dec-2021	31-Mar-2022	Planned	15	15	4	On-going recruitment drive		Not Applicable	Treat	Reviewed in SPEG increased level of risk.
RSK-055	01-Oct-2021	Robyn Norris	Operational	Staffing shortages within the theatre department. The staffing demands within theatres has significantly increased, these changes have arisen from changes and developments in our service. For the theatre team to safely cover the theatre sessions additional staff are	Patients being cancelled due to a lack of staff, we also experience issues due to the amount of junior staff within the department – creating difficulties with skill mix.	Region	Anaesthetics & Theatres		22-Dec-2021	31-Jan-2022	Planned	12	15	6	GAPS: There are significant gaps in the theatre rota - 26 WTE posts are required to meet latest review of theatre staffing requirements.	This risk is currently being mitigated by the use bank, approx. 80 /100 shifts of varying lengths per week. Agency staff approx. 300 hours per week.	Not Applicable	Treat	Copy of theatres risk register was sent to the interim Operational Manager for Theatres on 14/12/2021. On
RSK-076	13-Oct-2021	Jodie Bonsell	Operational	Endoscopic Stack system in ENT outpatients is not linked to EPR (Cerner Millennium) CAUSE: Lack of visibility of patient records in a secure system	Patients – Clinicians unable to see images from previous visits and compare current and previous to look for changes Medical Staff will not be able to liaise with other Trusts within BLMK framework	Region	Head & Neck		09-Dec-2021	31-Jan-2022	Planned	9	15	6	Need to establish Link between systems		Not Applicable	Treat	Risk reviewed at ENT CIG risk is ongoing. Team suggested risk should be raised, however risk is currently rated as high
RSK-082	15-Oct-2021	Samantha Burns	Operational	With the implementation of green pathways for elective care patients, the Trauma and Orthopaedic department has lost capacity to escalate on to elective lists for trauma patients. As such with just one trauma list per day, there may be insufficient capacity to meet	Without sufficient trauma capacity in place, the department may not be able to operate on all trauma patients within the required timelines leading to poor outcomes.	Region	Musculoskeletal		09-Dec-2021	31-Jan-2022	Planned	12	15	6	Divisional Director for Operations to work with T&O and Theatre teams to implement all day weekend emergency theatre lists.,Utilisation of theatre pm 1	Cancellation of elective activity if required.(15-Oct-2021)	Not Applicable	Treat	23/11/2021 risk reviewed at T&O CIG meeting. Risk is ongoing therefore needs to remain at current rating and level.

Significant Risk Register

Reference	Created on	Owner	Category	Description	Impact of risk	Scope	Region	Location	Last review	Next review	Status	Original score	Current score	Target	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-090	21-Oct-2021	Jamie Stamp	Operational	IF the Trust cannot access and report on inpatient activity, capacity and demand THEN Therapy Services are unable to plan and develop services	LEADING TO poor patient experience, inability to demonstrate the effectiveness of the service and an inability to benchmark and compare data with other Trusts due to lack of data submission	Region	Therapies		13-Dec-2021	11-Jan-2022	Pending	15	15	6	Inpatient data/ dashboard on a monthly basis to inform the effectiveness of services	Therapies Service working with the Information Team to establish where data is located by validating data entries(21-Oct-2021),Therapies Service collecting manual data to	Not Applicable	Treat	Risk discussed and approved at CIG and local therapy governance meeting
RSK-101	25-Oct-2021	Melissa Davis	Operational	The maternity service at MKUK makes use of Phase 1 theatres for all cases, we do not have our own dedicated set of theatres. Elective Caesarean work is completed the Theatre 1 during a booked morning session, Theatre 3 is set for obstetric emergencies. All	Mother and Babies - Increased risk of poor outcome if theatre delay. Staff – Psychological trauma of dealing with potentially avoidable poor outcome.	Region	Women's Health		14-Dec-2021	18-Jan-2022	Planned	15	15	6	Cannot currently mitigate		Not Applicable	Not Applicable	Reviewed with KS and LR- Advised to lower target score to 6.
RSK-114	28-Oct-2021	Jamie Stamp	Operational	The risk is that the paediatric team can not provide a full dietetic service to children and young people in the Milton Keynes area	"Financial due to missed targets Reputation due to long waiting times Reputation and financial due to increased infection rates Staff leaving due to poor working conditions.	Region	Therapies		10-Dec-2021	01-Nov-2021	Overdue	15	15	15		Existing staff are working some additional hours but this remains insufficient to meet the needs of the service.(28-Oct-2021)	Not Applicable	Not Applicable	
RSK-124	04-Nov-2021	Celia Hyem-Smith	Operational	IF there is a lack of clinical space available for patient treatment THEN Physiotherapy will be unable to meet the demand for existing patients leading to increased	LEADING TO failure to meet contracts, lost revenue, poor patient experience and poor staff morale	Region	Therapies		10-Dec-2021	30-Nov-2021	Overdue	15	15	15	Review of space in Therapies	Extended working hours(04-Nov-2021),Introduction of shift pattern(04-Nov-2021),Introduction of telephone triage clinics(04-Nov-2021),Group treatment sessions(04-Nov-2021)	Not Applicable	Not Applicable	Risk transferred to Radar from Datix
RSK-130	04-Nov-2021	Deborah Noble	Hazard / Health & Safety	If there is insufficient capacity for Breast Screening (to support social distancing) THEN women may have been delayed an invite for screening, and therefore a delay in diagnosing breast	LEADING TO potential delays in detection of breast cancer and a delay in treatment	Region	Diagnostic & Screening		10-Dec-2021	24-Jun-2021	Overdue	20	15	4		Guidance issued as to the management of the women to ensure that no-one is missed has been issued by Hitachi/PHE and has been implemented by the	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-139	04-Nov-2021	Emma Mitchener	Operational	IF there is no dedicated Obstetric Theatres and Theatre Team THEN Maternity do not having a guaranteed emergency theatre available 24hrs a day	LEADING TO Mother and Babies - Increased risk of poor outcome if theatre delay. Staff – Psychological trauma of dealing with potentially avoidable poor outcome. Financial implication to the trust.	Region	Women's Health		14-Dec-2021	18-Jan-2022	Planned	15	15	9			Not Applicable	Not Applicable	Reviewed by KS and LR- advised to retain current scoring but link with another risk associated with theatres (101)
RSK-140	04-Nov-2021	Celia Hyem-Smith	Operational	IF there are insufficient Physiotherapy staff THEN there is a risk that the women and men's health Physiotherapy Service may be unable to meet its referral demand. There may be increased waiting	LEADING TO Potential for poor clinical outcome, poor patient experience, complaints and staff stress Potential delay to patient treatment Potential for patients with new diagnosis of cancer and pregnant women are not seen in a timely fashion further	Region	Therapies		10-Dec-2021	30-May-2021	Overdue	15	15	8	Budget reallocation and VCP for Band 6 post	Non clinical time including training, development and audit are being minimised to increase the number of available patient appointments(04-Nov-2021),Job plans are being	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-141	04-Nov-2021	Celia Hyem-Smith	Operational	IF outpatients can only review urgent patients virtually by telephone or video call due to the Covid-19 pandemic THEN there will be increasing numbers of patients	LEADING TO litigation and/or complaints due to lack of timely treatment intervention, potentially resulting in permanent and unnecessary disability.	Region	Therapies		10-Dec-2021	30-May-2021	Overdue	15	15	6	To develop strategy for validating routine patient waiting list	Virtual management of patients - Video and telephone clinics(04-Nov-2021),Additional IT sourced to support virtual management(04-Nov-2021),Reconfiguration of department	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-142	04-Nov-2021	Jamie Stamp	Operational	IF there is insufficient capacity and ongoing unsustainable demand for dietetic input for Paediatric patients (both inpatient and outpatient) . IF Home Enterally Fed Paediatrics patients continue to be seen our outpatient structure which is not adequate to	LEADING TO patient care and patient safety may be at risk, vulnerable children may become nutritionally compromised, the service may be unable to assess and advise new patients and review existing patients in a timely manner, and there may be an impact on	Region	Therapies		10-Dec-2021	01-Dec-2021	Overdue	15	15	3		Existing staff are working some additional hours but this remains insufficient to meet the needs of the service(04-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-143	04-Nov-2021	Elizabeth Thwaites	Operational	IF workload continued to increase in Pathology, requiring additional specimen storage, equipment, and staff THEN there is a risk that the available space within	LEADING TO an inability to retain specimens for the period of time required to meet RCPath guidance; an increased risk of formalin spillage / increased levels of formalin vapour; an increased risk to staff and to specimens because of cramped workspace e.g.	Region	Diagnostic & Screening		10-Dec-2021	09-Jan-2022	Pending	15	15	6	Sink to be fitted and put into use in new space (13-Dec-2021)	Storage of specimens minimised. Review of work flow and processes to improve space efficiency(04-Nov-2021),Business Case has been accepted - plans to be confirmed	Not Applicable	Not Applicable	Space Plan 1 underway. 90K has been granted from Digital funds to go ahead with further plans and this was approved at CBIG
RSK-158	12-Nov-2021	Adam Baddeley	Operational	If the escalation beds are opened the additional patients that will need to be seen will put additional demand on the Therapy deaprtment to manage and support patient flow during periods of significant pressure.	Increased demand on occupational therapy and physiotherapy staff Patients are likely to decondition if the demand is too high for the therapy staff to manage	Region	Therapies		15-Dec-2021	11-Jan-2022	Pending	16	15	12		Therapy staff attend board rounds and work with the MDT to determine priority patients. The skills mix and workforce is reviewed on a daily basis between occupational Therapy and	Low	Treat	Risk score increased due to escalation beds remaining open leading to insufficient capacity to see all patients referred to OT and PT on a
RSK-247	26-Nov-2021	Jamie Stamp	Operational	The wait times for ventilated babies and children requiring transfer to a tertiary centre are increasing due to increasing pressures across the system. This has resulted in the children's physiotherapy and on call team being asked to assess and treat ventilated	A ventilated child requiring support with airway clearance may not receive the assessment and treatment they require whilst waiting at MKUH for transfer. This may have a negative impact on their respiratory status and clinical outcome	Organisation			16-Dec-2021	27-Nov-2021	Overdue	15	15	6			Not Applicable	Treat	
RSK-306	06-Dec-2021	Deborah Noble	Operational	There is a national shortage of BD vacuum biopsy needles due capacity constraints at their sterilisation facility.	Patients would normally undergo a 1st line VAB for microcalcifications but due to the needle shortage would need to have a 14g core instead. Without VAC needles women with a B5a / B5b lesion who would normally undergo a VAB to potentially	Location		Breast Care Unit - Imaging	10-Dec-2021	06-Jan-2022	Pending	15	15	4			Low	Treat	
RSK-310	22-Dec-2021	Melissa Davis	Operational	The rate of incident reporting within Maternity has decreased significantly in the last 3 months. The average incident reporting a month up to August was 132 incidents a month. In September there were 96, October 82 and when Radar went live the incident	The absence of effective incident reporting negatively impacts maternity's ability to demonstrate effective governance processes and procedures, both within internal trust mechanisms and to the external stakeholders.	Region	Women's Health		23-Dec-2021	23-Dec-2021	Overdue	15	15	6			Not Applicable	Not Applicable	

Corporate Risk Register

Report Date: **05-Jan-2022**

Status Legend:
NotApplicable
Compliant
Planned
Pending
Overdue

Risk Score Legend:	
	Un scored
1 - 3	Low
4 - 7	Moderate
8 - 12	Significant
13 - 25	High

Reference	Created on	Owner	Category	Description	Impact of risk	Scope	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-035	28-Sep-2021	Helen Chadwick	Operational	If there is a high turnover of staff due to: work pressure, not having the opportunity to work at the top of their licence, lack of capacity for development, lack of capacity for supervision / support. Also difficulty in recruiting particularly to 8a posts. Loss of staff to primary care which offers more attractive working hours. Then there will be insufficient staff in pharmacy to meet demands of the organisation and ensure patient safety in the use of medicines.	Leading to: 1. increased length of stay due to TTO delay 2. increase in prescribing errors not corrected 3. increase in dispensing errors 4. increase in missed doses 5. failure to meet legal requirements for safe and secure use of medicines All resulting in adverse patient outcomes. Lack of financial control on medicines expenditure Breach of CQC regulations	Organisation	09-Dec-2021	28-Sep-2021	Overdue	20	20	6	Actively recruiting, listening events with staff, implementing 1-1 system to support staff, reviewing work activities of 8a's and above to identify what could stop for a period of time. Recruitment of additional Pharmacy technicians requested Aug19. Approved end of 2020. 3 appointed and in training.		Not Applicable	Treat	Gaps in controls: Use of senior staff to support not viable long term - 28/5/21 This action has resulted in further deterioration in morale and ability to make change, increased losses Maternity leave returners leaving for more flexible / family friendly working hours
RSK-125	04-Nov-2021	Adam Biggs	Operational	IF there is a surge of COVID-19 patients impacting on Trust ability to maintain patient care and clinical services, or loss of staff to support clinical and non-clinical services due to high levels of absence, or a loss of national stockpile in PPE or medical devices (ventilators) resulting in the Trust not receiving deliveries to preserve the safety of patients and staff THEN there is a risk of reduced capabilities in responding to a Novel Coronavirus (COVID-19) impacting on patient care within clinical and non-clinical services, with the inability to maintain safety for staff and patients due to national pressures on supplies and infrastructure	LEADING TO Loss of clinical and non-clinical services, risk to patient care, risk to staff wellbeing and financial impacts	Organisation	09-Dec-2021	07-Feb-2022	Planned	25	20	20		COVID-19 operational and contingency plans in place(04-Nov-2021),PPE logged daily covering delivery and current stock(04-Nov-2021)	Not Applicable	Not Applicable	Trust follows national guidance on all responding mechanisms covering COVID-19 alongside its Category one responsibilities
RSK-126	04-Nov-2021	Zuzanna Gawlowski	Operational	IF cot spacing in the Neonatal Unit does not comply with BAPM guidance or the latest PHE guidance for COVID-19 (the Unit is seeking to increase both total cot spacing and cot numbers by 4 HDU/ITU cots in line with Network 5 year projections of acuity and demand, and spacing in line with National Recommendations) THEN there will be overcrowding and insufficient space in the Neonatal Unit, exacerbated by need for social distancing due to COVID-19. The milk kitchen was condemned due to this	LEADING TO an inability to meet patient needs or network requirements. We will now also be unable to meet PHE recommendations for social distancing This may result in a removal of Level 2 status if we continue to have insufficient space to adequately fulfil our Network responsibilities and deliver care in line with national requirements. This may also impact on our ability to protect babies and their families during COVID	Organisation	20-Dec-2021	18-Jan-2022	Planned	25	20	9	Business Case for Refurnishing Milk Kitchen and Sluice	Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards(04-Nov-2021),Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID(04-Nov-2021),Added to capital plan(04-Nov-2021),Feasibility study completed(04-Nov-2021)	Not Applicable	Treat	Risk transferred from Datix to Radar
RSK-001	06-Sep-2021	Tina Worth	Hazard / Health & Safety	IF all known incidents, accidents and near misses are not reported; THEN the Trust will be unable to robustly investigate all incidents and near-misses within the required timescales;	LEADING TO an inability to learn from incidents, accidents and near-misses, an inability to stop potentially preventable incidents occurring, potential failure to comply with Duty of Candour legislation requiring the Trust to report all known incidents where the severity was moderate or higher, potential under reporting to the Learning from Patient Safety Events (LfPSE) system, and potential failure to meet Trust Key Performance	Organisation	21-Dec-2021	30-Mar-2022	Planned	20	16	12		Incident Reporting Policy(06-Sep-2021),Incident Reporting Mandatory/Induction Training(06-Sep-2021),Incident Reporting Training Guide and adhoc training as required(06-Sep-2021),Datix Incident Investigation Training sessions(06-Sep-2021),Daily review of incidents by Risk Management Team to identify potential Serious Incidents and appropriate escalation(06-Sep-2021),Serious Incident Review Group (SIRG) ensure quality of Serious Incident Investigations(06-Sep-2021),SIRG ensure appropriate reporting of Serious Incidents to Commissioners(06-Sep-2021),Standard Operating Procedure re Risk & Governance Team supporting the closure of incident investigations during unprecedented demand on service(06-Sep-2021),Implementation of new Risk Management Software to make incidents easier to report and improve engagement with staff(06-Sep-2021)	Low	Treat	Risk reviewed & remains current. Note reduction in incident reporting rate with roll out of Radar. Review in 3 months
RSK-127	04-Nov-2021	Karan Hotchkin	Financial	IF the Trust does not have a sufficient capital expenditure limit (CDEL) then the Trust will not be able to complete the level of planned capital investment THEN	LEADING TO Insufficient capital expenditure limit to accommodate the Trusts investment.	Organisation	10-Dec-2021	07-Jan-2022	Pending	20	16	10		The Trust is introducing enhanced in-year capital spend monitoring to proactively manage in-year underspends across other capital schemes.(04-Nov-2021),Where agreed by management (e.g., subject to risks and strategic need) underspends across other capital schemes could free-up capital expenditure limit for utilisation against bond schemes.(04-Nov-2021)	High	Treat	Risk transferred from Datix to Radar
RSK-132	04-Nov-2021	Julie Orr	Operational	IF there are a lack of Discharge Coordinators (Registered Nurses B6 level) due to vacancies and sudden long term sickness, with an additional Discharge Coordinator due to have major surgery leading to additional long term sickness THEN there is a risk that patient discharges will significantly be delayed, especially those requiring complex coordination of the discharge process	LEADING TO Increased length of stay (LOS) for complex discharges, leading to a potential for an increase in hospital acquired infections, de-conditioning Potential to affect the stranded and super stranded patient numbers and a failure achieve National target set for 2019-20, with associated impact on ED performance Increased delayed transfers of care (DToC) Poor patient experience due to the delays in discharge/discharge planning and referrals Other services capacity not being fully utilised due to delays in internal assessments Need for the Head of Clinical Services & Trust Lead for Discharge to take on some of the functions impacting on their daily roles significantly Increased workload & stress level for the remaining Discharge Coordinators in post Reduction in mandatory training compliance due to inability to release staff	Organisation	09-Dec-2021	30-Nov-2019	Overdue	20	16	9		Covering a small number of shifts with former Discharge Coordinator carrying out bank shifts, when available(04-Nov-2021),Recruited in to one vacancy and interviewing in to Bucks Coordinator role(04-Nov-2021),Reviewed role and delegated minor responsibilities to Rotational Operations Liaison Officers(04-Nov-2021),Support requested from key nursing areas who have the skills to support a number of aspects relating to the role & discharge process- awaiting confirmation(04-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix

Corporate Risk Register

Reference	Created on	Owner	Category	Description	Impact of risk	Scope	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-134	04-Nov-2021	Karan Hotchkin	Financial	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability THEN there may be an increase in operational expenditure in order to manage COVID-19	LEADING TO an impact of H2 funding streams being worked through, reductions in non-NHS income streams as a direct result of COVID-19, Impaired operating productivity leading to costs for extended working days and/or outsourcing and potential for material increase in efficiency requirement from NHS funding regime to support DHSC budget affordability.	Organisation	10-Dec-2021	07-Jan-2022	Pending	20	16	8		Cost and volume contracts replaced with block contracts (set nationally) for clinical income(04-Nov-2021),Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until end of March 2022)(04-Nov-2021),Budgets to be reset for FY22 based on financial regime; financial controls and oversight to be reintroduced to manage financial performance(04-Nov-2021),Cost efficiency programme to be reset to target focus on areas of greatest opportunity to deliver(04-Nov-2021)	High	Treat	Risk transferred from Datix
RSK-305	06-Dec-2021	Karan Hotchkin	Financial	If there is insufficient strategic capital funding available	then the Trust will be unable to invest in the site to maintain pace with the growth of the Milton Keynes population's demand for hospital services	Organisation	09-Dec-2021	07-Jan-2022	Pending	16	16	9	The trust has a process to target investment of available capital finance to manage risk and safety across the hospital		Medium	Treat	Risk was approved by Finance and Investment committee on 30/12/2021
RSK-247	26-Nov-2021	Jamie Stamp	Operational	The wait times for ventilated babies and children requiring transfer to a tertiary centre are increasing due to increasing pressures across the system. This has resulted in the children's physiotherapy and on call team being asked to assess and treat ventilated children. The physiotherapists do not currently have the training and competencies to complete this.	A ventilated child requiring support with airway clearance may not receive the assessment and treatment they require whilst waiting at MKUH for transfer. This may have a negative impact on their respiratory status and clinical outcome	Organisation	16-Dec-2021	27-Nov-2021	Overdue	15	15	6			Not Applicable	Treat	
RSK-002	06-Sep-2021	Tina Worth	Compliance	IF recommendations and actions from audit are not evidenced, monitored and completed in the Trust; THEN required changes to practice may not implemented and we may not be meeting best practice criteria;	LEADING TO potential impact on the top 3 Trust objectives (patient Safety, Clinical Effectiveness, Patient Experience), potential poor quality of service and associated impact on resources and potential CQC concerns re audit activity and learning from national audits	Organisation	04-Jan-2022	30-Mar-2022	Planned	15	12	3	Scheduled implementation of Radar audit module	Audit report templates available to identify audit action plans(06-Sep-2021),Monitoring via Clinical Audit & Effectiveness Committee (CAEB)(06-Sep-2021),Terms of Reference (ToR) for Clinical Audit & Effectiveness Board revised to include quality improvement, GIRFT etc(06-Sep-2021),Escalation/exception reporting to Management Board(06-Sep-2021),Refresh of SharePoint data base to assist with data capture, with Level 1 audit a priority(06-Sep-2021),Structure review - Staff realignment to support audit agenda(06-Sep-2021),Pilot of new governance approach to reports/CIG meetings(06-Sep-2021)	Low	Treat	Risk unchanged - awaiting RADAR audit module roll out
RSK-003	06-Sep-2021	Tina Worth	Compliance	IF existing Radar governance system does not support meeting Trust/legal/stakeholder requirements and are unsupported by the Trust IT department or an external IT provider; THEN the Trust is unable to meet statutory and mandatory Good Governance requirements and accreditations;	LEADING TO potential delays in care, inappropriate/incorrect/sub-optimal treatment; potential increase in incidents, complaints and claims; reduced CQC rating and potential enforcement actions	Organisation	21-Dec-2021	30-Mar-2022	Planned	25	12	4	Scheduled implementation of new system Radar	SharePoint and Q-Pulse in place(06-Sep-2021)	Low	Treat	Risk made bespoke for Radar & grading changed
RSK-008	06-Sep-2021	Tina Worth	Compliance	IF the Trust does not have an appropriate system to record mortality and morbidity data; THEN the Trust will not be able to record and/or provide accurate reports for governance or the Trust Board	LEADING TO non-compliance with the National Mortality & Morbidity 'Learning from Death' Framework	Organisation	04-Jan-2022	30-Mar-2022	Planned	15	12	6		Governance Team putting forward deaths for Structured Judgement Reviews (SJRs) based on previously agreed clinical criteria e.g. sepsis related(06-Sep-2021),Learning from Deaths policy as a tool to indicate required processes and cases that require review(06-Sep-2021),Implementation of the new system - CORs(06-Sep-2021)	Medium	Treat	Risk unchanged. M&M refresh scheduled for new year by Associate Medical Director
RSK-115	29-Oct-2021	Marea Lawford	Compliance	Annual and quarterly test reports for Autoclaves and washer disinfectors used for a critical process have not been received in a timely manner from the estates department. in line with HTM guidelines reports should be signed off by the user, an authorized person and/or an authorized engineer for compliance after testing, reports are going up to 6 weeks without being viewed by any of the above yet machines are in use. Under the FMEA (failure modes and estimation analysis) we should be able to prove control, monitoring and validation of the sterilisation process as a control measure and we cannot. not having a AP(D) to maintain the day to day operational aspects of the role is a further risk, as both units are reviewed 1 day per month - a bulk is this time is spend checking records and the other aspects of the AP(d)role do not get the sufficient time required to review and follow up.	possible loss of ISO 13485 accreditation due to non-compliance to national standards. Issues with steam supply, steam generators and maintenance may be being discussed or maybe are not highlighted. HSDU are not aware of any formal meetings with Estates and the AE(D) to discuss any gaps in the trust not having an AP(D),this was meant to be a temporary solution, but we are in year 3 of no AP(D).	Organisation	31-Dec-2021	01-Mar-2022	Planned	20	12	6		Estates management informed and plans in place to receive reports on time and to standard. Independent monitoring system in place monitoring machine performance. Weekly PPM carried out on machinery. An action plan has been created by estates, to include training the specialist estates officer so he can gain the recognised qualification he needs to carry out the role of the Authorised person for decontamination(AP(D)) and for additional training of the estates competent persons(CP(D) who test the decontamination equipment.(29-Oct-2021)	Low	Treat	Due for review in 3 months time. The Estates member who was in training to be a AP9d) is leaving, so there will be less support and more likely less opportunities for handovers and day to day operational management from estates over steam issues and reports could suffer as a consequence.
RSK-202	23-Nov-2021	Karan Hotchkin	Financial	IF Transformation delivery is not adequately resourced and prioritised and/or schemes are unrealistic and not well planned THEN There is a risk that the Trust is unable to achieve the required efficiency improvements through the transformation programme leading to an overspend against plan	LEADING TO the Trust potentially not delivering its financial targets leading to TO potential cash shortfall and non-delivery of its key targets	Organisation	10-Dec-2021	07-Jan-2022	Pending	20	12	9		Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partners(23-Nov-2021),Cross-cutting transformation schemes are being worked up(23-Nov-2021),Savings plan for 21/22 financial year not yet fully identified(23-Nov-2021)	Medium	Treat	Risk transferred from Datix
RSK-211	23-Nov-2021	Angela Legate	Hazard / Health & Safety	IF infection / colonisation with pseudomonas aeruginosa from contaminated water occurs within the Cancer Centre THEN there is a risk of infection and complications this could cause to immuno-suppressed cancer patients. Mitigations in place to avoid risk to patients and staff in Cancer Centre	LEADING TO susceptible patients within augmented care units such as Ward 25 and chemotherapy Suite potentially coming to harm	Organisation	16-Dec-2021	30-May-2022	Planned	16	12	8	Plans for sampling and microbiological testing of water is in place	For direct contact with patients water where testing has shown absence of P.aeruginosa(23-Nov-2021),For direct contact with patients water supplied through a point of use (POU) filter(23-Nov-2021),For direct contact with patients sterile water (for wound washing if required)(23-Nov-2021),Signs at all taps alerting people to refrain from drinking or brushing teeth with water(23-Nov-2021),Bottled water available(23-Nov-2021),Correct installation and commissioning of water systems in line with HTM 04-01 is adhered to. Schematic drawings are available for water systems(23-Nov-2021),Flushing of water outlets is carried out daily and documented (07:00 – 09:00 HCA)(23-Nov-2021)	Not Applicable	Treat	Risk transferred from Datix

Corporate Risk Register

Reference	Created on	Owner	Category	Description	Impact of risk	Scope	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-212	23-Nov-2021	Matthew Sandham	Hazard / Health & Safety	IF we are unable to retain nursing staff employed in critical posts THEN we will lose skilled workforce	LEADING TO more vacancies and skill gaps	Organisation	16-Dec-2021	17-May-2022	Planned	16	12	8		Programme for overseas recruitment implemented(23-Nov-2021),Lots of bespoke Nursing development courses offered eg 150 staff nurses through a university post registration module. 200 HCAs through an Open University module Increasing Secondments for HCAs to pre-reg nurse training . 20 Matrons and ANPs through a post-graduate management course. 40 Senior Sisters and Sister through a bespoke leadership programme. 35 RNs on Stroke Unit have gone through a bespoke stroke programme. Rns through a bespoke gastro programme. Participation in NHS Leadership academy course at all levels of the Trust(23-Nov-2021),Monitoring of appraisal rates and statutory/Mandatory training ratse at Workforce Board and Management Board(23-Nov-2021),New reward and recognition scheme launch (Going the Extra Mile Awards and Annual Staff Awards)(23-Nov-2021),Workforce Assurance Committee has been established(23-Nov-2021),Overseas recruitment drive(23-Nov-2021),Monitoring via staff survey feedback and local action plan based outcomes(23-Nov-2021),Health and well being promotion and education via Occupational Health(23-Nov-2021),We Care programme Booklet and survey under development(23-Nov-2021),We Care programme of support(23-Nov-2021),Links with HETV to increase commissions for registered clinical staff(23-Nov-2021),On Line exit interview process in place from July 2015(23-Nov-2021),Lobbied HETV for more commissions for nurse places(23-Nov-2021),Onboarding(23-Nov-2021),Reviewing flexible working policy(23-Nov-2021),Introduction of recruitment retention premia(23-Nov-2021)	Not Applicable	Treat	Risk transferred from Datix
RSK-230	25-Nov-2021	Adam Biggs	Operational	There is a risk of a major incident occurring requiring the trust to respond above service levels that could result in impacting normal service. Eg/elective and inpatient care.	LEADING TO changes in routine working processes and procedures across the Trust for the duration of the major incident response and recovery phases.	Organisation	09-Dec-2021	07-Nov-2022	Planned	16	12	8		Major incident response plan (IRP)(25-Nov-2021),Action Cards have been removed from the Major Incident Response Plan and are held as a separate annex(25-Nov-2021),CBRN arrangements outlined within the IRP(25-Nov-2021),Mass casualty response outlined within the IRP(25-Nov-2021),Regional casualty dispersal process in place(25-Nov-2021),Local resilience Forum working group meetings attended, with tactical and strategic levels represented by CCG and NHSE&I(25-Nov-2021),Training and Exercise programme in place to ensure the Trust meets national best practice and statutory obligations(25-Nov-2021),EPRR annual work plan in place and agreed with Accountable Emergency Officer (AEO) that is scrutinised and reviewed through the Emergency Planning Steering Committee on a quarterly basis attended by senior and key staff(25-Nov-2021),Annual NHSE&I EPRR Core Standards review conducted by BLMK CCG to ensure MKUH is meeting its statutory obligations, with internal report sent to Managing Board and Trust Public Board for sign-off(25-Nov-2021)	Not Applicable	Not Applicable	This will remain an open risk as Major Incident will always have the potential to occur internally or externally to varying degrees dictated on the event.
RSK-232	25-Nov-2021	Adam Biggs	Operational	IF there is an extreme prolonged weather conditions (heat/cold) THEN there is potential for wards/departments to be unable to maintain/provide effective service provision at required standards during prolonged extreme weather conditions	LEADING TO Service disruption/delays, Staff health & wellbeing, Patient safety, Adverse media publicity Breaches of Health & Safety at Work Act, Management of Health & Safety at Work Regulations, Workplace Health, Safety & Welfare Regulations	Organisation	09-Dec-2021	14-Nov-2022	Planned	12	12	12		Business continuity plans in some areas(25-Nov-2021),Heat wave plan(25-Nov-2021),Extreme weather policy(25-Nov-2021),Cold Weather Plan(25-Nov-2021)	Not Applicable	Not Applicable	Will remain an Open risk due to climate change resulting on the ongoing risk off extreme weather occurring
RSK-237	25-Nov-2021	Paul Sukhu	Strategic	IF the Trust is unable to spend the full amount of the Apprenticeship Levy each month THEN money which could have been used to develop our staff will be forfeit	LEADING failure to maximise taxpayers money. The Trust may not be able to use the apprenticeship levy to fund staff education, training and development. Inability to maximise the new apprenticeship standards may impact on recruitment, retention and career development	Organisation	25-Nov-2021	30-Nov-2021	Overdue	15	12	2		Apprenticeship Manager attends the Nursing, Midwifery and Therapies Education Forum to promote apprenticeship benefits(25-Nov-2021),NHS People Plan commitment to support apprenticeships and other key national entry routes(25-Nov-2021),There is a national tender for the radiography apprenticeships underway led by HEE(25-Nov-2021),Apprenticeship strategy approved, maximising Levy use going forwards(25-Nov-2021),Medical apprenticeship consultation ongoing(25-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-238	25-Nov-2021	Paul Sukhu	Hazard / Health & Safety	IF poor moving and handling practice happens, THEN staff and patients may get injured due to poor moving and handling	LEADING TO litigation, sickness absence and increased temporary staffing backfill. Staff and/or patient injury Subsequent reduction in staff numbers Poor reputation and publicity Potential risk of litigation and prosecution	Organisation	25-Nov-2021	30-Nov-2021	Overdue	12	12	6	Currently manual handling training is carried out every three years and the Manual Handling and Ergonomics Advisor visits all departments to carry out risk assessments, offer advice and ad-hoc training as required		Not Applicable	Not Applicable	Risk transferred from Datix
RSK-239	26-Nov-2021	Lynn Neat	Hazard / Health & Safety	IF there is insufficient Resourcing within the patient administration areas including training areas, and there is significant wider organisational change (e.g. eCare, mycare) THEN there could be inadequate administrative capacity to support current clinical demand	LEADING TO Potential litigation, poor patient experience, potential serious incident, inappropriate / delayed patient care, delays to organisational change roll-outs	Organisation	10-Dec-2021	29-Jun-2020	Overdue	16	12	6		Recruitment exercises(26-Nov-2021),Recruitment through secondments(26-Nov-2021),weekly operational status meetings(26-Nov-2021),Additional senior support provided(26-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-243	26-Nov-2021	Lynn Neat	Operational	IF there is Insufficient administrative staffing and staffing mix to support the business need THEN there is a risk that the administrative functions of the business will fail at worst, or delay patient care at best	LEADING TO Potential delays to patient care, due to delays in administration processes	Organisation	10-Dec-2021	06-Oct-2021	Overdue	16	12	6		Dependent on Bank Staff(26-Nov-2021),Staff working overtime(26-Nov-2021),Control added in error(26-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-244	26-Nov-2021	Lynn Neat	Compliance	IF Clinicians/Authors are not selecting the correct MRN when creating clinic letters or discharge summaries THEN patients could see other patients clinical information	LEADING TO Potential GDPR / patient information breach	Organisation	10-Dec-2021	06-Oct-2021	Overdue	16	12	6	Discharge summaries (not yet live) - these are still visible on MyCARE, but are marked as "withdrawn". eCARE development & Zesty are working on a solution	Clinic letters - Authors are trained to use Clinic Builder when creating letters as this pulls in eCARE demographics(26-Nov-2021),Clinical Letters - Letters can be marked "in error" on eCARE. However, this does not translate to the MyCARE patient portal(26-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix

Corporate Risk Register

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RSK-245	26-Nov-2021	Lynn Neat	Operational	IF there is an absence of a prospective and retrospective outpatients slot utilisation report THEN the Patient Access Team and the wider Trust will be unable to effectively and efficiently fill unused slots and review the level of slots wasted, leading to a loss of income, increased waiting lists and poor relationships between departments	LEADING TO leading to a loss of income, increased waiting lists and poor relationships between departments	Organisation	10-Dec-2021	27-Nov-2021	Overdue	12	12	6		Team leaders in the Central Booking Office allocating this as a task at daily huddles, ie outpatient schedulers to view the front end of eCare to identify unfilled slots(26-Nov-2021),Patient Access and Transformation Team working with Information and IT to establish if a report will be technically possible(26-Nov-2021)	Not Applicable	Not Applicable	
RSK-253	26-Nov-2021	Craig York	Operational	IF the Trust does not maintain its 4 year PC replacement cycle (including PC Monitors) THEN the IT Department will be unable to provide a secure and performant infrastructure for clinical and business applications	LEADING TO reduced level of service and functionality	Organisation	09-Dec-2021	25-Feb-2022	Planned	12	12	6		Stock for replacement programme 2021/22 available(26-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-254	26-Nov-2021	Craig York	Hazard / Health & Safety	If Nursing staff accidently select the incorrect prescription chart within eCARE THEN patients could receive medication which is prescribed for another patient.	LEADING TO potential harm to patients	Organisation	15-Dec-2021	25-Feb-2022	Planned	12	12	3		eCARE alert if mismatch between wrist band & electronic drug chart. Correct workflow taught in eCARE training. Monthly scanning compliance report(26-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-256	26-Nov-2021	Craig York	Compliance	IT the current server version is out-dated THEN the server is vulnerable, and a potential Cyber attack target.	LEADING TO negative impact on patient care. Should the system fail completely, with no further support offered from CliniSys.	Organisation	09-Dec-2021	25-Feb-2022	Planned	15	12	2	Testing under way with Pathology,Test issues raised and resolution activity taking place	Hardware migrated(26-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-259	29-Nov-2021	Ayca Ahmed	Operational	If the Clinical Engineering and Medical Equipment Library Teams are unable to access the Medical Equipment Asset Management Database THEN they will not be able record PPMs, repairs, loans, report on assets for training logs and associated tasks and provide KPI reports in compliance with MHRA standards and as per the CQC guidelines – Regulation 15 Premises and Equipment. and be compliant	LEADING TO potential impact to clinical safety	Organisation	09-Dec-2021	31-Jan-2022	Planned	16	12	4	Business Case approved, out to mini competition to market for alternative asset database	IT provided access to remote desktop to connect to the server directly(29-Nov-2021),Draeger (CE) has access to the FMFirst database(29-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-262	29-Nov-2021	Phil Eagles	Hazard / Health & Safety	IF the Trust Fire Dampers are not surveyed and remedial works funded THEN remedial work not being completed	LEADING TO the travel of fire between compartments causing risk to life, greater damage to the estate, poor public image and subsequent interventions from the Fire Brigade with potential enforcement notices.	Organisation	09-Dec-2021	31-Jan-2022	Planned	20	12	8		A combination of fire door maintenance, fire alarm system, compartmentation inspections and remedials, fire damper inspections and remedials, automatically closing fire doors, emergency lighting, fire extinguishers and other elements of the fire strategy mitigates the reliance on any one component of fire safety(29-Nov-2021),Mandatory fire training(29-Nov-2021),Fire wardens(29-Nov-2021),Authorised Engineer (AE)appointed March 2020(29-Nov-2021),Annual inspections(29-Nov-2021),Funded annual remedial programme(29-Nov-2021),Site wide Damper annual audit, risk based approach to any remedials(29-Nov-2021),£10K of repair work ordered and new inspection(29-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-263	29-Nov-2021	Phil Eagles	Hazard / Health & Safety	IF the Trust Fire Compartmentation are not surveyed and remedial works funded THEN remedial work not being completed	LEADING TO the travel of fire between compartments causing risk to life, greater damage to the estate, poor public image and subsequent interventions from the Fire Brigade with potential enforcement notices	Organisation	09-Dec-2021	31-Jan-2022	Planned	20	12	8		fire door maintenance, fire alarm system, compartmentation inspections and remedials, fire damper inspections and remedials, automatically closing fire doors, emergency lighting, fire extinguishers and other elements of the fire strategy mitigates the reliance on any one component of fire safety(29-Nov-2021),Mandatory fire training(29-Nov-2021),Fire wardens(29-Nov-2021),Annual Capital bids rolling program(29-Nov-2021),Annual audit regime in place(29-Nov-2021),Authorised Engineer (AE)appointment made March 2020(29-Nov-2021),Annual audit in place(29-Nov-2021),Annual Remedial programme in place, risk based priority(29-Nov-2021),Identified remedials were completed Jan 2021(29-Nov-2021),21/22 programme approved at May 2021 Trust Exec Group(29-Nov-2021),Audit completed June 2021, included all plant room spaces(29-Nov-2021),20% of Hospital streets audited annually on a rolling program(29-Nov-2021),Works identified including 140 fire doors to be fitted on electrical cabinets. Prioritisation on risk basis, Order for £10K placed with Nene Valley(29-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-264	29-Nov-2021	Phil Eagles	Hazard / Health & Safety	IF the Trust Fire Doors are not regularly surveyed and remedial works funded THEN remedial work not being completed	LEADING TO the travel of fire between compartments causing risk to life, greater damage to the estate, poor public image and subsequent interventions from the Fire Brigade with potential enforcement notices.	Organisation	09-Dec-2021	31-Jan-2022	Planned	20	12	8		A combination of fire door maintenance, fire alarm system, compartmentation inspections and remedials, automatically closing fire doors, emergency lighting, fire extinguishers and other elements of the fire strategy mitigates the reliance on any one component of fire safety(29-Nov-2021),Mandatory fire training(29-Nov-2021),Fire wardens(29-Nov-2021),A new audit and prioritization has been established for 2019 onwards, with prioritised areas as discussed at Management Board July 2019(29-Nov-2021),Plant Room Doors surveyed(29-Nov-2021),Guaranteed Capital agreed brought service in house January 2020(29-Nov-2021),Authorised Engineer (AE)appointed March 2020(29-Nov-2021),Many Fire Doors have been replaced since Jan 2020 as part of the prioritisation programme(29-Nov-2021),Rolling programme with backlog to overcome issues(29-Nov-2021),21/22 programme approved at May 2021 Trust Exec Group(29-Nov-2021),Reviews options for new AE, out to tender(29-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-265	30-Nov-2021	Mark Brown	Hazard / Health & Safety	IF there is local power failure and failure of emergency lights, due to age of existing fittings and lack of previous investment THEN there may be a failure to protect persons allowing a safe evacuation of the area	LEADING TO poor patient experience and safety, non-compliance with regulation, loss of reputation	Organisation	09-Dec-2021	24-Nov-2021	Overdue	20	12	8		Future investment requirements identified by PPM , reactive maintenance and Estates Specialist Officer(30-Nov-2021),PPM checks in place with regular testing by direct labour(30-Nov-2021),Rolling program of capital investment(30-Nov-2021),Rolling PPM program PPM 3 hour E-light testing program in place(30-Nov-2021),List of known remedials to be completed and prioritised(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix

Corporate Risk Register

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RSK-266	30-Nov-2021	Phil Eagles	Financial	IF the Trust are unable to take up the HIP (Health Infrastructure Plan) Programme THEN The Trust would have to fund all future developments from either internally generated funding defined for backlog investment or borrow the money	LEADING TO the Trust being unable to meet the needs of the future MK population with regard to the size and quality of the estate	Organisation	22-Dec-2021	27-Mar-2022	Planned	16	12	8		Seed funding approved by DHSC to support the development of a Strategic Outline Case (SOC)(30-Nov-2021),SOC has been formally completed(30-Nov-2021),Regular monthly meetings on a formal basis with NHSE/I and DHSC(30-Nov-2021),Regular dialogue taking place with NHSE/I Strategic Estates Advisor(30-Nov-2021),Regular dialogue taking place at Board level(30-Nov-2021),Monthly reporting structure in place with NHSE/I(30-Nov-2021),Programme Board chaired by CEO set-up with agreed ToR(30-Nov-2021),Wider engagement with MK Council(30-Nov-2021),Wider engagement with senior colleagues in the Trust commenced(30-Nov-2021),Engagement with CCG undertaken(30-Nov-2021),SOC Submitted to NHSEI, OBC to be progressed in quarter 4(30-Nov-2021)	Not Applicable	Not Applicable	Reviewed bu Associate Director of Estates, corrected the current risk rating from 8 to 12
RSK-267	30-Nov-2021	Kim Rahbek	Hazard / Health & Safety	IF there is a lack of suitable training drills and/or fire escape routes being blocked/partially blocked by consumables THEN there could be a failure to evacuate individuals safely in the event of actual or suspected fire	LEADING TO a negative impact on patients safety. Individuals at risk of injury, ill health or other harm, death. Trust vulnerable to enforcement action, claims, litigation, complaints, adverse publicity	Organisation	09-Dec-2021	31-Jan-2022	Planned	16	12	4		Hospital Street Task and Finish Group set up and Chaired by Director of Corporate Affairs. First meeting 22 June 2021 requested attendees to carryout Hospital Street FRA of their areas and submit to the next group(30-Nov-2021),Dump the Junk established, and continuing to be managed by Soft Services, to remove unwanted items from hospital streets(30-Nov-2021),Procurement continuing to review flow of stock into the hospital(30-Nov-2021),Arrangements made during the Fire Risk Assessment to carryout a fire drill either as a full drill, walk through or desktop exercise(30-Nov-2021),Launched Desktop evacuation drills training for wards and local awareness March 2020 (COVID caused delay in rolling out fully)(30-Nov-2021),Fire safety included in Department huddles, with Departments overseeing fire safety within the department(30-Nov-2021),Departments submit quarterly fire safety audits which include issues which may inhibit evacuation(30-Nov-2021),Staff inductions and mandatory training(30-Nov-2021),Induction and refresher training includes progressive horizontal evacuation training(30-Nov-2021),Passive fire safety controls in place including fire detection, fire alarms, fire doors etc(30-Nov-2021),Active fire safety controls in place with planned preventative maintenance of assets in place and undertaken by in-house Estates team or contracts in place with external contractors(30-Nov-2021),Annual Fire Wardens training, with Fire Wardens based across the Trust(30-Nov-2021),Table top exercise carried out with Emergency Planning Officer(30-Nov-2021),Regular spot-checks by Trust Fire safety Advisor(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-268	30-Nov-2021	Kim Rahbek	Hazard / Health & Safety	IF fire doors around the Trust are being propped open THEN there is a risk that fire/smoke will not be contained within the compartment in the event of a fire	LEADING TO the travel of fire between compartments causing risk to life, greater damage to the estate, poor public image and subsequent interventions from the Fire Brigade with potential enforcement notices.	Organisation	09-Dec-2021	31-Jan-2022	Planned	16	12	4		Departments discuss fire safety and the appropriate use of fire doors regularly at staff huddles(30-Nov-2021),Minor New Works procedure in place for Departments to raise a business case if doors require fittings with hold open devices linked to the fire alarm system. Or, to request additional cooling if excess heat is being created when fire doors are closed(30-Nov-2021),Wedges, bins or anything else used to hold open fire doors removed by staff or Trust Fire Safety Advisor if spotted(30-Nov-2021),Fire doors and their purpose covered in detail in the staff induction and mandatory training(30-Nov-2021),Quarterly department audits(30-Nov-2021),Comprehensive fire risk assessments(30-Nov-2021),Local Fire evacuation drills arranged following fire risk assessment(30-Nov-2021),Passive fire safety controls in place including fire detection, fire alarms, fire doors etc(30-Nov-2021),Active fire safety controls in place with planned preventative maintenance of assets in place and undertaken by in-house Estates team or contracts in place with external contractors(30-Nov-2021),All 60 minute compartments have auto-closing hold open devices which are tested with the fire alarm testing and fire door inspections, which release on fire alarm activation(30-Nov-2021),Fire compartmentation(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-269	30-Nov-2021	Phil Eagles	Hazard / Health & Safety	IF the Trust fails to comply fully with current DoH HTM 04-01 Parts A&B, Addendum relating to Water Systems and HTM 00 as identified in the Water Risk assessment THEN The Trust will be unable to provide assurance of a fully compliant water safety system	LEADING TO Increased risk to patients and staff, loss of reputation, financial loss to the Trust.	Organisation	09-Dec-2021	31-Jan-2022	Planned	16	12	8	Tender awarded to Evolution, 2 year contract commenced 1st July 2019. extended for 6 months. New tender to be drafted	A Water Services Management Group operates quarterly, with agreed membership and agenda items(30-Nov-2021),Audit document and action plan has been circulated to the Group for discussion and progression at the next meeting(30-Nov-2021),Independent contractor commissioned to regularly test water outlets. Controls and testing regimes in place(30-Nov-2021),Review and Water Services Management Group membership includes independent contractor and Authorising Engineer(30-Nov-2021),Whole site risk assessments are current and risk reviewed at each meeting(30-Nov-2021),Risk assessment undertaken of augmented care areas(30-Nov-2021),House keepers are flushing water out lets in clinical areas and return flushing sheets to estates, Hotel Services Audit manager to track progress and compliance(30-Nov-2021),Phase 1 and Cancer Centre risk assessments completed(30-Nov-2021),Phase 2 Risk Assessment completed June 2021, actions underway(30-Nov-2021),Risk assessments for outlying buildings planned 2022(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix

Corporate Risk Register

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RSK-274	30-Nov-2021	Phil Eagles	Hazard / Health & Safety	IF the Trust worn flooring is not replaced THEN there is a risk of failure of flooring	LEADING TO trip hazard & infection control issues	Organisation	09-Dec-2021	31-Jan-2022	Planned	15	12	6		Capital bid to be placed annually(30-Nov-2021),Ward 6 and Ward 1 full floor replacement completed(30-Nov-2021),Business Case written, funded 21/22(30-Nov-2021),Adhoc floor repairs made with temporary taping of any failures occurring(30-Nov-2021),Going to the market for new contractor, out to tender(30-Nov-2021),Crown Industrial flooring making small repairs(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-276	30-Nov-2021	Anthony Marsh	Operational	If the flat roofs identified in the Langley Roof report and 6 facet survey as requiring replacement or upgrading, are not replaced THEN there is a risk of roof failure in relation to flat roofs across the Trust	LEADING TO Water ingress - Potential damage to equipment, disruption to service, damage to reputation	Organisation	09-Dec-2021	31-Jan-2022	Planned	15	12	3	Replacement/upgrade of flat roofs identified in the 6 facet survey	Inspections and repairs as needed(30-Nov-2021),Updated annual 6 facet survey by Oakleaf(30-Nov-2021),Large patch repairs undertaken as emergency business cases(30-Nov-2021),1 x Post Grad roof fully replaced 19/20(30-Nov-2021),Ward 10 - 50% of roof patch repairs completed 19/20(30-Nov-2021),Phase 1, Phase 2 and Community Hospital survey completed.(52 roof leaks noted in 12 months Jan 19 -Aug 20) 16 leaks in 1st week of October 2020(30-Nov-2021),Pharmacy small roof replaced September 20(30-Nov-2021),Business Case approved for 4 to 5 year rolling programme(30-Nov-2021),Community Hospital work completed July 2021(30-Nov-2021),Phase 1 and Phase 2 of the hospital works outstanding. Funding to be approved(30-Nov-2021),Funding for phase 2 included in carbon zero funds to be announced Jan 2022(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-281	30-Nov-2021	Phil Eagles	Operational	If the lift located in Outpatients (servicing levels 3, 4 of yellow zone, and Staff Health & Wellbeing) fails THEN disabled & mobility reduced/sight impaired individuals unable to access workplace or services – unable to fulfil contractual obligations. Persons entrapped in lift unable to exit. Delayed access/treatment of an individual taken ill whilst trapped. Claustrophobia, panic attacks, psychological harm, deterioration of condition	LEADING TO Reduced availability of staff, unable to carry out duties, reduced clinical input/unable to see clients (internal/external) in a timely manner – increased workload for other staff leading to increased work pressure/stress Loss of income of external clients who cannot be seen due to absence of clinician Service user dissatisfaction – complaints/reputation of service and organisation affected Adverse publicity if unavailability of service reported to local press/reputation of organisation and service affected The organisation would be in breach of statutory duties under Health & Safety At Work etc Act 1974, Equality Act 2010 – failure to provide safe access/egress/safe place of work – potentially leading to enforcement action/further interest of Health & Safety Executive Inspectorate	Organisation	09-Dec-2021	31-Jan-2022	Planned	12	12	9		There is an SLA is place that states that the lift will be repaired within 4 hours, normally 1-2hours(30-Nov-2021),ResQmat are on the landings on floors 3 & 4 and should be used in the event disabled persons and those with limited mobility, are unable to leave their respective floors, although staff are not trained in their use(30-Nov-2021),Call bell/telephone in lift to call for assistance(30-Nov-2021),Monthly lift inspections in place(30-Nov-2021),6 Monthly PPM in place(30-Nov-2021),Annual insurance inspections in place(30-Nov-2021),ResQmat training video in place created by Manual Handling adviser(30-Nov-2021),Refurbishment of ward 14 lift carried out(30-Nov-2021),Ward 16 undergone H&S improvements(30-Nov-2021),On the Capital Programme(30-Nov-2021),Outpatients Business Case approved for M&E study, with any identified anticipated to be completed end of FY 2022(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-289	30-Nov-2021	Phil Eagles	Compliance	IF the Trust does not sufficiently invest in implementing previous Disability & Discrimination Act (DDA) findings THEN this will LEAD TO a failure to meet current DDA standards due to design access to Trust facilities and way finding.	LEADING TO non-compliance with the DDA findings, poor patient experience	Organisation	09-Dec-2021	31-Jan-2022	Planned	12	12	6	Order placed start date to be agreed, estimated completion date Feb 2022	Interactive Google map order completed(30-Nov-2021),Approval required to invest in future action plan(30-Nov-2021),Exploring external funding options for 'Accessibility' funds(30-Nov-2021),To be considered as part of the strategic plan(30-Nov-2021),Revenue funding for update to audit/survey approved(30-Nov-2021)	Not Applicable	Not Applicable	
RSK-292	30-Nov-2021	Michael Stark	Hazard / Health & Safety	IF the medical gas safety alarms are not upgraded THEN due to their age the medical gas alarm safety alarm may fail	LEADING to risk to patient care, and patient and staff safety and non compliance with regulations	Organisation	21-Dec-2021	21-Nov-2022	Planned	12	12	4	Maintenance schedule and reactive repairs. Authorised Engineer appointed - Steve Goddard (21-Dec-2021),MGPS quarterly PPM carried out by specialist contractor. (21-Dec-2021),Estates Medical Gas AP to monitor (21-Dec-2021)		Not Applicable	Not Applicable	
RSK-299	30-Nov-2021	Phil Eagles	Hazard / Health & Safety	IF the Summary Record of Estates 5 year and Prioritised Backlog Maintenance risk based priority programme is not fully implemented THEN plant and equipment may fail in various areas of the hospital	LEADING TO infection control, financial implications, loss of services and reputation damage	Organisation	09-Dec-2021	31-Jan-2022	Planned	9	12	4		All areas are reviewed on a monthly basis by Estates Service Manager, or sooner if equipment/plant breakdown demands(30-Nov-2021),Business cases for plant replacement to be put forward FY21/22(30-Nov-2021),Compliance Officer reviewing to identify significant costs(30-Nov-2021),Review of recent 6 Facet Survey to identify future funding requirements e.g. Roof, Ventilation, Plant, HV, drainage(30-Nov-2021),March 2021 20% physical and remaining 80% desktop survey completed(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-300	30-Nov-2021	Anthony Marsh	Operational	IF the call bell system is not replaced/upgraded THEN the call bell system could fail as parts obsolete for some systems to obtain	LEADING TO increased risk to patients and possible service disruption and poor patient experience	Organisation	09-Dec-2021	31-Jan-2022	Planned	9	12	3	MB to draw up up the tender package, going to market	An emergency back up system of 30 units has been purchased in the event of current system failing. There is also an additional spare unit(30-Nov-2021),Ward 4, 5 and Milton Mouse & A&E Majors were replaced in FY18/19(30-Nov-2021),ADAU replaced as emergency business case October 2019(30-Nov-2021),Endo replaced in Jan 2020(30-Nov-2021),Vizcall no longer in business, plan to replace all Vizcall systems in 20/21 - Vizcall test equipment and spares purchased for in house support(30-Nov-2021),Above the line funding for 2 x wards and ED agreed for 2021 with Ascom(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Radar

Corporate Risk Register

Reference	Created on	Owner	Category	Description	Impact of risk	Scope	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-007	06-Sep-2021	Tina Worth	Hazard / Health & Safety	IF the team Fire Warden is not adequately trained or they are not present during a related emergency; THEN there would be no focal point for fire safety matters for local staff and supporting line managers on fire safety issues, and the team may not be represented in Fire Safety Committee meetings, and they will not be able to organise and assist in the fire safety regime within their local area	LEADING TO staff and other individuals visiting level 1 in Oak House potentially not being evacuate in a timely manner due to the lack of oversight. The lack of single focused oversight could cause confusion, delays in evacuation and people being left behind. This could lead to smoke inhalation, burns, death. Fire checking and prevention procedures may not be robust enough to identify potential hazards and prevent a fire from happening. Breach of statutory regulations	Organisation	21-Dec-2021	30-Mar-2022	Planned	15	10	5	Risk & Clinical Governance Team Fire Warden to attend Fire Warden Training,There was a suggestion that posters were put up for staff to follow when Kevin is not in.,There was a recommendation that in light of the working from home arrangements, it might be appropriate for everyone to have the training so that there is adequate cover.	Fire Warden advised to work within current knowledge and skill gained through mandatory fire training(06-Sep-2021),No team member to attempt to fight fires with equipment untrained to use(06-Sep-2021),Risk assessment shared with team / Staff awareness(06-Sep-2021),Quarterly fire safety audits completed(06-Sep-2021),Good housekeeping practicalities - reiterated at team huddle(06-Sep-2021),Fire safety signage displayed -action cards and assembly points identified, clearly visible to team members and others visiting corridor(06-Sep-2021),Fire alarm system checked regularly in line with Trust policy and is audible in corridor(06-Sep-2021),Team members have undertaken and are up to date with mandatory training (compliance checked monthly)(06-Sep-2021),Team risk assessment for lone working on back of Covid changes which covers fire(06-Sep-2021)	Low	Treat	Additional controls added as requested by Kate Jarman
RSK-015	21-Sep-2021	Laura Sutton	Hazard / Health & Safety	This a ligature risk assessment ward 1 in various locations: - Bay 1,2 3 and 4 (6 Beds per bay) - Siderooms 1,2 and 3 - Bathroom/Toilets - Kitchen - Attending to and/or witnessing vulnerable patients/ self harm/suicide attempts - Sluice - Store cupboards/Clinic rooms/Corridors - Ligature points - Ligatures	Patients admitted with acute mental health problems. Majority involve those who have attempted suicide or caused deliberate self harm. Leading to physical injury/cuts/overdose/ill health/death - Patients admitted with acute mental health problems. Majority involve those who have attempted suicide or caused deliberate self harm. These persons can vary in sex and age. - Patients admitted with acute mental health problems. Majority involve those who have attempted suicide or caused deliberate self harm. - Staff/Patients/Visitors: Psychological impact, stress, anxiety, breakdown; Absence from work; Reduced staffing through absence Ongoing mental health impact	Organisation	20-Dec-2021	03-Jan-2022	Overdue	15	10	10		See attached Risk Assessment.(21-Sep-2021)	Not Applicable	Treat	Reviewed at SPEG: actions taken to reduce the likelihood of the occurrence.
RSK-200	23-Nov-2021	Karan Hotchkin	Financial	IF the Trust is unable to successfully tender for external audit services in 2021 THEN financial audits and other required annual assurance exercises will not take place	LEADING TO the Trust failing in its statutory obligations.	Organisation	10-Dec-2021	07-Jan-2022	Pending	20	10	10	A tender will take place for appointment of external audit firm beyond FY22	Discussions have been held with the current external audit firm and agreement has been reached to extend the contract for a year to August 2022.(23-Nov-2021)	Medium	Treat	Risk transferred from Datix
RSK-242	26-Nov-2021	Adam Biggs	Operational	There is a risk of a CBRN/HAZMAT incident occurring through either intentional or unintentional means requiring a specialised response through national guidelines and expert advice potentially impacting on Trust services and site safety to patients and staff. CBRN (chemical, biological, radiological, nuclear)	Possible impact on closing or disrupting ED operations, with further risk to all operations on how the Trust operate depending on the nature of the incident i.e. novichok incident at Salisbury	Organisation	09-Dec-2021	20-Nov-2022	Planned	10	10	10			Not Applicable	Not Applicable	
RSK-248	26-Nov-2021	Craig York	Operational	IF the core IT network fails (due to its age) THEN at least half of the IT network (if not all of it) will fail and IT will stop working for all devices,	LEADING TO an inability to access key systems such as eCARE, imaging, pathology, HSDU, plus many more	Organisation	09-Dec-2021	25-Feb-2022	Planned	20	10	5	Replacement procured, implementation planned		Not Applicable	Not Applicable	Risk transferred from Datix
RSK-260	29-Nov-2021	Phil Eagles	Hazard / Health & Safety	IF people working at height are not correctly trained THEN there is a risk from fall from height	LEADING TO staff/contractor injuries, potential claims, non compliance with statutory regulations and loss of reputation	Organisation	09-Dec-2021	30-Jan-2022	Planned	15	10	5	RP to be appointed by Alan Hambridge	Staff training. Ladder/equipment inspections(29-Nov-2021),Written processes(29-Nov-2021),New lifting equipment purchased(29-Nov-2021),General H&S training conducted(29-Nov-2021),Cherry Picker obtained-staff trained(29-Nov-2021),RAMS from contractors reviewed by Compliance Manager(29-Nov-2021),Edge protection in place in all locations where plant or PV panels exist(29-Nov-2021),Treatment Centre now has edge protection replacing latchway system(29-Nov-2021),Trained RP in August 2021(29-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-036	28-Sep-2021	Helen Chadwick	Hazard / Health & Safety	If there is a lack of appropriate staff (Specialty Pharmacist) available. No dedicated post and no capacity in others then there is a risk that Pharmacy Policies and Procedures may not be reviewed and updated in a timely manner	Leading to: Potential for Policies & Procedures to be out of date Potential for staff to follow out of date Policies & Procedures	Organisation	16-Dec-2021	28-Sep-2021	Overdue	16	9	8	Development of eCare Try to release staff to review policies		Not Applicable	Treat	Number of policies out of date remain high
RSK-201	23-Nov-2021	Karan Hotchkin	Financial	IF there is lack of control over the expenditure position due to COVID and uncertainty about the future financial funding regime THEN the Trust may have insufficient cash to meet its financial obligations	LEADING TO Low / negative cash balances and interruptions to supplier payments	Organisation	10-Dec-2021	07-Jan-2022	Pending	20	9	9		Monthly cash flow forecasting is undertaken to establish at which point the Trust balances become close to £1m (historically the value advised by NHSEI to be held)(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix
RSK-206	23-Nov-2021	Karan Hotchkin	Financial	IF the Trust is unable to recruit staff of the appropriate skills and experience; there continues to be unplanned escalation facilities; There are higher than expected levels of enhanced observation nursing; and there is poor planning for peak periods / inadequate rostering for annual/other leave. THEN the Trust may be unable to keep to affordable levels of agency and locum staffing	LEADING TO Adverse financial effect of using more expensive agency staff and potential quality impact of using temporary staff	Organisation	10-Dec-2021	07-Jan-2022	Pending	16	9	9		Weekly vacancy control panel review agency requests(23-Nov-2021),Control of staffing costs identified as a key transformation work stream(23-Nov-2021),Capacity planning(23-Nov-2021),Robust rostering and leave planning(23-Nov-2021),Escalation policy in place to sign-off breach of agency rates(23-Nov-2021),Fort-nightly executive led agency reduction group meeting with aim of delivering reduction in both quantity and cost of agency used(23-Nov-2021),Agency cap breaches are reported to Divisions and the FIC(23-Nov-2021),Divisional understanding of how to reduce spend on temporary staffing to be developed(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix

Corporate Risk Register

Reference	Created on	Owner	Category	Description	Impact of risk	Scope	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-214	24-Nov-2021	Nadean Marsh	Operational	IF there is insufficient nursing staffing THEN there is a risk that the number of patients requiring nutritional assistance at meal times exceeds staff availability	LEADING TO patients nutritional needs potentially not being met, impacting on poor outcomes, patient experience and length of stay	Organisation	16-Dec-2021	31-Jan-2022	Planned	15	9	6		Protected meal times(24-Nov-2021),Red trays/jugs(24-Nov-2021),Meal time assistants(24-Nov-2021),Dining Companions Launched May 2018(24-Nov-2021),Senior Sister highlighting patients who require assistance at daily safety huddle(24-Nov-2021)	Not Applicable	Treat	Risk transferred from Datix
RSK-235	25-Nov-2021	Paul Sukhu	Operational	IF the Trust is unable to fill rotas THEN there may be insufficient medical cover	LEADING to increased clinical risk. We may not be able to easily provide sufficient clinical cover, leading to reduced service delivery, deteriorating patient experience	Organisation	25-Nov-2021	30-Nov-2021	Overdue	16	9	9		Recruitment and retention premia for certain specialties(25-Nov-2021),Advanced Nurse Practitioners development and integration in progress(25-Nov-2021),New SAS grade established(25-Nov-2021),New publication for International Medical Graduates developed(25-Nov-2021),Acting Down Policy in place(25-Nov-2021),Routine/regular evidence based trends inform early recruitment activity for shortage deanery specialties (e.g. medicine, paediatrics)(25-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-236	25-Nov-2021	Paul Sukhu	Operational	IF there is inability to retain staff employed in critical posts THEN we may not be able to provide safe workforce cover	LEADING TO clinical risk. Increasing temporary staffing usage and expenditure Increased turnover Decreased stability rates Increased stress levels within trust Reduced morale	Organisation	25-Nov-2021	30-Nov-2021	Overdue	16	9	9		Variety of Organisational Development and Reward initiatives, including Event in the Tent, P2P, Schwartz Rounds, Living our Values, Annual Staff Awards and feedback from staff being acted upon(25-Nov-2021),Monitoring via staff survey feedback and local action plan based outcomes(25-Nov-2021),Health and Wellbeing promotion, education and prevention via Staff Health and Wellbeing(25-Nov-2021),Online onboarding and exit interview process in place(25-Nov-2021),Flexible working and Agile Working policies in place(25-Nov-2021),MK Managers Way in place(25-Nov-2021),Recruitment and retention premia in place, including Golden Hello for Midwives(25-Nov-2021),Enhanced social media engagement in place and ongoing(25-Nov-2021),Annual funding initiatives to upskill staff and retain them through ongoing education e.g. Chief Nurse Fellowships, PGCE and Rotary Club Bursary fund(25-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-241	26-Nov-2021	Lynn Neat	Hazard / Health & Safety	IF administrators are not copying and saving clinical letters in EDM THEN access to the most up to date information will not be available	LEADING TO Clinicians will not have access to the most recent clinical letters and other dictations which could lead to delay in treatment and potentially missing updated medication and treatment given	Organisation	10-Dec-2021	31-Dec-2021	Overdue	16	9	6		Training to all Administrators ahead of their areas going live with the BigHand upgrade(26-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-250	26-Nov-2021	Craig York	Hazard / Health & Safety	IF staff across MKUH continue to use eCARE in the same way, that the volumes of requests made to the IT Department remain at their current rate, and the volume of change and project work continues at the current volume THEN the IT Department will become less responsive and a range of functions within eCARE will continue to be left without action	LEADING TO increased clinical risk, increased risk to performance of eCARE, potential disruption to staff, and delays in the deliver or projects and realising their benefits	Organisation	09-Dec-2021	25-Feb-2022	Planned	15	9	3	Prioritisation of workload is in place to cover the most impacting of issues or projects, however this only reduces the potential impact slightly		Not Applicable	Not Applicable	Risk transferred from Datix
RSK-255	26-Nov-2021	Craig York	Operational	IF the Trusts Data Warehouse is hosted on SQL Servers 2008 R2, which are no longer supported by Microsoft THEN there is increased vulnerability due to the unsupported servers not receiving any security and technical updates from Microsoft	LEADING TO potential for the Trust Information Data Warehouse to fail or be subjected to a security attack. The impact will vary depending on the failure. If there is a security attack on the servers there will be a data breach under GDPR leading to reputational damage and financial consequences. If the data warehouse were to fail, the Trust will not be able to fulfil any internal and national reporting requirements including RTT and financial reporting, submission of CDS, ECDS (to SUS), etc. This will have operational and financial impact leading to compromised patient safety and patient experience.	Organisation	09-Dec-2021	25-Feb-2022	Planned	20	9	6		Support now in place with Microsoft as a result of the service moving across to IT(26-Nov-2021),Migration of the Data warehouse onto virtual infrastructure completed(26-Nov-2021),Databases now being migrated to the cloud for additional security and resilience(26-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-272	30-Nov-2021	Anthony Marsh	Operational	IF the Passenger Lifts are not maintained THEN there is a risk of failure of components	LEADING to malfunction. Patients or visitors could get stuck in the lift, this could potentially cause panic or delay treatment. The public image of the trust could be affected.	Organisation	09-Dec-2021	27-Mar-2022	Planned	15	9	3		Maintenance Contracts are in place(30-Nov-2021),Insurance inspections are place(30-Nov-2021),Lift modernisation inspection has been completed and 5 year plan underway since FY17/18(30-Nov-2021),Eaglestone lift upgraded and some remedial and safety upgrades during FY19-20(30-Nov-2021),W14 upgraded 2020(30-Nov-2021),Luing Cowley Lift awaiting upgrades, these are difficult as no alternative when not in service, business case being drafted(30-Nov-2021),Maintenance contract out for tender(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-279	30-Nov-2021	Anthony Marsh	Hazard / Health & Safety	IF pedestrians in the hospital grounds walk over the verges, grassed areas, mounds, slopes, sloped/high curbs and do not stick to the designated pathways THEN Patients, visitors and staff could slip, trip or fall causing injury including fractures, sprains, strains	LEADING TO legal and enforcement action against individuals/and or the Trust leading to fines/compensation/exposure in local press leading to adverse publicity	Organisation	09-Dec-2021	27-Mar-2022	Planned	12	9	6		Sloping curbs painted yellow where they may be crossed(30-Nov-2021),Fencing or railings in some areas to stop access(30-Nov-2021),Rolling Paths annual program to repair paths and roads(30-Nov-2021),Grass kept cut by grounds team(30-Nov-2021),Grass kept cut by grounds team(30-Nov-2021),Keep off the Grass signage in place(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-282	30-Nov-2021	Anthony Marsh	Operational	IF there is a lack of on-site appointed person for decontamination - AP (D) THEN the Trust will not be able to implement and operate the Management's safety policy and procedures relating to the engineering aspects of decontamination equipment	LEADING TO non-compliant machines – working but not correctly; machine Failures – suddenly unusable, loss of production, out-sourcing; equipment released that is not disinfected or sterile – risk to staff; equipment released that contains endotoxins – risk to patients / SSI's	Organisation	09-Dec-2021	31-Jan-2022	Planned	12	9	6	An external AP(D) will be needed for Endoscopy, however the AE(D) is currently covering this responsibility	We are unable to employ or sub-contract and independent AP (D), the AE(D) is covering this role currently working with our internal, trained but yet to be appointed Estates Officer(30-Nov-2021),The AE(D) is coming to site once a month and spends his time validating servicing reports and giving feedback(30-Nov-2021),An Estates Officer to hold the role of AP(D), from June 2021(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix

Corporate Risk Register

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RSK-283	30-Nov-2021	Ayca Ahmed	Operational	IF medical equipment is damaged due to misuse, inappropriate use, storage, transportation, and/or inappropriate cleaning THEN the medical equipment may be unavailable due to damage	LEADING TO delay in patient care and treatment; cost of parts; cost of repairs; purchasing replacement	Organisation	09-Dec-2021	30-Dec-2021	Overdue	12	9	6			Not Applicable	Tolerate	Risk transferred from Datix
RSK-284	30-Nov-2021	Ayca Ahmed	Operational	IF staff members do not adhere to the Medical Devices Management Policy THEN they may not follow the correct procurement procedures for Capital and Revenue medical equipment purchases	LEADING TO them being not fit for purpose equipment being purchase; more costly; non-standardised; lack maintenance contract; lack of training for staff; incompatible/lack of consumables and accessory; additional IT integration costs	Organisation	09-Dec-2021	30-Dec-2021	Overdue	12	9	6			Not Applicable	Tolerate	Risk transferred from Datix
RSK-194	13-Nov-2021	Veronica Gordon	Compliance	IF the Viewpoint software is not supported THEN there will not have any further software or security updates. The trust will have an unsupported system for recording of ultrasound reports. Accuracy, consistency and reliability of sharing of information between healthcare professionals and trusts will be negatively impacted.	LEADING TO Increased security risks to Trust IT networks and infrastructure. Potential loss of the system, resulting in significant delays to obstetric ultrasound reporting	Organisation	19-Dec-2021	01-Mar-2021	Overdue	12	8	8		Viewpoint service contract currently in place with expiry 31/03/2021. Current system is operating.(13-Nov-2021)	Not Applicable	Tolerate	Risk transferred from Datix
RSK-213	24-Nov-2021	Nadean Marsh	Compliance	IF Local Authority is unable to ensure Deprivation of Liberty Safeguards (DoLS) are provided within allowed time period. THEN Potential to lead to patients being unlawfully detained	LEADING TO associated legal challenges, poor patient experience, negative impact on reputation of the Trust	Organisation	16-Dec-2021	31-Mar-2022	Planned	15	8	8		Due the national picture guidance has been given to local authorities with regards to triaging needs and actions to be taken.(24-Nov-2021),Locally acknowledged that if the circumstances and actions taken in regards to restrictions placed on an individual have not changed then the risks associated with the delay in the DOLS process is that of the Local Councils and not of MKUHFT(24-Nov-2021)	Not Applicable	Tolerate	Risk transferred from Datix
RSK-257	26-Nov-2021	Craig York	Operational	IF the server MKH-CRIS-01 continues to run Red Hat Linux Enterprise Version 6, Version 6 currently has 337 vulnerabilities THEN the server will be extremely vulnerable to being exploited by a third-party threat actor	LEADING TO negative impact on patient care due to lack of the service	Organisation	09-Dec-2021	25-Feb-2022	Planned	15	8	6		The server is currently on the clinical VLAN, leading to security benefits.(26-Nov-2021),Additional support procured to mitigate the security risk(26-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-285	30-Nov-2021	Phil Eagles	Hazard / Health & Safety	IF footpaths and roadways are not maintained and inspected sufficiently and regularly THEN this could lead to trips and falls if not correctly maintained	LEADING TO harm to patients, staff and the general public, and damage to vehicles and other road users	Organisation	09-Dec-2021	27-Mar-2022	Planned	12	8	4		Inspections and ad-hoc repairs(30-Nov-2021),Annual Audit to be completed(30-Nov-2021),Annual Capital bid to be placed on the capital program(30-Nov-2021),Some remedial captured by capital works at Cancer Centre(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-290	30-Nov-2021	John Blakesley	Strategic	IF there are changes in Commissioner purchasing intentions / Strategic Transformation Project (STP) THEN there is a risk that services could be put out to completition	LEADING TO delay in development of strategic projects	Organisation	22-Dec-2021	27-Mar-2022	Planned	12	8	4		Maintain close working arrangements with local CCGs and NHS England etc(30-Nov-2021),STP representative is on the project teams(30-Nov-2021),Amendment of Agenda to include STP item for policy/strategy update(30-Nov-2021),MKUH Deputy Chief Exec now appointed chair of STP Estates Forum(30-Nov-2021),Single block contract(30-Nov-2021)	Not Applicable	Not Applicable	Reviewed by Associate Director of Estates, no change to current risk rating
RSK-291	30-Nov-2021	Phil Eagles	Operational	IF the existing surface water drainage system is not suitably maintained or repaired THEN the surface water drainage system could fail	LEADING TO flooding and contamination and loss of service	Organisation	09-Dec-2021	31-Jan-2022	Planned	12	8	4		Reactive maintenance repairs(30-Nov-2021),A drain survey scheduled annually(30-Nov-2021),CCTV works has indicated areas of root re-growth with pipe damage to storm water pipes, works being undertaken during summer/autumn 2021(30-Nov-2021),BDP created scope for full site survey under the HIP program to identify shortfall in current data and future plan requirements. A new link is likely to be required as part of South Site development(30-Nov-2021),Road Gulley on PPM(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-293	30-Nov-2021	Mark Brown	Operational	IF the current fuse boards are not updated to miniature circuit breakers THEN existing fuse-boards could fail	LEADING to delays in repairs/replacement resulting in possible service disruption and poor patient experience	Organisation	09-Dec-2021	31-Jan-2022	Planned	12	8	4		PPM testing and repairs(30-Nov-2021),Fixed electrical testing program in place to identify any potential risks and actions required(30-Nov-2021),Replaced Circuit breakers/fuses FY 20/21(30-Nov-2021),Ongoing rolling program refurbishment(30-Nov-2021),Ward 1 completed 2021(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-301	30-Nov-2021	Phil Eagles	Operational	IF the existing foul water drainage system is not suitably maintained or repaired THEN the system could fail	LEADING TO cause flooding, contamination and loss of service	Organisation	09-Dec-2021	27-Mar-2022	Planned	8	8	4		Reactive maintenance repairs(30-Nov-2021),Wards 1-5 identified as risk areas(30-Nov-2021),Some CCTV inspection has been completed(30-Nov-2021),Scope of works being reviewed for proactive maintenance(30-Nov-2021),Multiple areas descaled ongoing programme(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-302	30-Nov-2021	John Blakesley	Compliance	IF the Trust fails to place contracts or renew contracts on-time, orders for reactive works arising from contractor visits are not raised, and/or the Trust fails to monitor completion of PPM and associated Reactive Tasks by Direct Labour or Contractors THEN there is a risk of CQC inspection leading to issuing of Improvement Notice	LEADING TO Failure to complete statutory and mandatory planned preventative maintenance on critical plant. Exposure of patients and staff to risks arising from plant and equipment which as not been adequately maintained.	Organisation	09-Dec-2021	31-Jan-2022	Planned	8	8	4		Work completed by Estates to address anticipated CQC concerns (ongoing)(30-Nov-2021),Evidence log folders updated(30-Nov-2021),Linked maintenance contracts to evidence documents and tracker, regularly reviewed(30-Nov-2021),Aligning existing documentation to KLOE and PAM for more detailed assurance(30-Nov-2021),Statutory Compliance post successfully appointed(30-Nov-2021),SharePoint set up with organised evidence(30-Nov-2021),PAM completed and return submitted(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred to Radar

Corporate Risk Register

Reference	Created on	Owner	Category	Description	Impact of risk	Scope	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-005	06-Sep-2021	Tina Worth	Hazard / Health & Safety	IF policies, guidelines and patient information are not reviewed and amended in a timely manner; THEN staff will be working with out of date information	LEADING TO potential error in patient care, non-compliance with legislative, national requirements, potential litigation and potential loss of reputation to Trust	Organisation	21-Dec-2021	30-Mar-2022	Planned	12	6	3	Implementation of Radar Document Management System to improve engagement and access to the documentation process	Trust Documentation Policy(06-Sep-2021),Library resource to source current references(06-Sep-2021),Governance Leads provide support to staff reviewing guidelines and policies(06-Sep-2021),Monthly trust documentation report shared with Governance Leads(06-Sep-2021),New process via Trust Documentation Committee for 'removal' of significantly breached documents(06-Sep-2021),Work plan in place to check approval of documents/links to national leaflets(06-Sep-2021)	Low	Treat	Risk reviewed & remains unchanged. Bespoke TDC scheduled for January 2022 to look at risk review of breached documents. Move to Radar document management scheduled for next year
RSK-010	06-Sep-2021	Paul Ewers	Compliance	IF the Radar Risk Management System does not meet the needs to the Trust and of legal reporting requirements THEN the Trust will not have an appropriate system to manage incidents, complaints, claims, compliments, safety alerts and risks	LEADING TO an inability for the Trust to defend itself against future claims/litigation leading to potential financial penalties, improvement notices, PFD notices from HM Coroner, adverse publicity etc., an inability to evidence compliance with CQC regulations and freedom of information requests, and potential for an increase in incidents, complaints and claims due to lack of learning from incidents.	Organisation	29-Dec-2021	31-Jan-2022	Planned	20	6	6		Project Manager identified along with 3 members of staff to provide cover and support to the project where necessary(06-Sep-2021),Radar Project Plan in place(06-Sep-2021),Radar Risk Assessment in place(06-Sep-2021),Working Groups identified to support design/build of system in line with Trust's requirements(06-Sep-2021),Radar Healthcare have a dedicated Project Manager and team in place to support MKUH with implementation(06-Sep-2021),Clearly defined roles added to the Project Plan(06-Sep-2021),Escalation process in place to Exec Sponsor(06-Sep-2021),Communication Strategy Developed(06-Sep-2021)	Low	Treat	Radar system is now live.
RSK-023	22-Sep-2021	Sally Burnie	Hazard / Health & Safety	Self harm Ward 25 - Persons with and without capacity may wish to end their lives - 1.Placement of patient with mental health diagnosis on Ward 25 Ligature points 2.Strangulation/hanging 3.Blades/knives 4.Medication	1.Patient & family Assessment to ensure medical need requires placement on Ward 25 2.Patient Long term disability Death 3.Patient Long term disability Death 4.Patient Long term disability Death	Organisation	20-Dec-2021	10-Jan-2022	Pending	15	6	6		Joint SLA / CNWL to ensure effective hand over structure is in place between mental health team and Ward 25 to understand risks(22-Sep-2021),Staff training to manage a emergency suicide situation Staff training on management of a high risk mental health patient Staff training to manage an emergency suicide situation Staff training on management of a high risk mental health patient Staff training to manage an emergency suicide situation(22-Sep-2021)	Not Applicable	Treat	Rehman, Raja - Clinical Governance Lead (Internal/Specialty/HaemOnc) 16/09/2021 16:24:18 CIG Review: mitigations have been in place and risk assessment are in place. unfortunately this remains a risk. no change
RSK-038	28-Sep-2021	Stephen Thomas	Operational	If Covid-19 impacts NHS Trusts through reduction in availability of Pharmacy staff as a result of infections, self-isolation and redirection to assisting with vaccination programs. & therefore Trusts are purchasing more ready-to-administer injections rather than make the doses themselves. With commercial companies have also been affected by staff having to self-isolate, reducing their capacity and ability to meet the increased demand for ready-to-administer products Then a number of commercial companies that provide ready-to-administer injections of chemotherapy, will have capacity issues that might prevent doses of urgently required chemotherapy from being obtained by the Pharmacy department for issue to cancer patients	Leading to: Non-availability of ready-to-administer products may prevent patients being treated as planned. Where ready-to-administer products can be obtained from commercial companies, an extended lead time has been implemented that does not permit timely purchase of required products.	Organisation	16-Dec-2021	30-Mar-2022	Planned	15	6	6		A number of commercial companies that provide ready-to-administer injections of chemotherapy, have capacity issues that might prevent doses of urgently required chemotherapy from being obtained by the Pharmacy department for issue to cancer patients(28-Sep-2021)	Not Applicable	Tolerate	
RSK-203	23-Nov-2021	Linda Baxter	Financial	IF the are negative impacts following new legislation following Brexit, COVID-19 pandemic and supplier bankruptcy THEN there is a risk that the supply of key clinical products may be disrupted	LEADING TO some deliveries and services may be delayed, disrupted or reduce resulting in impact on patient care	Organisation	10-Dec-2021	07-Jan-2022	Pending	16	6	6		Trust's top suppliers have been reviewed and issues with supply under constant review(23-Nov-2021),Procurement business partners use the NHS Spend Comparison Site and local knowledge supported by the clinical procurement nurse to source alternative products(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix
RSK-204	23-Nov-2021	Linda Baxter	Financial	IF data sent to external agencies (such as NHS Digital, Advise Inc and tenders) from the Procurement ordering system contain patient details THEN there is a risk that a data breach may occur with reference to GDPR and Data Protection Act as the procurement department deals with large volumes of data.	LEADING TO a data breach and potential significant fine	Organisation	10-Dec-2021	07-Jan-2022	Pending	16	6	6		All staff attend an annual mandatory training course on Information Governance(23-Nov-2021),Staff are encouraged to use catalogues which reduces the requirements for free text(23-Nov-2021),Data sent out to external agencies is checked for any patient details before submitting(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix
RSK-205	23-Nov-2021	Linda Baxter	Financial	IF there is Incorrect processing through human error or system errors on the Procurement systems THEN there is risk that there may be issues with data quality within the procurement systems	LEADING TO Incorrect ordering resulting in a lack of stock and impacting on patient safety	Organisation	10-Dec-2021	07-Jan-2022	Pending	12	6	6		Monthly reviews on data quality and corrections(23-Nov-2021),Mechanisms are in place to learn and change processes(23-Nov-2021),Data validation activities occur on monthly basis(23-Nov-2021),A desire to put qualifying suppliers in catalogue(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix
RSK-207	23-Nov-2021	Karan Hotchkin	Operational	IF there is major IT failure internally or from external providers THEN there is a risk that key Finance and Procurement systems are unavailable	LEADING TO 1. No Purchase to pay functions available ie no electronic requisitions, ordering, receipting or payment of invoices creating delays for delivery of goods. 2. No electronic tenders being issued. 3. No electronic raising of orders or receipting of income	Organisation	10-Dec-2021	07-Jan-2022	Pending	12	6	6		If its an external issue, SBS the service provider of the purchase to pay and order and invoicing has a business continuity plan in place(23-Nov-2021),If its an internal issue. The Trust has arrangements with the CCG who also use SBS to use their SBS platform(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix
RSK-208	23-Nov-2021	Karan Hotchkin	Financial	IF funding from charities significantly reduce due to the Covid-19 Pandemic THEN there will be a significant reduction in funds available	LEADING TO Reduction in pump primed specialist clinical roles previously funded by charities such as Macmillan	Organisation	10-Dec-2021	07-Jan-2022	Pending	12	6	6		Regular monitoring of the situation and escalate any areas of concern to Executive Directors(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix

Corporate Risk Register

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RSK-209	23-Nov-2021	Karan Hotchkin	Financial	IF staff members falsely represent themselves, abuse their position, or fail to disclosure information for personal gain THEN the Trust/Service Users/Stakeholders may be defrauded	LEADING TO financial loss and reputational damage	Organisation	10-Dec-2021	07-Jan-2022	Pending	12	6	6		Anti-Fraud and Anti-Bribery Policy(23-Nov-2021),Standards of Business Conduct Policy including Q&A section(23-Nov-2021),Standing Orders(23-Nov-2021),Local Counter Fraud Specialist in place and delivery of an annual plan(23-Nov-2021),Proactive reviews also undertaken by Internal Audit(23-Nov-2021),Register of Gifts and Hospitality(23-Nov-2021),Register of Declarations(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix
RSK-216	24-Nov-2021	Nadean Marsh	Hazard / Health & Safety	If agreed processes for multi agency working are not appropriately managed THEN the information and shared working agreements may fail.	LEADING TO potential failures in care provision which may have a detrimental effect on patients and their families, members of staff and the Trust. The complexities of multi agency working especially within safeguarding requires sharing of information between multiple agencies and within agencies. Currently there are multiple pathways for sharing of information within and externally from the Trust. This carries a potential legal and financial cost to the Trust if not appropriately managed within agreed legal frameworks.	Organisation	16-Dec-2021	29-Sep-2021	Overdue	9	6	6		Memorandum of understanding for the MK Safeguarding adult and children's board and for the subgroups that feed into this multi agency board, of which the Trust is a signatory(24-Nov-2021),There are electronic safeguarding forms available to staff to raise safeguarding concerns to the relevant external safeguarding adult or children's teams, SABR1, MARF. MARF now go to what is known as the Multi-Agency Hub and that has POLICE, EDUCATION, HEALTH AND SOCIAL SERVICES(24-Nov-2021),The Safeguarding Leads attend MARAC AND MARM COMMITEES which are Multi-Agency(24-Nov-2021),Safeguarding has an electric promoting welfare tab on EDM to identify individuals at risk(24-Nov-2021),Safeguarding children have a sharing information electronic form to help identify to school nurses and health visitors children who have attended or may be at risk due to the child behind the adult(24-Nov-2021),Maternity services use confidential communique on the Amalga system This has been widened to include children's and also the safe storage and collection of the MARF forms(24-Nov-2021),Trust Safeguarding Committee is multi agency(24-Nov-2021),MKHFT sits on the Milton Keynes Safeguarding Adults and Children's Boards(24-Nov-2021),MKHFT has named leads for Safeguarding Adults and Children Dr, Nurse and Midwife(24-Nov-2021),Named Executive lead for Safeguarding(24-Nov-2021),Ongoing training programme for all staff(24-Nov-2021)	Not Applicable	Tolerate	Risk transferred from Datix
RSK-220	25-Nov-2021	Angela Legate	Hazard / Health & Safety	IF there are insufficient side rooms THEN it may not always be possible to isolate patients and there is a risk that patients with a highly transmissible infection are not able to be isolated in a single room	LEADING TO Potential risk of an outbreak that can affect large numbers of patients and staff, ward closures, reduced numbers of staff, loss of revenue and increased waiting times.	Organisation	16-Dec-2021	27-Jun-2021	Overdue	15	6	6		Public Health alerts(25-Nov-2021),ED and Assessment areas priorities use of single rooms(25-Nov-2021),Board agreement for new build to incorporate en-suite facilities(25-Nov-2021),Space Committee review re-establishment of single rooms where currently used as offices(25-Nov-2021),Daily Safety huddle captures number of patients requiring isolation against number of single rooms available(25-Nov-2021),Breaches in isolation is reported on Datix(25-Nov-2021)	Not Applicable	Tolerate	Risk transferred from Datix
RSK-225	25-Nov-2021	Dawn Budd	Compliance	IF staff do not adhere to the Information Governance Policies THEN there is a risk that staff members may access records of family, friends and other staff members	LEADING TO potential breach in confidentiality and potential criminal prosecution under section 55 of the Data Protection Act, Negative publicity and complaints.	Organisation	16-Dec-2021	05-May-2022	Planned	12	6	6		Role based Access(25-Nov-2021),Audits on adhoc basis(25-Nov-2021),Information Governance Policy(25-Nov-2021),Staff Code of Conduct(25-Nov-2021),Statements in Contract(25-Nov-2021),Information Governance Mandatory Training(25-Nov-2021),Message on Screensavers, Acute User Email and CEO Weekly Newsletter(25-Nov-2021)	Not Applicable	Tolerate	Risk transferred from Datix
RSK-229	25-Nov-2021	Aniruddha Dwarakanath	Compliance	IF there is poor quality of data input into the eCare system THEN there could be consequential impact on the data flow into the Trust data warehouse and reporting for both performance management and contracting (commissioners) data	LEADING TO Impacts all performance reporting. Impacts “Contracts” reporting leading to a loss of income for the Trust	Organisation	09-Dec-2021	30-May-2022	Planned	12	6	6		Extensive list of data quality reports to identify poor data quality(25-Nov-2021),Data Quality team is in place, who undertake a compliance function to review sample records to ensure early capture of data quality issues(25-Nov-2021),Control scripts to identify data quality issues when the data is loaded into the Data Warehouse(25-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-249	26-Nov-2021	Craig York	Operational	IF the WiFi fails (as a result of the age of the hardware) THEN WoWs, Welch Allyn machines, and many other devices that rely on the WiFi will not work	LEADING TO significant negative impacts across the patient experience	Organisation	09-Dec-2021	25-Feb-2022	Planned	16	6	4	Replacement procured, pending implementation		Not Applicable	Not Applicable	Risk transferred from Datix
RSK-252	26-Nov-2021	Craig York	Hazard / Health & Safety	IF eCARE does not prevent non-prescribers from prescribing medication which could then be administered to a patient THEN there could be limitations in restricting access to individual Smart Card holders permissions or individuals do not adhere to the correct workflow	LEADING TO Medications could be prescribed and administered to a patient that are not clinically required & could be contraindicated	Organisation	15-Dec-2021	25-Feb-2022	Planned	9	6	6	Monthly audit of in place a mechanism where medications prescribed by non-physicians are audited monthly against the known list of Non-Medical Prescribers/pharmacists/Midwives. Inconsistencies will be escalated to CNIO for investigation	eCARE training of correct process -eCARE training includes advice on only performing tasks related to professional registration and job role(26-Nov-2021),Code of conduct - NMC -eCARE pop up requires staff to state who advised them to prescribe medication & how (verbally/written)(26-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-273	30-Nov-2021	Ayca Ahmed	Compliance	If the Trust Wards and Departments fail to demonstrate their medical equipment is maintained to correct standards THEN there is a risk of the Trust not complying with CQC Regulation 15 Premises and Equipment and risk to patient care	LEADING TO non-compliance and negative impact on the reputation of the Trust	Organisation	09-Dec-2021	31-Jan-2022	Planned	15	6	3		Robust PPM maintenance schedule in place, audits of the rolling programme(30-Nov-2021),Audits monitored at Medical Devices Committee(30-Nov-2021),Escalation process in place to respond to 'unfound items'(30-Nov-2021),September 2018 , 6 Years contract approved(30-Nov-2021),Contract KPI's agreed as part of new contract(30-Nov-2021),Annual review of asset base and contract base reset linked to Capital Programme(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-004	06-Sep-2021	Paul Ewers	Compliance	IF the Trust is unable to access legacy data on Datix, when the current contract expires (30th November 2021); THEN there will be an inability to view/print/export incidents, complaints, claims, safety alert and risk records prior to 4th October 2021;	LEADING TO an inability for the Trust to defend itself against future claims/litigation - resulting in potential financial penalties, improvement notices etc. and also an inability to evidence compliance with CQC regulations and Freedom of Information requests.	Organisation	20-Dec-2021	29-Jun-2022	Planned	25	5	5	Long-term options reviewed - Proposed 3x read-only licences to Datix Client on an ongoing basis (in line with NHS retentions policy)	Purchase of 14 read-only licences to Datix Client(06-Sep-2021),Options appraised and Purchase Order raised for 14x Datix Client read-only licences(11-Oct-2021),Manual Data Transfer of records open on Datix(11-Oct-2021)	Low	Tolerate	12 month licence in place for access to Datix Client

Corporate Risk Register

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RSK-217	24-Nov-2021	Nadean Marsh	Hazard / Health & Safety	IF patients are unable to feed orally and need an alternative feeding method to meet their nutritional needs and staff do not feel confident to pass Nasogastric Tubes (NG Tubes) due to the low patient numbers requiring them THEN there is a risk that Nasogastric (NG) Feeding Tubes are not inserted and/or positioned safety, or there is a delay in confirming that the NG Tube is not positioned correctly	LEADING TO 1) Potential for aspiration which could lead to subsequent death. 2) Poor and unreliable identification of correct placement of NGT can lead serious harm or death of a patient. This type of event is a NPSA "Never Event". 3) Patients would experience a delay in feeding. 4) If bedside documentation is not fully completed or is inaccurately completed as per NPSA recommendations.Patients may be fed inappropriately in an unsafe environment. 5) Incomplete documentation may also lead to a delay in a patient's nutritional needs being met and their discharge delayed. 6) Potential for staff to be unaware of what documentation requires completing.	Organisation	16-Dec-2021	29-Apr-2022	Planned	15	5	5		All NPSA recommendations were acted upon in 2011 in the Trust as per NPSA requirements by the ANP for Nutrition(24-Nov-2021),Nutrition Committee overseeing this alert and is standard item on agenda from Dec 16. Clinical Medical and Nutritional ANP leading on the action plan(24-Nov-2021),Policies, protocols and bedside documentation reviewed to ensure compliance(24-Nov-2021),Ongoing programme of audit. Previous audit data presented to NMB Spring 2016(24-Nov-2021),Dietetic Amalga database identifies patients who require Nasogastric feeding(24-Nov-2021),Trust declared compliance with 2016 Nasogastric Tube Misplacement: Continuing Risk of Death or Severe Harm Patient Safety Alert (NHS/PSA/RE/2016006)(24-Nov-2021),The NG tube used by the trust was changed in 2020 to a tube that is more radiopaque and is therefore easier to interpret on X-ray(24-Nov-2021),pH strips are purchased from one supplier to avoid confusion with colour interpretation(24-Nov-2021),Two nutrition nurses available to place NG tubes if there are no trained clinical staff available(24-Nov-2021),Radiographers trained to interpret x-rays for confirmation of NG tube tip position. This speeds up reporting and avoids junior medical staff having to assess X-rays(24-Nov-2021)	Not Applicable	Tolerate	Risk transferred from Datix
RSK-297	30-Nov-2021	Kim Rahbek	Hazard / Health & Safety	IF staff/visitors/patients use poor quality after-market chargers/transformers THEN there is potential for them to cause small explosions, smoke, fire and electrocution by defective equipment	LEADING TO patients, visitors and staff could come to harm and in an extreme case die from a building fire caused by this event	Organisation	09-Dec-2021	27-Mar-2022	Planned	10	5	5		Ad hoc inspection of personal charging equipment prior to use(30-Nov-2021),Automatic fire detection within wards and patient waiting areas(30-Nov-2021),Fire retardant furnishings in place on ward and in waiting areas(30-Nov-2021),Advice on charging electronic devices updated in the Fire Policy, a poster for awareness created for public areas, information sent out on CEO's Friday message to all staff(30-Nov-2021),Ad hoc inspection of personal charging equipment prior to use(30-Nov-2021),Electrical installation tested in accordance with standard for all items available to be tested at the time of the annual PAT test inspections (this does not cover items brought in by patients and visitors)(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-020	22-Sep-2021	Simon Nicholson	Hazard / Health & Safety	ligature point areas in ED for Adult and C&YP in all areas of department ED patients may use ligature points to self harm. There has been an incident where a mental health patient used a door closer as a ligature point.	Leading to increased safety risk to patients, safe and adverse publicity	Organisation	20-Dec-2021	08-Nov-2021	Overdue	9	4	2	Repeat Ligature Risk Assessment for 2020 required,ensure all staff are aware of the new Policy - "Ligature Risk Awareness"	Patients assessed and those at risk of self harming are placed in an area they can easily be observed.(22-Sep-2021),New mental health room has been ligature and risk assessed by CNWL team(22-Sep-2021),Remind all staff about keeping swipe doors closed so they don't access rooms where they are not observeble Last ligature audit was April 2019 and actioned.(22-Sep-2021),Risk Assessment of adult and C&YP areas reviewed April 2019(22-Sep-2021),Check list in place to risk asses each Adults and C&YP attending with MH/DSH issues to identify personalised action plan(22-Sep-2021),Follow up ligature RA completed as advised by H&S lead for trust Risk Assesment completed - identified need for collapsible clothes hangers in public toilets - request to estates to install and completed; x1 non-compliant cord pull also in toilet - changed(22-Sep-2021)	Not Applicable	Treat	Rehman, Raja - Clinical Governance Lead (Internal/Specialty/HaemOnc) 13/09/2021 15:20:25 CSU Leadership review: satisfied with current rating. no change.
RSK-215	24-Nov-2021	Nadean Marsh	Compliance	IF Child Protection (CP) Medicals are not completed THEN there is potential for delay in proceedings for Child Protection and could mean the children remain in care longer than they should	LEADING TO the police and Social Services having to return to get the medicals completed, an increased risk to the child's safety and potential litigation against the Trust	Organisation	16-Dec-2021	31-Mar-2022	Planned	9	4	4	Named Doctor to review the process of booking the patients in,Ongoing discussions are being held with CCG and Designated Doctor to progress an agreeable pathway	Social Service made aware that the earlier we know about CP Medicals the easier it is to get them in and out(24-Nov-2021),A interim process has been agreed that SW requesting CP Medical contacts the SGC Lead who will coordinate booking through ward 4 and discuss with on call consultant(24-Nov-2021)	Not Applicable	Tolerate	Risk transferred from Datix

Corporate Risk Register

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RSK-221	25-Nov-2021	Nadean Marsh	Operational	IF the Tissue Viability Service is under resourced THEN there is a risk that the Tissue Viability Team does not have sufficient capacity to meet demands on the service	LEADING TO Potential delay in effective wound management and may lead to increased harm to patients from pressure ulcers or delay in effective wound healing	Organisation	16-Dec-2021	31-Mar-2022	Planned	12	4	4		Matrons trained by Tissue Viability Lead(25-Nov-2021),All pressure ulcers to be validated by Matrons and senior responsible for area and record on Datix and in patients records(25-Nov-2021),University Wound care course available 3-4 places per year - outcome of these skilled practitioners to share their knowledge in practice(25-Nov-2021),All RN attend essential skills training which provides practical education in regards to care of the most vulnerable patients which includes recognition and care of pressure areas and some wound care knowledge.(25-Nov-2021),Additional training is being provided by the companies who supply the agreed wound care dressings which are on the formulary.(25-Nov-2021),The nurse advisor for Hill Rom provides additional monitoring and training to wards 1 day a week as agreed in the contract.(25-Nov-2021),Plenary session planned and additional training sessions being coordinated to support ward staff.(25-Nov-2021),Introduction of summits for hospital acquired grade 3 & above pressure ulcers(25-Nov-2021)	Not Applicable	Tolerate	Risk transferred from Datix
RSK-223	25-Nov-2021	Angela Legate	Hazard / Health & Safety	IF there are a reduced number of isolation rooms due to the need to provide additional space for medical teams, allied health services and office space. THEN there is a risk that The Trust cannot therefore safely care for patients with high risk transmissible diseases (i.e. multi-drug resistant tuberculosis, viral hemorrhagic fever etc.)	LEADING TO the potential for staff, patient and public exposure to life threatening diseases	Organisation	16-Dec-2021	27-May-2021	Overdue	9	4	4		Patient pathway identified using current resources from the ED to recieving wards in medicine and paediatrics. Capital programme in place for single room upgrade across the hospital(25-Nov-2021),Upgrades to ED isolation facilities(25-Nov-2021),Oxford and London hospitals now able to receive a small number of high risk patients(25-Nov-2021),Ward 22 - 14 single rooms with en-suite(25-Nov-2021)	Not Applicable	Tolerate	Risk transferred from Datix
RSK-233	25-Nov-2021	Paul Sukhu	Hazard / Health & Safety	IF we are unable to recruit sufficient qualified nurses THEN we may not have safe staffing levels in wards and departments	LEADING TO potential reduction in patient experience and patient care, giving rise to clinical/safety risk.	Organisation	25-Nov-2021	30-Nov-2021	Overdue	16	4	4		Apprenticeship routes for nursing(25-Nov-2021),System in place to recruit student nurses from placements at MKUH(25-Nov-2021),Enhanced adverts, social media and recruitment open day tool kit for Divisions to use(25-Nov-2021),NHS People Plan strengthens action on education and new roles(25-Nov-2021),National NHS England recruitment publicity(25-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-258	29-Nov-2021	Phil Eagles	Operational	IF the Switchboard resources cannot manage the service activity THEN this may result in poor performance	LEADING TO failure To meet KPI's and Emergency Response Units will put Patients, Staff and Visitors at risk and Communication with Users will give poor perception of the We Care action initiative	Organisation	09-Dec-2021	27-Mar-2022	Planned	20	4	4		Re-profiled staff rotas(29-Nov-2021),Bank staff employed where possible(29-Nov-2021),IT Department implemented IVR to assist in reducing the volume of calls through the switchboard(29-Nov-2021),Contingency trained staff available to assist(29-Nov-2021),Two additional workstations/consoles created in Estates Information office and Security office to allow for remote working(29-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-261	29-Nov-2021	Mark Brown	Hazard / Health & Safety	IF adequate PAT testing is not carried out in a systematic and timely manner THEN untested faulty equipment could be used	LEADING TO poor patient and staff safety and increased claims against the Trust	Organisation	09-Dec-2021	27-Mar-2022	Planned	8	4	4		Visual checks carried out by user(29-Nov-2021),100% PAT testing completed annually by contractor(29-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-270	30-Nov-2021	Kim Rahbek	Hazard / Health & Safety	IF trust wide staff do not attend the Mandatory Fire Safety Training THEN there is a risk staff may not be aware of what to do in the event of a fire evacuation	LEADING TO reduced staff and patient safety	Organisation	09-Dec-2021	27-Mar-2022	Planned	16	4	4		Department managers need to ensure all staff attend as required and to be advised by Learning & Development(30-Nov-2021),Sufficient training sessions provided by Facilities to enable all staff an opportunity to attend a session. (Currently suspended due to COVID)(30-Nov-2021),Work books are also available to assist with access to training(30-Nov-2021),Content of training has been revised to make it MK Hospital specific(30-Nov-2021),Fire Warden training implemented(30-Nov-2021),Trust training target achieved and exceeded consistently(30-Nov-2021),Trust training monitored centrally, failure to attend and progress is now linked to pay progression(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-287	30-Nov-2021	Phil Eagles	Operational	IF the medical vacuum pump fails to function or becomes non-compliant with HTM requirements THEN the vacuum plant may not be available	LEADING TO Potential loss of service, reduced patient safety and substandard care.	Organisation	09-Dec-2021	27-Mar-2022	Planned	12	4	4		PPM, schedule and reactive repairs in place as required(30-Nov-2021),Steve Goddard has been appointed Authorised Engineer and has conducted a site wide inspection. No specific issues were identified(30-Nov-2021),Phase 1 plant was replaced 2017(30-Nov-2021),Phase 2 Plant to be considered for replacement in future due to age, although no issues currently(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-288	30-Nov-2021	Phil Eagles	Hazard / Health & Safety	IF the medical oxygen supply fails to function or becomes non-compliant with HTM requirements THEN the oxygen plant may not be available	LEADING TO potential loss of service, reduced patient safety and substandard care	Organisation	09-Dec-2021	27-Mar-2022	Planned	12	4	4		PPM Schedule, and reactive repairs as required(30-Nov-2021),Robust contingency plan is in place with liquid O2(30-Nov-2021),Steve Goddard has been appointed as Authorised Engineer(30-Nov-2021),Estates Officer has been appointed as AP(30-Nov-2021),SHJ appointed as maintenance contractor(30-Nov-2021),AP training booked for and additional estates officer and estates service manager(30-Nov-2021),VIE capacity upgrade 2021(30-Nov-2021),Draft feasibility to achieve second VIE, linked to HIP programme(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix

Corporate Risk Register

Reference	Created on	Owner	Category	Description	Impact of risk	Scope	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-294	30-Nov-2021	Anthony Marsh	Hazard / Health & Safety	IF staff do not carry out either informal (i.e. experience-based) or formal risk assessments before attempting a work task THEN there is a risk of personal injury to staff carrying out routine work	LEADING TO poor staff safety, injury and financial loss	Organisation	09-Dec-2021	27-Mar-2022	Planned	12	4	4		All staff receive formal risk assessment training, and are competency assessed for their roles. External contractor commissioned to review estates risk assessments regularly(30-Nov-2021),Risk awareness training is performed annually along with asbestos awareness training for all workshop staff as part of the H&S training package(30-Nov-2021),Training plan updated and implemented(30-Nov-2021),Facility to add Risk Assessments by task type to MICAD PPM tasks(30-Nov-2021),Weekly huddle meeting with maintenance staff to include H&S(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-295	30-Nov-2021	Anthony Marsh	Hazard / Health & Safety	IF there is a lack of knowledge on use or poor condition of ladder THEN there is a risk of fall from height from ladders	LEADING TO risk of harm to staff, poor public image, a potential investigation by HSE	Organisation	09-Dec-2021	27-Mar-2022	Planned	12	4	4		Staff issued with safe use of ladder guidance(30-Nov-2021),Ladder inspections PPM schedule in place to check(30-Nov-2021),New replacement ladders have been installed, tagged and registered(30-Nov-2021),A competent training person needs to be identified to provide continual training(30-Nov-2021),RP Appointed(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-296	30-Nov-2021	Kim Rahbek	Hazard / Health & Safety	IF there is a lack of suitable equipment to transfer disabled patients and visitors downstairs in the event of an evacuation from Ward 14, Post Grad' and OPD THEN Disabled people on the 2nd level may be at risk of not being able to escape in the event of a fire in the building	LEADING TO poor patient safety, injury or loss of life	Organisation	09-Dec-2021	27-Mar-2022	Planned	12	4	4		ResQ mats are installed in the areas identified. if training includes people with disabilities, training takes place downstairs(30-Nov-2021),Training monitoring log in place(30-Nov-2021),Trust Fire Advisor completes audit equipment as part of local risk assessments(30-Nov-2021),Service contract for Resq mats in place(30-Nov-2021),Annual inspections scheduled(30-Nov-2021),Ward 14 lift refurbished(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-240	26-Nov-2021	Lynn Neat	Operational	IF clinicians and authors are not approving letters within the Trust and National time frames THEN there could be possible delay in treatment and updating patient GP of potential medication amendments and outcome of clinic visit	LEADING TO Potential delays to treatment, referral to tertiary centres, General Practitioner unaware of possible medication amendments and or advice	Organisation	10-Dec-2021	31-Dec-2021	Overdue	12	3	3		Outpatient Admin Manager runs letters report and is able to identify areas of concern/clinicians who are failing to approve clinic letters are required(26-Nov-2021),Individual contact is made to alert the clinicians of overdue letters and assist with ratification. If not actioned, escalate to Medical Director and Director of Corporate Affairs(26-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix
RSK-280	30-Nov-2021	Anthony Marsh	Hazard / Health & Safety	IF anti barricade devices are not fitted to doors that were risk assessed as requiring one THEN there is a risk of patients self-harming behind the locked or closed door.	LEAD TO injury to patients, non-compliance with national safety alert (EFA/2017/002)	Organisation	09-Dec-2021	27-Mar-2022	Planned	12	3	3		Single lock one sided door(30-Nov-2021),In the event of a patient barricading themselves Security attend the ward and assist to remove patient(30-Nov-2021),In the event of an abusive or threatening patient, clinical staff carry out treatment with a second member of staff, or security attend the ward and monitor the patient whilst in the day room(30-Nov-2021)	Not Applicable	Not Applicable	Risk transferred from Datix

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Meeting Title	Board of Directors	**Date:** January 2022
Report Title	Board Assurance Framework	**Agenda Item: 17**
Lead Director	**Name:** Kate Jarman	**Title:** Director of Corporate Affairs and Communication
Report Author	**Name:** Kwame Mensa-Bonsu	**Title:** Trust Secretary

Key Highlights/ Summary	Board Assurance Framework containing the principal risks against the Trust's objectives. 1. The risk score for Risk Entry 14 (page 33) has been revised downwards – from 20 to 15 – this is due to the significant investment made against the substantial possible consequences if the risk of cyber-attack were to materialise and all operational systems were severely affected. 2. The risk score for Risk Entry 20 (page 43) has been revised upwards – from 12 to 16 – this is because of anticipated challenges to recruitment activity over the winter season.			
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Noting** [ ]	**For Review** [ ]

Strategic Objectives Links	All
Board Assurance Framework (BAF)/ Risk Register Links	All

Report History	Trust Executive Group
Next Steps	Board Committees
Appendices/Attachments	Board Assurance Framework

The Board Assurance Framework – Summary of Activity in December 2021

COVID-19 Risks

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

Strategic Maternity Risks to be Reviewed to the BAF and the Risk Register by February 2022

1. Impact of Continuity of Carer Model
2. Staffing – Recruitment and Retention
3. Volume, acuity/ complexity of births

The Board Assurance Framework

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

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

Strategic Objectives

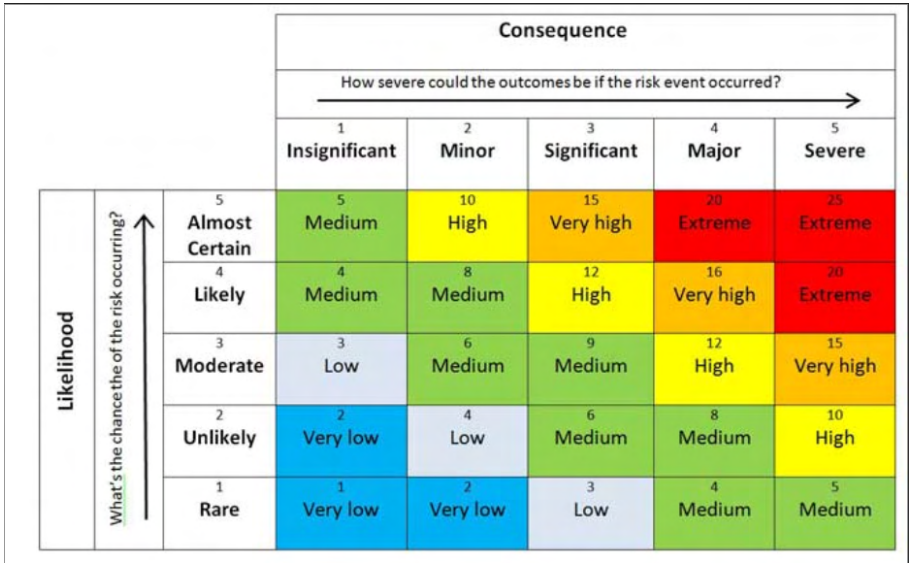
1. Keeping you safe in our hospital
2. Improving your experience of care
3. Ensuring you get the most effective treatment
4. Giving you access to timely care
5. Working with partners in MK to improve everyone's health and care
6. Increasing access to clinical research and trials
7. Spending money well on the care you receive
8. Employ the best people to care for you
9. Expanding and improving your environment
10. Innovating and investing in the future of your hospital

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

Assurance ratings:

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

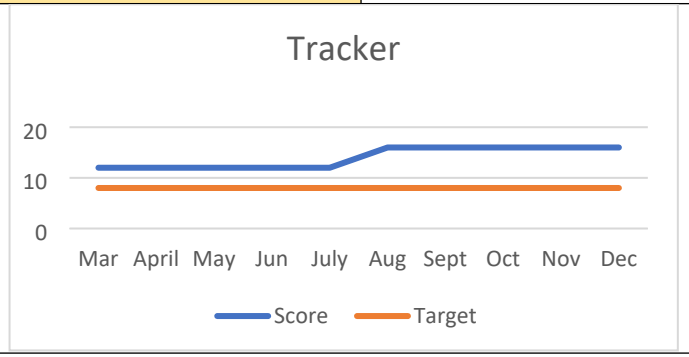
5X5 Risk Matrix:



RISK 1: If the Trust's ED does not have adequate staffing and estate capacity, and effective escalation plans, it will not be able to maintain patient safety during periods of overwhelming demand.

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust's ED does not have adequate staffing and estate capacity, and effective escalation plans, it will not be able to maintain patient safety during periods of overwhelming demand.				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Operations	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	14/12/21	**Risk Rating**	16	8		

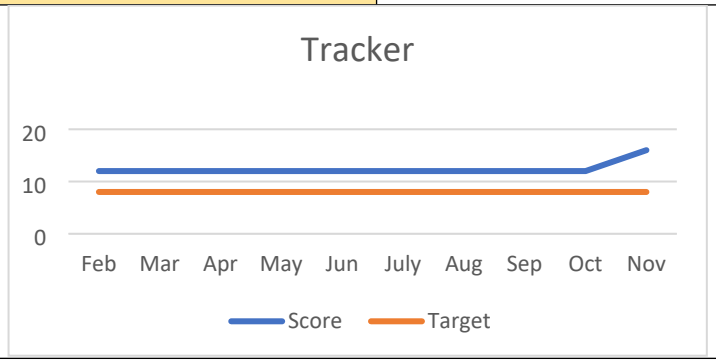


Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Significant increase in activity and number of patients through the ED Significantly higher acuity of	Clinically and operationally agreed escalation plan Adherence to national OPEL escalation management system	ED staffing levels - vacancies in nurse staffing, higher than normal staff absences and sickness	Ongoing recruitment drive and review of staffing models and skill mix. Redeployment of staff from	Daily huddle / silver command and hospital site meetings in hours. Out of hours on call management structure.	Short term sickness or unexpected staffing levels / surges Details of Winter Plan not yet complete.	Appropriate escalation. Director of Operations oversight delivering	

patients through the ED Major incident/ pandemic – constraints on space and adherence to IPC measures.	Clinically risk assessed escalation areas available. Surge plans, COVID-specific SOPs and protocols have been developed. Emergency admission avoidance pathways, SDEC and ambulatory care services.	Increased volume of ambulance conveyances and handover delays. Over-crowding in waiting areas at peak times. Admission areas and flow management issues. Reduction in bed capacity / configuration issues through estates work.	other areas to the ED at critical times of need. Enhanced clinical staff numbers on current rotas Services and escalation plans under continuous review in response to shrinking pandemic numbers and related non covid pressures	ED dashboard on Trust information portal. System-wide (MK/BLMK/ICS) Partnership Board, Alliance & Weekly Health Cell. Daily system resilience report (BLMK) Regional and National reporting requirements - Daily COVID sitrep.		the Winter Plan.	

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If an effective reporting, investigation and learning loop is not established and maintained, the Trust will fail to embed learning and preventative measures following serious incidents/ Never Events.				**Strategic Objective**	Improving Patient Safety	
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid	
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat	
Date of Review	15/11/21	**Risk Rating**	16	8			

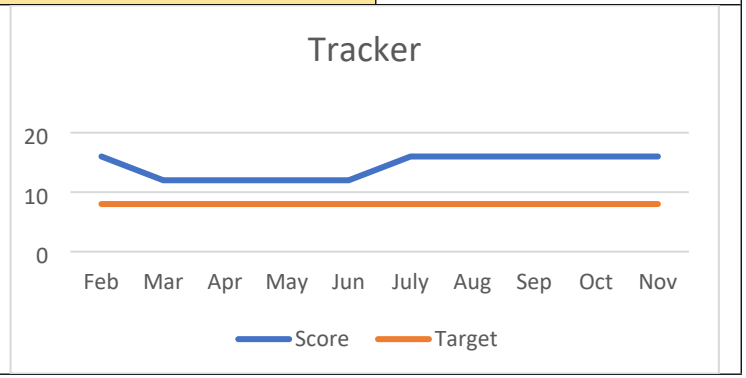
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Not appropriately reporting, investigating or learning from incidents. A lack of systematic sharing of learning from incidents.	Improvement in incident reporting rates SIRG reviews all evidence and action plans associated with Sis Actions are tracked	Establishing Learning and Improvement Board Establishing Divisional Quality Governance Boards	October 2020 - ongoing October 2020 - ongoing	NRLS data SIRG CCG Quality Team	None Currently	None Currently	

A lack of evidence that learning has been shared	Trust-wide communications in place Debriefing systems in place Training available Appreciative Inquiry training programme started (December 2020) Commencement of patient safety specialist role (April 2021)	QI/ AI strategies and processes well embedded	October 2020 – ongoing				

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust is unable to accurately predict demand (for example, relating to the COVID-19 pandemic) and re-purpose its resources (physical, human and financial) with agility, the Trust will fail to manage clinical risk during periods of sustained or rapid change in the level or type of demand.				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	15/11/21	**Risk Rating**	16	8		



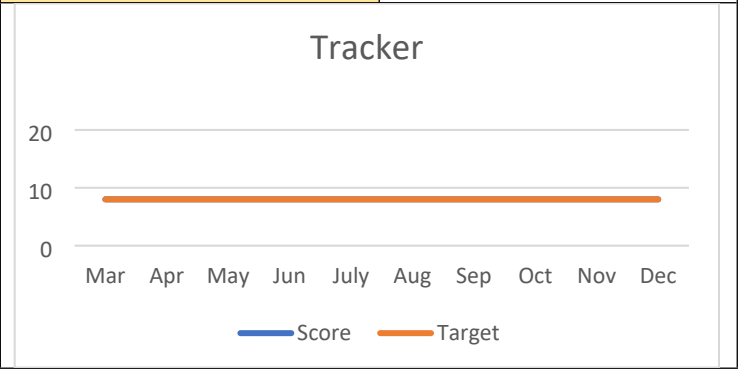
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Rapid or sustained period of upheaval and change caused by the Covid-19 pandemic and need to respond and maintain	Board approved major incident plan and procedures Rigorous monitoring of capacity, performance and quality indicators	Inability to accurately predict or forecast levels of activity and risk	Ongoing dialogue with community partners	MK place-based and ICS-based planning and resilience fora	Incomplete oversight of OP delays	Enhanced visibility of OPD PTL and non RTT pathways	

clinical safety and quality Risks have increased (since May 2021) in view of the combination of planned and emergency demand which exceeds pre-pandemic levels, coupled with a resurgence in COVID cases is placing the Trust under significant pressure. Number of vacant beds fewer / inpatient density higher.	Established command and control governance mechanisms Gold (Daily) Level 3/4 Incident management			Regional and national data and forecasting COVID MARC Meeting (Data, Intelligence, Collaboration with partners)			

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust does not carefully manage its significant digital change programme, then the delivery of clinical services may be impaired				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Deputy Chief Executive	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	14/12/21	**Risk Rating**	8	8		

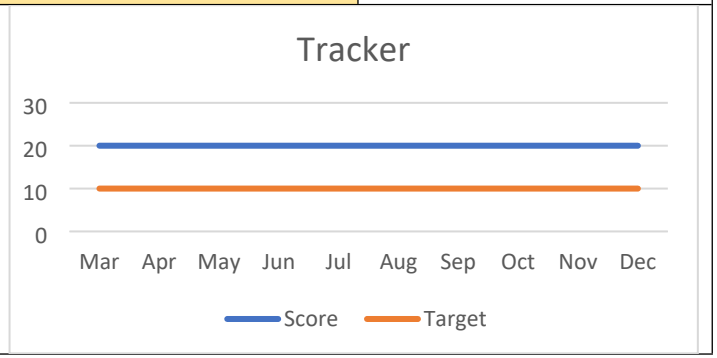


Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Inadequate assessment of clinical risk/ impact on clinical services or practices Inadequate resourcing Inadequate training	Robust governance structures in place with programme management at all levels Clinical oversight through CAG Thorough planning and risk assessment Regular review of resourcing	None currently	Continue to maintain programme governance and keep resourcing under review	Established governance and external/ independent escalation and review process	None currently	Continued iterative testing of products post-roll out	

	Regular review of progress Risks and issues reported Track record of successful delivery of IT projects						

RISK 5: If the Trust is unable to provide capacity to match demand for elective care, (such as for cancer and screening programmes), there is a risk that this could lead to patient harm.

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust is unable to provide capacity to match demand for elective care, (such as for cancer and screening programmes), there is a risk that this could lead to patient harm.						**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm		
Executive Lead	Director of Operations	**Consequence**	5	5	**Risk Appetite**	Avoid		
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat		
Date of Review	14/12/21	**Risk Rating**	20	10				

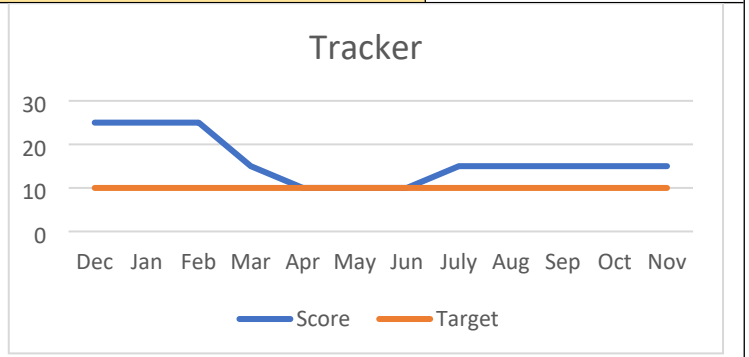
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Cessation of all routine elective care, including cancer screening and other pathways, during the peaks of the Covid-19 pandemic	Compliance with national guidance Granular understanding of demand and capacity requirements with use of national tools.	None Currently	Continue to maintain programme governance and keep resourcing under review	Established governance and external/ independent escalation and review process Regional and national monitoring.	None Currently	None Currently	

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

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust does not establish and maintain effective capacity management processes it will be unable to cope with high demand for ITU and inpatient care during a public health crisis (or due to the Covid-19 pandemic)				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	5	5	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	15/11/21	**Risk Rating**	15	10		



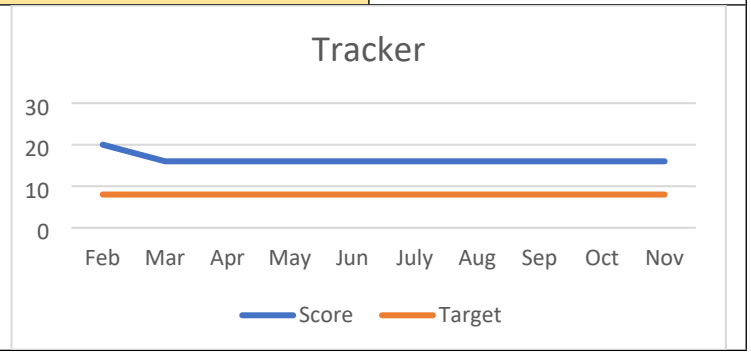
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Demand for ITU and inpatient beds exceeds capacity, including escalation capacity within the hospital and regionally.	Increased capacity across the hospital Increased capacity for ITU Clear escalation plans	Inability to accurately forecast demand	Ongoing dialogue with community partners	Tested escalation plans Active part of regional networks Clear view of CPAP support for	None currently	None currently	

Risks have increased (since May 2021) in view of the combination of planned and emergency demand which exceeds pre-pandemic levels, coupled with a resurgence in COVID cases is placing the Trust under significant pressure.	Real time visibility of regional demand/ capacity			COVID-19 patients Medical Director and Chief Nurse liaising with teams			

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

Strategic Objective 2: Improving Patient Experience

Strategic Risk	If the radiotherapy pathway provided until 2019/20 in Milton Keynes by Genesis Care (under contract with OUH) is not replaced, the access and experience of patients on clinical oncology (radiotherapy) pathways will continue to be negatively impacted.				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	15/11/21	**Risk Rating**	16	8		



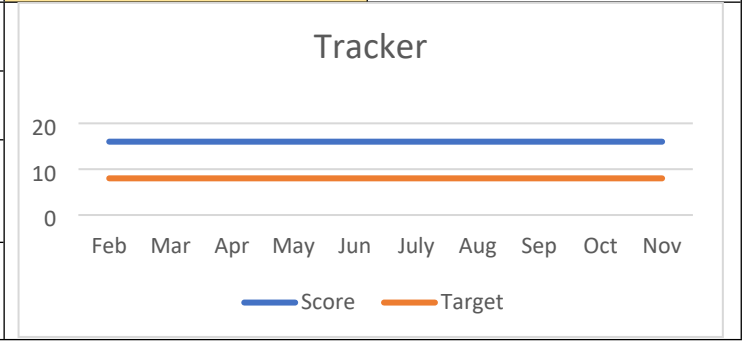
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Break down in the established relationship (subcontract) between Oxford University Hospitals and the private Genesis Care facility (Linford Wood, Milton Keynes)	Contingency for the provision of treatment to patients in Oxford and the ongoing provision of palliative and prostate radiotherapy at Linford Wood or in Northampton	Contracting and commissioning process outside the Trust's direct control or management Specific issues with the ICS CDEL limits	Continued lobbying for resolution	Minutes of established radiotherapy executive group	Lines of assurance outside the Trust's direct control Impact of ICS capital control limits	Continued work with partners	

which has provided local radiotherapy to MK residents for the last six years. This breakdown results in less choice and longer travel distances for patients requiring radiotherapy. Patients tend not to differentiate between the different NHS provider organisations. This risk materialised 16.12.2019 when the contract expired and no extension was agreed.	Promotion of agreement between OUH and Northampton General Hospital to facilitate access to facilities at Northampton for those who prefer treatment in this location. Proactive communications strategy in relation to current service delivery issues.						

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

Strategic Objective 2: Improving Patient Experience

Strategic Risk	If the Trust does not effectively work with patients and families in delivering care and positive patient experience the national patient surveys may not demonstrate improvement.				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Chief Nurse	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	16/11/21	**Risk Rating**	16	8		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Lack of appropriate intervention to improve patient experience (measured through the national surveys). Children and Young People Survey	Corporate Patient and Family Experience Team function, resources and governance arrangements in place at Trust, division and department levels, including but not limited to:	Engagement with patients for Co-production of service developments.	To develop bank of patients to engage with for involvement in wider organisational changes. **Lead:** Head of Patient and	**Annual:** PLACE surveys National Patient Experience Improvement Framework NHSI Assessment and action plan **Quarterly:** Quarterly reports with themes and	Comprehensive analysis of patient ethnic groups to ensure meeting all requirements. Link with EDI Leads.	Liaise with information dept for info on patient demographics.	

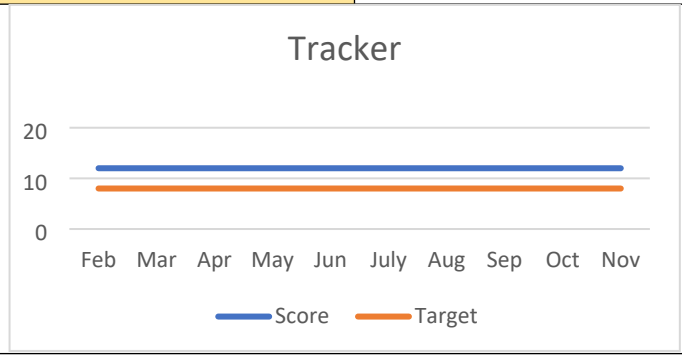
Adult Inpatient Survey Urgent and Emergency Care Survey Maternity Survey Cancer Patient Experience Survey	• Patent Experience Strategy • Learning Disabilities Strategy • Dementia Strategy • Nutrition steering group • Catering steering group • Domestic planning group • Discharge steering group • Induction training '15 Step 'Challenge Monthly Patient Experience Board, with each quarter having a theme: 1.Governance 2. 'Listening' review of all feedback. 3. 'Learning and Change' from		Family Experience. **Timescale:** October 2021 – subject to national restrictions re COVID-19. FFT: Commencing partnership with PEP)Patient Experience Platform) who will collate and analyse all FFT/social media and other public feedback monthly and produce a report and dashboard **Timeframe:** Starts 1st November 2021	areas of for improvement. Patient experience strategy action plan progress. Perfect Ward Patient Experience Audit. **Monthly:** FFT results – thematic review. Monthly operational meeting to review and triangulate data for top themes and inform focused areas of work for next month's activities. Department surveys **External Reviews:** Healthwatch Maternity Voices partnership (MVP)			

	feedback and co-production **Timeframe**: Starts October 2021			Cancer Patient Partnership **Website:** 'You said we did'			

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

Strategic Objective 2: Improving Patient Experience

Strategic Risk	If the Trust does not effectively work to use feedback from complaints and PALS contacts to inform learning and embed related changes patient experience will not be improved.				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Chief Nurse	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	16/11/21	**Risk Rating**	12	8		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Lack of appropriate intervention to improve patient experience following receipt of complaints and PALS contacts.	Corporate Patient Experience Team function, resources and governance arrangements in place at Trust, division and department levels, including but not limited to:	Quality surveillance system to triangulate feedback from complaints with incidents and other quality measures across the organisation.	Current review underway for systems to link and triangulate data.	**Annual:** Complaints and PALS Report **Quarterly:** Quarterly reports with themes and areas of for improvement. Patient experience strategy action plan progress.	**Patients' specific** needs supporting them to feedback: Cognitively impaired Learning Disabilities Sensory Deficit: vision, hearing, speech	Develop mechanisms for feedback for all groups. Use demographic to demonstrate complaints sources.	

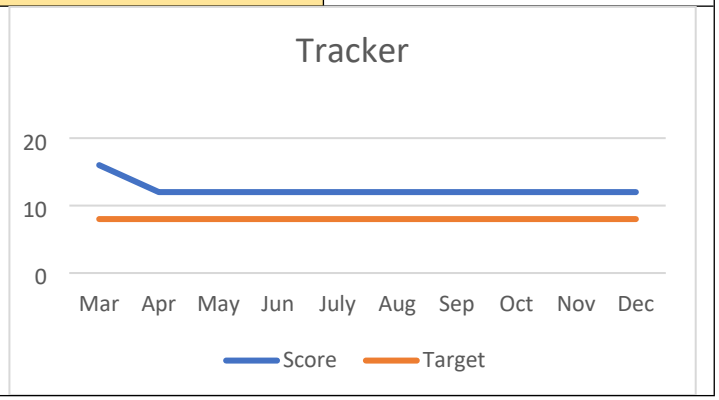
	• Patent Experience Strategy • Learning Disabilities Strategy • Dementia Strategy • Nutrition steering group • Catering steering group • Domestic planning group • Discharge steering group • Induction training Customer service training – NHS Elect program Leadership training includes how to receive feedback from patients. Appreciative inquire approach to support complaints handling and response letters. Monthly divisional meetings with Head of Patient and Family Experience	Audit of identified learning in divisions to ensure learning embedded.	Divisions to audit learning from feedback and report to Patient Experience Board.	Perfect Ward Patient Experience Audit. **Monthly:** Monthly Patient Experience Board, with each quarter having a theme: 1.Governance 2. 'Listening' review of all feedback. 3. 'Learning and Change' from feedback and co-production **Timeframe**: Starts October 2021 Divisional review of learning from complaints in CIG. Complaints questionnaire for complaints re	Language difficulties Children and young people. Link with EDI leads and Trust Networks		

	to review themes, complaints, associated changes, and learning.			process and experience. PALS KPIs responding to feedback in a timely manner to initiate change and learning. **Website:** 'You said we did			

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

Strategic Objective 3: Improving Clinical Effectiveness

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

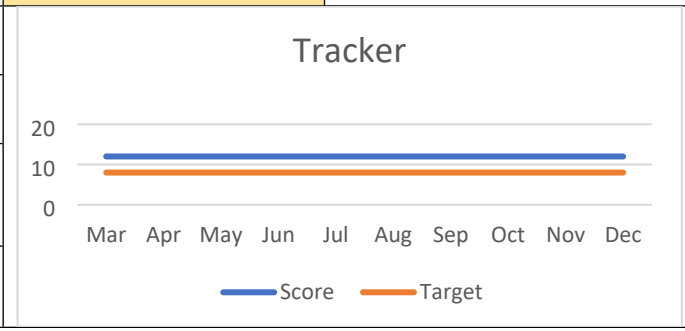


Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
1. Lack of understanding/ awareness of audit requirements by clinical audit leads 2. Resources not adequate to support data collection/	1. Designated audit leads in CSUs/ divisions 2. Clinical governance and administrative support - allocated by division 3. Recruited additional clinical governance post to	1. Resource to complete audits 2. Audit policy out of date	1.Resource review currently underway 2. Audit policy has been redrafted and awaiting	Clinical Audit and Effectiveness Board External benchmarking	1.External benchmarking 2. Independent audit	Add to internal audit plan for 2021/22	

interpretation/ input 3. Audit programme poorly communicated 4. Lack of engagement in audit programme 5. Compliance expectations not understood/ overly complex	medicine to support audit function (highest volume of audits) 3. Audit programme being simplified, with increased collaboration and work through the QI programme 4. Audit compliance criteria being segmented to enable focus on compliance with data returns; opportunity for learning/ changing practice and communication/ engagement 5. Monthly review of all compliance requirements, including NICE and policies		approval by the March 2022 Audit Committee				

RISK 11: If the Trust is unable to establish robust governance around data quality processes, there is the risk that this could lead to patient harm, reputational damage and regulatory failure.

Strategic Objective 3: Improving Clinical Effectiveness

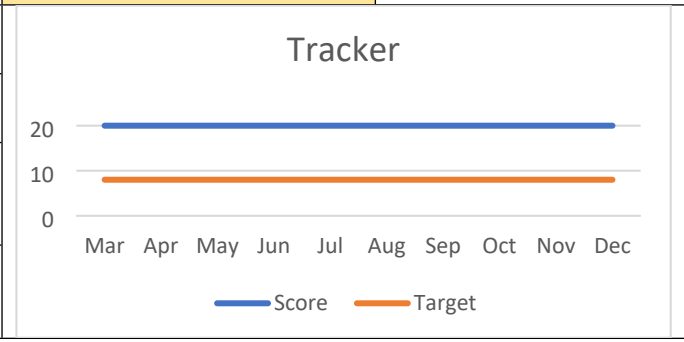
Strategic Risk	If the Trust is unable to establish robust governance around data quality processes, there is the risk that this could lead to patient harm, reputational damage and regulatory failure.				**Strategic Objective**	Improving Clinical Effectiveness	
Lead Committee	Audit	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	
Executive Lead	Director of Operations	**Consequence**	4	4	**Risk Appetite**	Minimal	
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat	
Date of Review	14/12/21	**Risk Rating**	12	8			

Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure because data quality processes are not robust	Robust governance around data quality processes including executive ownership Audit work by data quality team More robust data input rules leading to fewer errors	RPAS will reduce the numbers of manual input errors Better training of the administration teams leading to more consistent recording of data	RPAS scheduled in for implementation in 2022 Director of Transformation working with OP areas to improve training	Data Quality Board External benchmarking	None Currently	None Currently	

RISK 12: If the Trust does not establish and maintain effective capacity management processes it will be unable to achieve waiting time targets due to seasonal emergency pressure (or further Covid-19 surges).

Strategic Objective 4: Ensuring Access to Timely Care

Strategic Risk	If the Trust does not establish and maintain effective capacity management processes it will be unable to achieve waiting time targets due to seasonal emergency pressure (or further Covid-19 surges).				**Strategic Objective**	Ensuring Access to Timely Care
Lead Committee	TEG	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Operations	**Consequence**	5	5	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	14/12/21	**Risk Rating**	20	10		



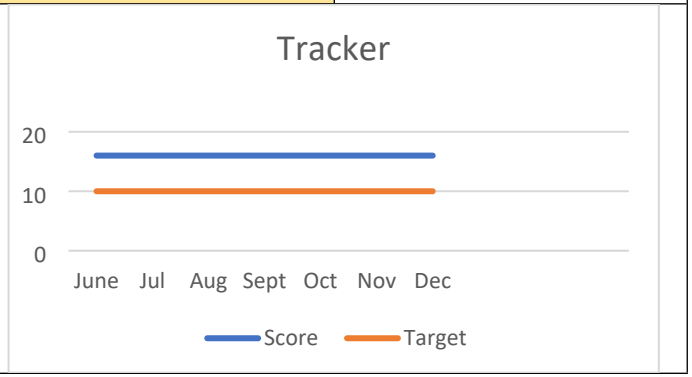
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Elective activity is suspended (locally or by national directive) to enable the Trust to cope with emergency demand or further Covid-19 surges, resulting in increasing waits for patients	Winter escalation plans to flex demand and capacity Plans to maintain urgent elective work and cancer services through periods of peak demand Agreed plans with local system	Unpredictable nature of both emergency demand and the surge nature of Covid-19 Workforce and space (in pandemic) rate limiting factors	Continued planning and daily reviews (depending on Opel and incident levels)	Emergency Care Board (external partners) Regional and national tiers of reporting and planning	None Currently	None Currently	

needing elective treatment – including cancer care	National lead if level 4 incident, with established and tested plans Significant national focus on planning to maintain elective care						

RISK 13: If the Trust does not have a sufficient capital expenditure limit (CDEL) then the Trust will not be able to complete the level of planned capital investment

Strategic Objective 10: Innovating and Investing in the future of the Trust

Strategic Risk	If the Trust does not have a sufficient capital expenditure limit (CDEL) then the Trust will not be able to complete the level of planned capital investment				**Strategic Objective**	Innovating and Investing in the future of the Trust
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	Director of Finance	**Consequence**	4	5	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	23/12/21	**Risk Rating**	16	10		

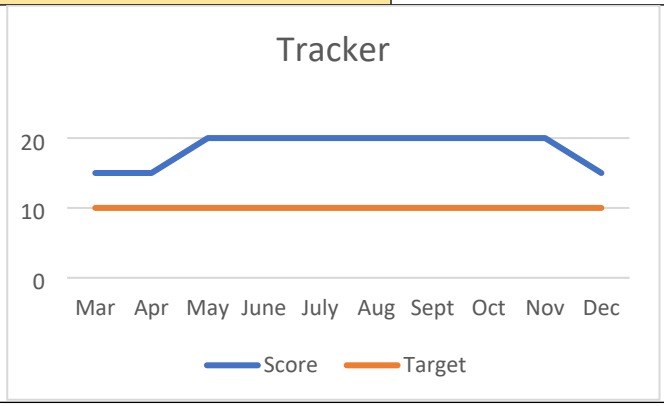


Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Following the FY21 year end audit the Trust had to adjust misstated capital expenditure of £4.5m relating to a capital bond. As a consequence, the Trust has brought forward capital	The Trust is introducing enhanced in-year capital spend monitoring to proactively manage in-year underspends across other capital schemes. Where agreed by management (e.g., subject to risks and	The Trust has limited control over the availability and reassignment of CDEL across the ICS and regional partners.	The Trust will report the capital expenditure position (MKUH and ICS) and associated risks to F&IC and regularly	Monthly capital report and BAF	CDEL reporting oversight at regional level	The Trust will engage with the NHSE/I Head of Finance for regular updates on the	

spending commitments of £4.5m into FY22 but does not have a sufficient capital expenditure limit to accommodate this investment.	strategic need) underspends across other capital schemes could free-up capital expenditure limit for utilisation against bond schemes. The Trust is engaging with NHSE/I regional colleagues and Integrated Care System partners to monitor planned capital expenditure limits (CDEL) across both ICS and regional organisations to proactively reassign available CDEL.		update the Audit Committee through the BAF			regional CDEL position	

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

Strategic Objective 10: Innovating and Investing in the future of the Trust

Strategic Risk	If the Trust does not maintain investment in its IT infrastructure and systems, then all operational systems will be severely affected by IT failures such as infiltration by cyber criminals.				**Strategic Objective**	Innovating and Investing in the future of the Trust	
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial	
Executive Lead	Deputy Chief Executive	**Consequence**	5	5	**Risk Appetite**	Minimal	
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat	
Date of Review	14/12/21	**Risk Rating**	15	10			

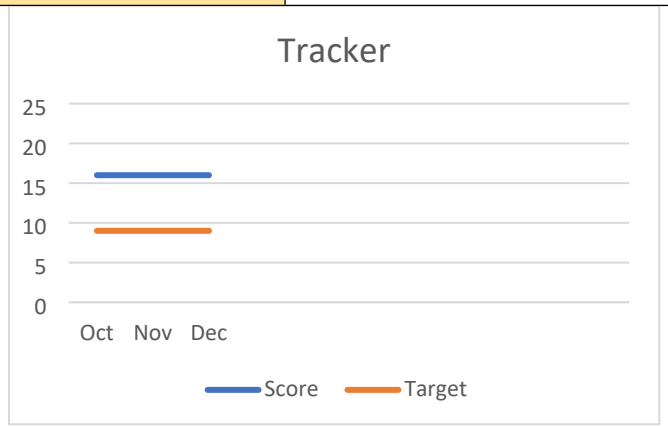
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Hardware failure due aged equipment Increasing Cyber-attacks across the world and in particular in Ireland	2 dedicated cyber security posts Good network protection from cyber security breaches such as Advanced Threat Protection (ATP) – A part of the national programmes	None identified	Continued review	External review and reporting Purchases new equipment to install in 9 months	None currently	None currently	

	to protect the cyber security of the hospital All Trust PCs less than 4 years old Purchase new hardware – not implemented yet EPR investment						

RISK 15: If there is insufficient strategic capital funding available, then the Trust will be unable to invest in the site to maintain pace with the growth of the Milton Keynes population's demand for hospital services

Strategic Objective 10: Innovating and Investing in the future of the Trust

Strategic Risk	If there is insufficient strategic capital funding available, then the Trust will be unable to invest in the site to maintain pace with the growth of the Milton Keynes population's demand for hospital services				**Strategic Objective**	Innovating and Investing in the future of the Trust
Lead Committee	Finance and Investment and Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	Director of Finance	**Consequence**	4	3	**Risk Appetite**	Cautious
Date of Assessment	02/11/21	**Likelihood**	4	3	**Risk Treatment Strategy**	Treat
Date of Review	23/12/21	**Risk Rating**	16	9		



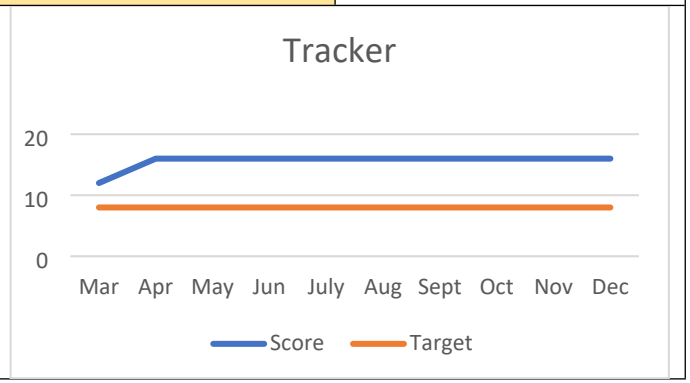
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
The current NHS capital regime does not provide adequate certainty over the availability of strategic capital finance. Consequently, it is difficult to progress development plans	The Trust has a process to target the investment of available capital finance to manage risk and safety across the hospital. The Trust is tactically responsive in pursuing central	The Trust does not directly control the allocation of strategic NHS capital finance	Continued review Close relationship management of key external partners	External New Hospital Programme review and reporting.	None Currently	None Currently	

in line with the strategic needs of the local population	NHSE/I capital programme funding to supplement the business-as-usual depreciation funded capital programme.						

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

Strategic Objective 10: Innovating and Investing in the future of the Trust

Strategic Risk	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.				**Strategic Objective**	Innovating and Investing in the future of the Trust
Lead Committee	Finance and Investment	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	Director of Finance	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	23/12/21	**Risk Rating**	16	8		



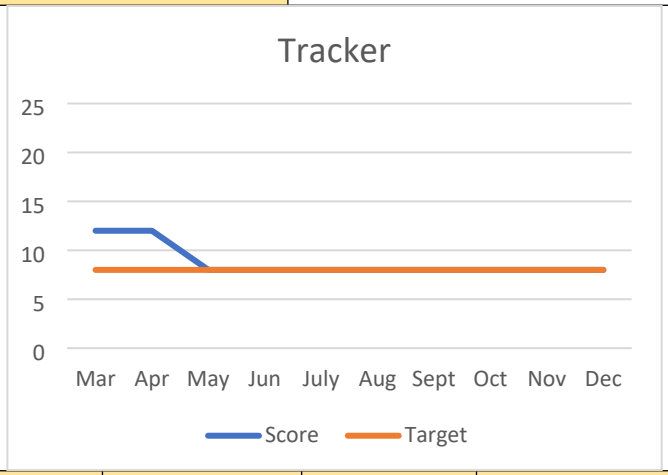
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Increase in operational expenditure in order to manage COVID-19 Reductions in non-NHS income streams as a direct result of COVID-19.	1. Cost and volume contracts replaced with block contracts (set nationally) for clinical income; 2. Top-up payments available where COVID-19 leads to additional costs over and above block sum	Fragmented financial regime during 2021/22, no details known for 2022/23 and beyond. Significant changes expected as NHS transitions from rounding regime heavily	Continued review of national funding intentions to maximise time to plan organisation response. Preparation of plans at earliest	Monthly financial performance reports. Cost efficiency reporting. BLMK ICS finance performance reports.	None Currently.	None Currently.	

Impaired operating productivity leading to additional costs for extended working days and/or outsourcing. Potential for material increase in efficiency requirement from NHS funding regime to support DHSC budget affordability. Unknown funding regime beyond 2021/22 and therefore clarity on required efficiency savings for 2022/23 and beyond.	amounts (until September 2021); 3. Budgets updated for FY22 based on prevailing finance regime (September – March 2022); financial controls and oversight to be reintroduced to manage financial performance. 4. Cost efficiency programme to be relaunched to target focus on areas of greatest opportunity.	influenced by the pandemic. Trust has minimal ability to influence.	opportunity once 2022/23 national guidance is published.				

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

Strategic Objective 10: Innovating and Investing in the future of the Trust

Strategic Risk	Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care				**Strategic Objective**	Innovating and Investing in the future of the Trust
Lead Committee	Finance and Investment and Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	Deputy Chief Executive	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	14/12/21	**Risk Rating**	8	8		



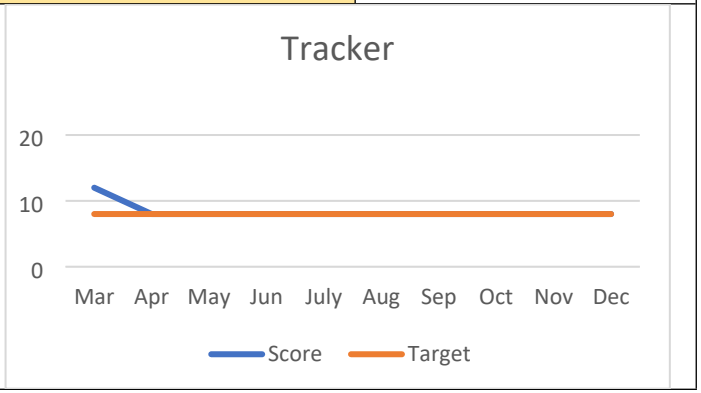
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
The current size of the Neonatal Unit does not meet the demands of the service. This risks high numbers of transfers of unwell babies and potential delayed repatriation of babies back to the hospital. There is a	Reconfiguration of cots to create more space Additional cots to increase capacity Parents asked to leave NNU during interventional procedures, ward rounds, etc to	External timeframe and approval process for HIP2 funding	Continued review	External review and reporting. Whilst a technical risk the likelihood has been downgraded on the basis of actual reporting	None Currently	None Currently	

risk that if the Trust continues to have insufficient space in its NNU, the unit's current Level 2 status could be removed on the basis that the Trust is unable to fulfil its Network responsibilities and deliver care in line with national requirements.	increase available space. HIP2 funding for new Women and Children's Hospital announced.						

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

Strategic Objective 8: Employing the Best People

Strategic Risk	If the Trust does not retain staff then posts will be vacant resulting in workforce shortages across the hospital or increased temporary staffing expenditure.				**Strategic Objective**	Employing the Best People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	21/12/21	**Risk Rating**	8	8		



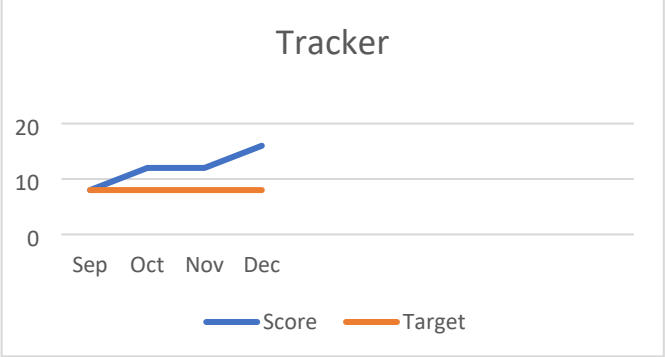
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Proximity to tertiary centres Lack of structured career development or opportunities for progression	Variety of organisational change/staff engagement activities, e.g. Event in the Tent Schwartz Rounds and coaching collaboratives Recruitment and retention premia We Care programme	None Currently	Continued review	External review and reporting Vacancy and Retention Rates	None Currently	None Currently	

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

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

Strategic Objective 8: Employing the Best People

Strategic Risk	If the Trust does not recruit to vacancies in the short term (0-18 months) then there will be workforce shortages across the hospital and/or increased temporary staffing expenditure.				**Strategic Objective**	Employing the Best People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Cautious
Date of Assessment		**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	21/12/21	**Risk Rating**	16	8		



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

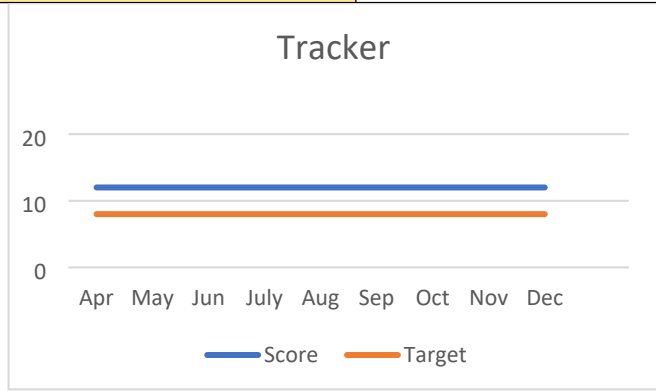
urology and trauma and orthopaedics Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply)	Exploration and use of new roles to help bridge particular gaps Use of recruitment and retention premia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

	working experience/ environment Targeted recruitment to reduce hard to fill vacancies						

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

Strategic Objective 8: Employing the Best People

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



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
National shortages of appropriately qualified staff in some clinical roles, particularly at consultant level	Monitoring of uptake of placements & training programmes Targeted overseas recruitment activity	None Currently	Continued review	External review and reporting Vacancy Rates	None Currently	None Currently	

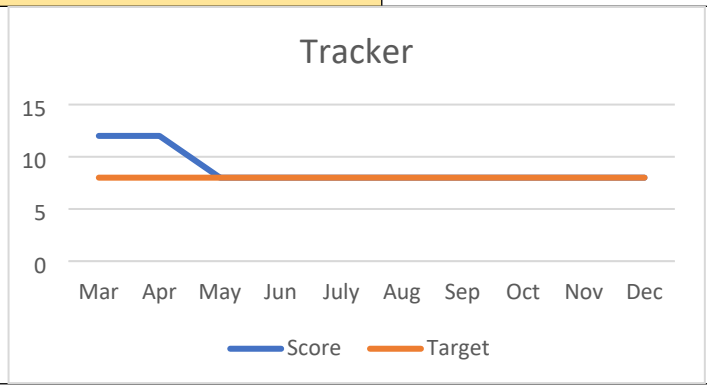
Brexit may reduce overseas supply Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply) Large percentage of workforce predicted to retire over the next decade Large growth prediction for MK - outstripping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

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

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

Strategic Objective 8: Employing the Best People

Strategic Risk	If the Trust does not maintain stocks of Personal Protective Equipment (PPE) and continue implementing the enhanced infection control measures it will be unable to maintain a safe working environment during the COVID-19 pandemic				**Strategic Objective**	Employing the Best People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	21/12/21	**Risk Rating**	8	8		



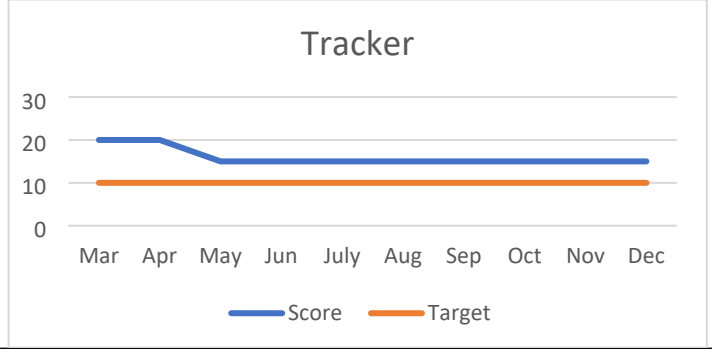
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Ability to maintain a safe working environment during the Covid-19 pandemic due to a lack of equipment, including PPE, or	Incident command structure in place Oversight on all critical stock, including PPE Immediate escalation of issues with	None currently – noted that this risk may escalate very quickly	None Currently	Completed Risk Assessments PPE Stock Level Reports Staff Test Stock Levels	None Currently	None Currently	

inadequate staffing numbers	immediate response through Gold/ Silver National and regional response teams in place Workforce and Workplace Risk Assessments completed and any necessary equipment or working adjustments implemented. Staff COVID-19 Self-Test and vaccine offer to all MKUH workers			Staff Vaccine Uptake Report			

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

Strategic Objective 8: Employing the Best People

Strategic Risk	If the Trust does not implement and progress staff health and wellbeing initiatives, there is the risk of staff burning out during or due to the COVID-19 pandemic				**Strategic Objective**	Employing the Best People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	5	5	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	21/12/21	**Risk Rating**	15	10		



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

	12 weeks of wellbeing focus January to March						

Agenda item 18.1
Public Board 13.01.22

Meeting of the Finance and Investment Committee held on 02 November 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

a. The Committee **approved** the capital schemes submitted for funding from the Targeted Investment Fund.

b. The Committee **approved** the funding for the international recruitment campaign.

Summary of matters considered at the meeting:

- Regarding the M06 Performance Dashboard, the Committee reviewed the trajectories of all key performance indicators. It was noted that staff absence and vacancies remained high.

- Regarding the M06 Finance Report, the Committee reviewed the trajectories of all the key income and expenditure indicators. The Committee noted

  a) receipt of sufficient funding to meet the Agenda for Change pay award funding and arrears settlement.

  b) that Bedford, Luton and Milton Keynes Integrated Care System had delivered its financial plan for the first half of the year.

- The Committee received an update on progress against the capital projects programme for 2021-22.

- The Committee reviewed the draft working position of the financial plan for the second half of the year (October 2021 to March 2022).

- The Committee noted the accruals and provisions for 2021/22.

Agenda item 18.2
Public Board 13.01.22

Meeting of the Finance and Investment Committee held on 30 November 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

a. The Committee **approved** the financial plan for the second half of 2021-22 (October 2021 to March 2022).

b. The Committee **approved** the replacement of the Finance Objectives.

Summary of matters considered at the meeting:

- Regarding the M07 Performance Dashboard, the Committee reviewed the trajectories of all key performance indicators. The significant increase in GP referrals was noted.

- Regarding the M06 Finance Report, the Committee reviewed the trajectories of all the key income and expenditure indicators.

- The Committee received an update on progress against the capital projects programme for 2021-22 where outstanding cases were on target to be approved by the end of the calendar year.

- The Committee recommended a review of Risk 14 on the Board Assurance Framework.

Agenda Item 18.3
Public Board 13/01/2021

Meeting of the Audit Committee held on 13 December 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

a. The Committee approved the write offs and losses, special payments and waivers from the previous quarter.
b. The Committee approved the Hospital Charity Accounts for 2020/21.
c. The Committee approved the Conflict of Interests, Hospital, Gifts, Donations and Sponsorship Policy

Summary of matters considered at the meeting:

External Auditor's Update
The Audit Committee acknowledged that the audit plan for 2021-22 would be shared at the next meeting.

Internal Audit Report
The Committee noted that Internal Auditors had completed 2 internal audit reports within the last quarter with positive opinions in the following areas:

- Key financial controls review
- Conflict of interest

The Committee noted the commencement of work by Internal Auditors on the design and implementation of new finance controls.

Local Counter Fraud Specialist (LCFS) Progress Report
The Committee reviewed the report and the noted the activities of the LCFS since September 2021.

Financial Controller's Report
The Committee was assured by the robust processes in place to recover debts from overseas patients.

Declaration of Interest
The Audit Committee recommended the Declaration of Interest Report for approval by the Trust Board.

Agenda item 18.4
Public Board 13/01/2022

Meeting of the Quality & Clinical Risk Committee held on 13 December 2021

REPORT TO THE BOARD OF DIRECTORS

Summary of matters considered at the meeting:

Clinical Quality Risks on the Board Assurance Framework (BAF) – The Committee noted the dynamic risk environment caused by COVID-19 and winter pressures together with the escalating risk in relation to the restoration of services.

Quarterly Highlight Report – The Committee reviewed and discussed the following themes:

a. The change in 'middle tier operational management' within the Women & Children's and Surgical Divisions.
b. The closure of routine service in dermatology following the retendering of the service contract to Virgin Healthcare. A risk summit with the Clinical Commissioning Group and Virgin Healthcare had been scheduled. Alternative solutions were being considered.
c. The steps being taken to increase the number of teams to facilitate homebirths recognising the challenges around staffing.

COVID Update – The Committee noted the increase in the number of COVID patients being hospitalised, particularly in relation to unvaccinated or partially vaccinated patients.

Complaints Quarterly Report Q2 – The Committee reviewed and discussed the report and noted that the top theme remained communication, with an increasing number of complaints relating to staff behaviour and attitude. Overall, the number of both formal and informal complaints had decreased. Work was ongoing to raise awareness across the organisation of learning disabilities.

Quarterly Trust-Wide Serious Incidents Report – The Committee reviewed and discussed the report, noting the mitigations in place in respect of staff shortages within Antenatal New Born Screening, deemed a serious incident by Public Health due to the increased potential for harm, despite no incidents occurring.

CNST Submission – The Committee discussed two CQC concerns received regarding Maternity Services both of which were being addressed and responded to.

Antimicrobial Stewardship Annual Report – The Committee noted the report

Milton Keynes University Hospital NHS Foundation Trust

Agenda item 18.5
Public Board 13/01/2022

Meeting of the Trust Executive Committee held on 8 December 2021

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

a. The new business case templates

b. The following capital business cases:
   - Ward and department redecoration
   - Video ureteroscopes chip upgrade

c. The following policies/guidelines/standard operating procedures:
   - RIDDOR Policy and Procedure
   - Probationary Period Policy and Procedure
   - Mass Casualty Standard Operating Procedure
   - MKUH CBRN HAZMAT Standard Operating Procedure

Summary of matters considered at the meeting:

- The Committee was briefed on the successful Staff Awards Ceremony held virtually in November with another ceremony planned for June 2022.
- The Committee was briefed on the Christmas gift boxes for all staff as a thank you for their hard work over the last year.
- The Committee noted the successful transition to the new incident reporting system.
- The Committee recommended the Whitehouse Park Business Case for approval in principle by the Trust Board.

Divisional updates:

- Problems with the dermatology service following a change in service provider were being addressed as a priority.
- The commencement of planning for services to be based in the new Maple Centre was noted.
- Plans for the Trust's vaccination centre were noted to be progressing well.
- The increasing acuity of COVID inpatients was discussed, together with an increase in paediatric inpatient acuity. To assist with the latter, additional mental health training for clinical teams was being explored.
- The effect on operational pressures of delays in diagnostic waits, high sickness absence rates, low staffing levels and low availability of temporary staff was discussed. Low staffing had led to significant incidents in some areas and concern was raised over staff fatigue and burnout. Staff sickness and a flooding incident in theatres had led to interruptions to elective work.

- The Committee noted the continuing increased weekly numbers of cancer referrals and long waiting times particularly in therapies outpatients and audiology.
- The Committee noted the successful celebration and promotion of cultural diversity by Hotel Services during Black History Month.

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Board of Directors**	**Date: 13 January 2022**
Report title:	**Use of Trust Seal**	**Agenda item: 19**
Lead director **Report author** **Sponsor(s)**	**Name: Kate Jarman** **Name: Julia Price**	**Title: Director of Corporate Affairs** **Title: Senior Corporate Governor Officer**
FoI status:	**Public**	

Report summary	To inform the Board of the use of the Trust Seal.						
Purpose *(tick one box only)*	**Information**	x	**Approval**		**To note**	x	**Decision**
Recommendation	That the Board of Directors note the use of the Trust Seal since March 2021						

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

Report history	None
Next steps	None
Appendices	

Use of Trust Seal

1. Purpose of the Report

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

2. Context

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

1 November 2021

Virgin Care Services Limited relating to a lease of part of Milton Keynes University Hospital Outpatients

Trust Board Meeting in Public

Forward Agenda Planner

Standing Items

Standing Business Items	Standing Trust Board Meeting In Public Items
Apologies	Patient Story
Meeting Quorate	Nursing Staffing Update
Declaration of Interests	Mortality Update
Minutes of the previous meeting	Performance Report
Action Tracker	Finance Report
Risk highlighted during meeting for consideration to CRR/BAF	Workforce Report
Escalation items for Board attention	Board Assurance Framework
AOB	Trust Seal
Forward Agenda Planner	Summary Reports from Board Committees
	Significant Risk Register Report
	Serious Incident Report

Additional Agenda Items

Month	Assurance Reports/Items
January	Objectives Update
	Antimicrobial Stewardship - Annual Report
March	Quality Priorities
	Freedom to Speak Up Guardian Annual Report
May	
July	CNST Maternity Incentive Scheme – Board Assurance Statement and Sign-Off
	Guardian of Safe Working Hours Annual Report
	Medical Revalidation Annual Report
	Objectives
	Annual Complaints Report
	Annual Claims Report
	Research & Development Annual Report
	Falls Annual Report
	Pressure Ulcers Annual Report

	Safeguarding Annual Report
September	Annual Digital Review
November	Infection Prevention and Control Annual Report