Bundle Trust Board Meeting in Public 5 May 2022

0 10:00 - Agenda
Chair
1. Agenda Board Meeting in Public - 05.05.22 v3.docx

1 10:05 - Apologies
Chair

2 10:05 - Declarations of Interest
Chair

3 10:05 - Previous Minutes of the Meeting
Chair
3. Minutes Trust Board Meeting in Public 03.03.22 AD Approved.docx

4 10:05 - Matters Arising
Chair
4. Board Action Log 03.03.22.pdf

5 10:05 - Chair's Report
Chair
5. Chair's Report Coversheet.docx
5a. Chair's report.docx

6 10:10 - Chief Executive's Report
Chief Executive - Verbal

6.a 10:30 - 2021 Staff Survey Report
Chief Executive and Director of Workforce
6a. Staff Survey Presentation - Board - April 2022 - No Notes.pptx

7 10:30 - Patient Story
Chief Nurse - To Follow

8 10:45 - Ockenden Final Report Update
Director of Patient Care and Chief Nurse
8. Final Ockenden Report Briefing Paper Trust Board May 2022_.docx

9 10:55 - Serious Incident and Learning Report
Director of Corporate Affairs/ Medical Director
9. SI report for Trust Board April 2022.doc

10 11:00 - Patient and Family Experience Report Q3
Director of Patient Care and Chief Nurse
10. PATIENT AND FAMILY EXPERIENCE Q3 2021-22 REPORT.docx

11 11:10 - Nursing Staff Update
Director of Patient Care and Chief Nurse
11. Nursing Staffing Report May 2022 V1.docx

12 11:15 - Workforce Report
Director of Workforce
12. Workforce Report M12 202122 TEC and Board.docx

13 11:20 - Freedom to Speak Up Guardian Annual Report
Freedom to Speak Up Guardian
13. FTSU Annual Report 2021 Final.docx

13.a 11:30 - Break

14 11:40 - Performance Report
Director of Operations
14. Executive Summary M12 Coversheet.docx
14.1 Executive Summary M12.docx

14.2 Board Scorecard M12.pdf

14.3 TEG and Board Report March 2022.pdf

15 11:45 - Finance Report

Director of Finance

15. Finance report M12 Public Board.pdf

16 11:50 - Research & Development Strategy Jan 2022-Dec 2025

Medical Director

16. Draft 3 year R&D strategy 2022-2025 24.01.2022.docx

17 12:00 - 2022/2023 Quality Priorities

Director of Corporate Affairs

17. Quality Priorities 2022 23 v 2.docx

18 12:05 - Significant Risk Register

Director of Corporate Affairs

18.1 Significant Risk Report for Public Board - May 2022.docx

18.2 Significant Risk Register - as at 28th April 2022.pdf

19 12:10 - Board Assurance Framework

Director of Corporate Affairs

19. Board Assurance Framework May 2022.docx

20 12:15 - Amendments to the Foundation Trust Constitution

Director of Corporate Affairs

20. Proposed amendments to the Foundation Trust Constitution.docx

20.1 Trust Constitution - Draft 230322.docx

21 12:20 - Summary Reports

Chair

21.1 FIC Summary Report 01 March 2022.docx

21.2 FIC Summary Report 05 April 2022.docx

21.3 Audit Committee Summary Report - 21 March 2022 meeting.docx

21.4 WDAC Summary Report -21 April 2022 Meeting.docx

21.5 TEC Summary Report 09 March 2022.docx

21.6 TEC Summary Report 13 April 2022.docx

21.7 Quality Clinical Risk Committee Summary Report - 21 March Meeting.docx

22 12:25 - Use of Trust Seal

Director of Corporate Affairs

22. Use of Trust Seal May 2022.docx

23 12:25 - Forward Agenda Planner

Chair

23. Trust Board Meeting In Public Forward Agenda Planner v 2.docx

24 12:30 - Questions from Members of the Public

Chair

25 12:30 - 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."

26 12:30 - Date of Next Meeting

Next Meeting in Public: Thursday, 07 July 2022

Agenda for the Board of Directors' Meeting in Public

Meeting to be held at 10.00 am on Thursday 05 May 2022
in the Conference Room at the Academic Centre

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 3 March 2022	Approve	Chair	Attached
4		Matters Arising	Note	Chair	Attached
Chair and Chief Executive Updates					
5	10.05	Chair's Report	Information	Chair	Attached
6	10.10	Chief Executive's Report - Overview of Activity and Developments a. 2021 Staff Survey Report	Receive and Discuss	Chief Executive Director of Workforce	Verbal Attached
Effectiveness of Care					
7	10.30	Patient Story – Chaplaincy Service	Receive and Discuss	Director of Patient Care and Chief Nurse	To Follow
8	10.45	Ockenden Final Report Update	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached
Patient Safety					
9	10.55	Serious Incident and Learning Report	Receive and Discuss	Director of Corporate Affairs/ Medical Director	Attached

Item No.	Timing	Title	Purpose	Lead	Paper
Patient Experience					
10	11.00	Patient and Family Experience Report Q3	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached
Workforce					
11	11.10	Nursing Staff Update	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached
12	11.15	Workforce Report Month 12	Receive and Discuss	Director of Workforce	Attached
13	11.20	Freedom to Speak Up Guardian Annual Report	Receive and Discuss	Freedom to Speak Up Guardian	Attached
11.30 – Break (10 mins)					
Performance and Finance					
14	11.40	Performance Report Month 12	Receive and Discuss	Chief Operations Officer	Attached
15	11.45	Finance Report Month 12	Receive and Discuss	Director of Finance	Attached
Strategy					
16	11.50	Research & Development Strategy Jan 2022-Dec 2025	Receive and Discuss	Medical Director	Attached
Assurance and Statutory Items					
17	12.00	2022/2023 Quality Priorities	Receive and Discuss	Director of Corporate Affairs	Attached
18	12.05	Significant Risk Register	Receive and Discuss	Director of Corporate Affairs	Attached
19	12.10	Board Assurance Framework	Receive and Discuss	Director of Corporate Affairs	Attached
20	12.15	Amendments to the Foundation Trust Constitution	For Ratification	Director of Corporate Affairs	Attached
21	12.20	(Summary Reports) Board Committees • Finance & Investment Committee 01/03/2022 and 05/04/2022	Assurance and Information	Chairs of Board Committees	Attached

Item No.	Timing	Title	Purpose	Lead	Paper
		• Audit Committee 21/03/2022 • Workforce and Development Assurance Committee 21/04/2022 • Trust Executive Committee 09/03/2022 and 13/04/2022 • Quality and Clinical Risk Committee 21/03/2022			
22		Use of Trust Seal	Noting	Director of Corporate Affairs	Attached
Administration and Closing					
23	12.25	Forward Agenda Planner	Information	Chair	Attached
24		Questions from Members of the Public	Receive and Respond	Chair	Verbal
25		Motion To Close The Meeting	Receive	Chair	Verbal
26		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	
12.30		Close			
Next Meeting in Public: Thursday, 07 July 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, 3 March 2022 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)
Dr Luke James	Non-Executive Director	(LJ)
Haider Husain	Non-Executive Director	(HH)
Helen Smart	Non-Executive Director	(HSm)
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)
Thomas Dunckley (Item 16)	HR Business Partner	(TD)
Helen Snaith (Item 7)	Meaningful Activities Facilitator	(HSn)
Katy Philpott	Associate Director of Operations, Women's and Children's Division	(KP)
Melissa Davies	Head of Midwifery	(MD)
Kwame Mensa-Bonsu	Trust Secretary	(KMB)
Julia Price	Senior Corporate Governance Officer (Minutes)	(JP)

1 Welcome and Apologies

1.1 AD welcomed all present to the meeting and acknowledged that this was AB's last meeting. She thanked him for his contribution to the organisation over the last six years.

There were apologies from Professor James Tooley, Non-Executive Director

2 Declarations of interest

2.1 There were no declarations of interest.

AB advised that he was a member of the Bedford, Luton and Milton Keynes Integrated Care Board (BLMK ICB) but was not aware of any conflicts arising from the agenda items.

3 Minutes of the Trust Board Meeting in Public held on 13 January 2022

3.1 The minutes of the Trust Board Seminar held on 13 January 2021 were reviewed and **approved** by the Board.

4 Matters Arising

4.1 Referring to the action log, KMB confirmed that a meeting to discuss monitoring and tracking of deep tissue injuries had been scheduled for 5 March 2022.

There were no other matters arising.

5 Chair's Report

5.1 There were no questions arising from the written report.

5.2 AD advised that, in March, similar to last year, the Board would be requested to provide feedback on board and sub-committee meetings

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

6 Chief Executive's Report – Overview of Activity and Developments

6.1 JH highlighted the Secretary of State's recent speech where he referenced Milton Keynes University Hospital in connection with improving technology across the NHS. In addition, the Chief Executive of the NHS had recently mentioned the organisation as an exemplar in relation to staff health and wellbeing.

6.2 The staff survey results were due shortly and would be presented to Board in due course.

6.3 The organisation was under significant pressure at the present time. The number of patients requiring admission due to Covid remained fairly constant but the number of non-Covid patients requiring a bed was increasing. However, performance against peers, particularly around the four-hour A&E target, remained very good, although national targets were not being met.

6.4 JB confirmed that that Trust was in receipt of £975k for the New Hospitals Programme for 2021-22 and a process was in place to request funds for 2022-23. The programme would continue to be managed over a number of years.

6.5 Highlighting International Women's Day, JH was pleased to report that a significant number of nominations had been made in recognition of women across the organisation where just over 70% of the workforce was female.

6.7 A collection point had been established within the hospital for those wishing to donate items as part of a Milton Keynes wide effort to support Ukraine.

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

7 Patient Story – Meaningful Activities

7.1 NBM introduced HSn, Meaningful Activities Facilitator, and explained that the role was being funded through the Hospital Charity for a year. Data was being collected on the value of the role in order for it to become substantive.

7.2 HSn advised that she took up the post in August 2021 and that she was based within the safeguarding team. She had been a health care assistant at the Trust in 2014 and returned after pursuing a degree in creative expressive arts, health and wellbeing. She explained that a meaningful activity includes physical, social and leisure activities, providing emotional, creative, intellectual and spiritual stimulation. This could cover a range of activities, for example, knitting, reading, painting and wordsearches which could be tailored individually or collectively.

7.3 HSn highlighted the case of a female patient, Dolly (not her real name), who was referred to her for emotional support. Initially, she spent two mornings with her in the ward's day room but the patient was

not interested in physical activities or in engaging with the other patients. She was emotional and felt isolated, struggling to engage with staff. At the time visitors were not allowed on site and she felt unable to hold meaningful conversations with anyone. HSn introduced her to another patient reporting similar issues who was from the same area in Milton Keynes and was also around the same age. They were able to chat together and eventually Dolly engaged with painting activities, later reporting that she was very proud of what she had created and that she had enjoyed participating. The other patient also reported feeling pleased with her accomplishments, important, happy and valued. Dolly re-gained her confidence and enjoyed engaging with other patients in the day room. Having asked to be wheeled to the day room initially her mobility improved and she was able to walk independently.

7.4 AD asked HSn how she would like to see the service develop and, advising that she had seen 177 patients since August 2021, HSn stated that more meaningful activities coordinators would allow for more positive benefits.

7.5 AB queried whether there was a scientific evidence base for this treatment and if so, it could become a commissioned service. NBM stated that it demonstrated that people should be treated holistically, adding that elderly patients were often withdrawn and deconditioned on admission to hospital and in between therapy, these activities could be motivating for people, encouraging them to want to go home. IR asked what the cross-over was between this role and that of occupational therapists. HSn confirmed that there was cross-over and that in her role, she was able to encourage patients to engage more fully with therapies through the use of meaningful activities.

7.6 HSn confirmed that she is looking to develop links with the community to tap into arts on prescription and is engaging with MK Arts for Health for patients to continue to gain benefit from the activities undertaken as inpatients.

7.7 AD thanked HSn for attending the meeting adding that she was looking forward to seeing how her role developed.

The Board **noted** the Patient Story.

8 Serious Incident and Learning Report

8.1 IR reported that there were ten serious incidents declared in January and February with investigations ongoing. He highlighted the maternal cardiac arrest incident which occurred when an epidural was given. All appropriate action was taken. He advised that this was a recognised complication that could be expected to occur every 8-10 years. However, it had occurred twice in three years at this hospital. Investigations had revealed no underlying issues and mother and baby were reported to be fine. Team working to recover the situation was reported as impressive.

8.2 In the past, incidents were investigated through a route cause analysis approach but pilots of a new approach, supported by the National Patient Safety Strategy, had been successful and the outcomes would be presented at the next Quality and Clinical Risk Committee.

8.3 Regarding quality improvement (QI), IR reported that Professor Belinda Dewar, Lead for Appreciative Inquiry, would be returning to provide additional support to the Trust.

8.4 JH asked how maternity cases would be handled given the recent announcement that the Healthcare Safety Investigation Branch (HSIB) would no longer be investigating these. KJ advised that a special authority would be created to deal with maternity investigations, freeing up HSIB to deal with other investigations. She advised that the Trust worked closely with HSIB and following a particular case, had agreed to involve families more closely to bridge with gap between the Trust's investigations and HSIB's. This would provide assurance to families on the immediate learning and remedial measures in place emanating from an incident whilst HSIB carried out their investigation. JH added that the Board should be aware that the Trust uses HSIB to provide independent assessment of cases and was keen to maintain this relationship. When in place, the new mechanism for maternity cases would be shared with

the Board and IR warned that cases in process were likely to be handed over for completion. DP advised that feedback from staff involved in HSIB investigations was positive and that they felt supported.

8.5 AD asked if there was a mechanism in place to review whether shared learning and remedial processes remained in place and IR advised that there were many and that sharing of key learning was an ongoing process. He also confirmed that investigative processes were alluded to at induction, though specific cases were not referenced.

The Board **noted** the Serious Incident and Learning Report.

9 Ockenden Assurance Report

9.1 NBM advised that the original Ockenden report was issued in December 2020 and that she expected the organisation to be fully compliant by April 2022 when two additional consultant appointments would be made, taking the establishment up to 14. When pandemic restrictions were lifted, HSm in her capacity as Maternity Champion, would resume walk rounds. A second Ockenden Report was expected by the end of March which would also contain recommendations.

9.2 HSm reported that she had attended the last Patient Experience Board and was amazed by the amount of work that had been undertaken. Highlighting the dramatic reduction in complaints regarding induction of labour, HSm asked how these improvements were being captured. NBM acknowledged that, given the volume, it was difficult to promote all the good work being undertaken. She explained that the Trust worked closely with the Milton Keynes Maternity Voices Partnership (MVP) who provided feedback that enabled better modelling for induction of labour. She added that as a result of their feedback over partners being asked to leave the Labour Unit at 8pm, they were now permitted to stay.

The Board **noted** the Ockenden Assurance Report

10 Morecambe Bay Assessment Report

10.1 NBM reported that the organisation was compliant with all but one of the recommendations, detailed on the risk register with an action plan. A systemic review of all deaths by medical examiners was also recommended but this would require a national change of policy. Maternity advocacy was also encouraged and NBM felt that midwives were good at speaking up and the Freedom To Speak Up Guardian had met with the team.

10.2 Highlighting the risk identified around the availability of a theatre solely for the use of obstetrics, HSm asked if there had been any incidents. It was explained that guidance indicated there should be a theatre available but there had not been any reported incidents. The new women and children's hospital would provide an opportunity to plan for this. IR clarified that an obstetric theatre was available but the recommendation was for two. The second one was used for electives. He added that there were three areas within the report that were unlikely to be met and which were being risk assessed. These related to:

- a Board Director of Midwifery;
- twelve hours of protected time per week for the Clinical Director of Obstetrics whose protected hours had already increased from four to eight hours and the view had been taken that a dispersed leadership approach would work better here; and
- adopting the modified early observation warning score (MEOWS) for pregnant women across the organisation. This would be challenging for the clinical workforce in terms of familiarity with the different scoring tools and also technically challenging for the organisation.

The Board **noted** the Morecambe Bay Assessment Report.

11 Maternity Self-Assessment

11.1 NBM advised that KJ was leading on the Big Conversation, a twelve-week programme, in collaboration with the MVP, launched on the back of the maternity survey to capture the experiences of women and families who had had a baby during the pandemic. KJ reported that, to date, many responses had been received, face to face events were planned and a report would be produced at the end of the campaign. JH explained that the work was linked to the patient experience report and survey (Item 12) which highlighted that families using the hospital's maternity services were not as happy as those elsewhere in the country. The report findings had been disappointing and remedial actions were required for women giving birth. AD felt that it would be beneficial to incorporate within the remedial actions supporting staff when things go wrong with a view to extending this approach across the organisation.

11.2 NBM advised that a lot of training had taken place around 'Birth Right', relating to informed consent and that the organisation was currently at 51% implementation compliance with the continuity of care model. By 2023, the majority of women nationally were expected to be on this pathway and, given the resource implications of this, a paper would be coming back to Board for approval at the appropriate time.

11.3 LJ highlighted the disappointing results from the patient survey in respect of treating people with kindness and understanding and he asked how the Big Conversation campaign would address this. KJ advised that the appreciative inquiry work would support midwifery and multi-disciplinary teams in addressing this issue. She referenced the difficulties staff faced during the pandemic when support staff had been stripped away. NBM acknowledged the disappointing results and explained that the survey had taken place during the third wave of the pandemic in February 2021, since when a significant amount of change had occurred and a new leadership team installed. The 2022 survey was conducted in February 2022. JH highlighted that the Board reviewed the results a year after the survey had taken place due to external forces and an action for the Executive Team would be to find a means of providing feedback on maternity services within six months to indicate progress. Having attended Patient Experience Board, HSm confirmed that significant progress had been made within maternity services.

Action: Executive directors to establish a means of providing patient feedback on maternity services to the Board within six months of the survey

11.4 HSm asked about the mechanisms for governance from peer review feedback and NBM explained that following the regional peer review, the maternity team undertook an internal review and gap analysis, the results of which progressed through the governance structure to Quality and Clinical Risk Committee.

11.5 Noting the requirement to bring the previous three items to Board, JH highlighted the considerable focus on maternity at this meeting. In context, he advised that there were one million patient contacts each year and 4000 births. As CEO, he felt that the balance of Board scrutiny on maternity could be to the detriment of the risks of other patient groups in the organisation, where waiting times were longer than desired, and access had been significantly reduced over the last two years. He asked the Board to consider how this balance could be redressed. IR suggested that the current focus on maternity was to ensure boards understood the issues before they were devolved into other fora. He said that it was clear nationally that boards had not been focusing on the issues given the long list of trusts whose issues had made national news. If the requirement to provide such a high volume of scrutiny on maternity services extended beyond 2023 with the expectation that challenges would be addressed uniformly across the country, he stated that he would become impatient. Since the latest report was due out at the end of March, JH anticipated that the situation would continue for many years, and he feared that in the meantime the balance of risk was skewed.

11.6 In response to a question from HT regarding ongoing involvement and input, NBM stated that the challenge for her was in avoiding maternity services becoming siloed and developing a separate industry with their own strategy. She was intent on ensuring that actions plans were carried out and resulted in lasting change throughout the service. HT also asked whether maternity services carried greater risk than others and JH responded that pre-pandemic this was the case but referencing the number of

patients unable to access services within appropriate timescales he felt that other services should be given the same level of oversight and scrutiny.

11.7 KJ highlighted the challenge around governance where the volume of papers did not necessarily equate to providing assurance and that not enough progress had been made across the NHS in addressing the underlying issues in maternity services. She suggested that a review of the role of the Quality and Clinical Risk Committee could result in the provision of greater Board assurance. AD agreed that the level of detail provided to the Board at the meeting was not required regularly and that there should be a better balance. Recognising the huge amount of work undertaken by the Head of Midwifery and the maternity team, JH agreed that assurance was not necessarily provided through action plans. It was agreed that the internal auditors would be requested to audit the maternity action plans as a means of providing assurance, on condition that this did not impact on the work of the maternity team.

Action: KJ to discuss maternity action plan audits with the Trust's internal auditors

11.8 JH queried how the Board gains assurance around other patient safety risks and AB offered the view that the executive team and management seek to minimise risks and build the strongest barriers. The Board needed to be assured that the risks identified and the judgements and actions around them were correct. Assurance was therefore partly obtained through what the Board sees and partly through external data. Given the national focus and the proportion of serious incidents within maternity at the Trust, AB felt that maternity was still a risk and therefore the focus should remain high. JH believed the Board had not yet given enough consideration to the risks arising from the pandemic such as additional potential harm to patients awaiting access to services. He wished to avoid passive assurance of the Board and he did not feel that there had been enough challenge over how the pandemic may have changed the requirements of the Board to gain assurance over various parts of the business. JC suggested that as information was still evolving, there was a lack of understanding of the level of risks from the pandemic and also a clear mandate over the data to be collected to provide assurance that these were being managed. It was agreed these issues would be discussed at Board Seminar.

Action: KMB to accommodate a discussion at Board Seminar

The Board **noted** the Maternity Self-Assessment.

12 Patient Experience Report – Maternity Unit

12.1 This item was covered under Item 11.

The Board **noted** the Patient Experience Report on the Maternity Unit

13 Nursing Staffing Update

13.1 NBM reported on the international recruitment campaign and advised that of 58 people interviewed, 22 people had been recruited, with 8 arriving in January and 14 in February. Additional training was being provided to the new recruits with many experienced nurses being supported to move straight into Band 6 posts, drawing positive interest from across the region. Support was being provided to assist the new recruits in adapting to a multi-disciplinary approach. Preceptorship courses were being provided for the international recruits.

13.2 An Emergency Department (ED) model of the Safer Care Tool was now available and would be implemented over the next quarter.

13.3 Andrea Piggott had been appointed as the Deputy Director of Patient Care and Gary Cooper-Stanton had taken up the role of Head of Practice Education.

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

14 Maternity Staffing Overview Report

14.1 NBM explained Birth Rate Plus was the only approved maternity staffing model. The report had been requested to come to Board. The final report would be shared with the Board once the recommendations on establishment had been identified by the Head of Midwifery.

The Board **noted** the Maternity Staffing Overview Report.

15 Workforce Report Month 10

15.1 DP provided the following highlights from the report:

- The vacancy rate continued to reduce and applications were beginning to increase.
- Sickness absence remained high but had come down significantly within the last few weeks.
- Statutory mandatory training and appraisals compliance remained good.
- The international recruitment campaign was proceeding well and DP explained that the aim was to recruit 16 nurses on each placement in view of the value of a large cohort.
- The embargoed staff survey results had been received and would be reviewed at Board in due course.

15.2 AD highlighted the medical and dental appraisal rate at 79% and IR suggested bringing a report on the framework for this. DP advised that an annual report was provided on this at Workforce and Development Assurance Committee. IR added that internal auditors were reviewing some aspects of consultant practices.

The Board **noted** the Workforce Report for Month 10

16 Equality, Diversity and Inclusion (EDI) Update

16.1 AD reminded the Board about a previous discussion on EDI and DP introduced TD to the meeting to present the update.

16.2 Introducing the Workforce Race Equality Standard (WRES) metrics, TD highlighted that 34% of employees identify as black, Asian and minority ethnic (BAME) against a local population of 26% but BAME candidates applying for a job at the Trust were less likely to be shortlisted than white candidates. BAME and white employees were equally likely to face bullying, harassment or abuse from service users in the last 12 months, however they faced more harassment from colleagues than white employees over the same period. In the last 12 months, almost double the amount of BAME employees faced discrimination from a colleague compared to white employees. A much lower proportion of the Trust Board identified as BAME compared to the general workforce population.

16.3 Regarding Workforce Disability Equality Standard (WDES) metrics, TD advised that 3.8% of the Trust's substantive workforce had declared a disability. In context, studies show that nationally 18% of working age adults had a disability. Disabled candidates were more likely to be shortlisted for Trust jobs than non-disabled candidates. In the last twelve months a higher percentage of disabled employees faced discrimination, harassment, bullying or abuse from service users, colleagues and managers than those without a disability. 7.1% of the Trust Board had declared a disability.

16.4 In order to enhance the metrics and ensure that they are communicated meaningfully, infographics had been produced for display across the organisation. The next steps were to engage more widely with the HR Team and the Divisions to ensure that each area gained a good understanding to support improvements.

16.5 In terms of the gender pay gap, women occupied 64.2% of the highest, and 82.2% of the lowest, paid jobs. Frameworks were being introduced into recruitment processes to ensure consistency and a review of responsibility allowances was underway.

16.6 There was an ambition to become an exemplar EDI Trust. Aims and objectives to achieve this included:

- Increasing the BAME workforce by 1% in 2021/22 and a further 2" in 2022/23
- Increasing the disability workforce by 2% in 2021/22 and a further 5% in 2022/23
- Increasing the BAME and disabled workforce in senior management roles
- Increasing promotion for BAME and disabled workforce
- Reducing bullying and harassment against BAME and disabled employees
- Reducing the gender pay gap

16.7 The EDI team worked extensively with the eight staff networks established since 2018: Pride, BAME, Ability, Women's, Faith & Belief, Armed Forces, Carers and Generational (in development). In support of the networks, the Trust had introduced the Inclusion Leadership Council and an EDI lead and executive sponsor for each network.

16.8 Progress to date included:

- Introduction of a talent management programme, chief nurse fellowships, values-based recruitment and CV and interview skills training to assist the progression of BAME employees
- Introduction of Above Difference Cultural Awareness training, extensive outreach by the team, for example to Islamic, Sikh and Hindu communities, Living Our Values programme, development of a disability inclusion plan to address bullying and harassment of BAME and disabled employees
- A gender pay gap data review which would result in the co-production of an action plan with the Women's network

16.9 Future actions included:

- A review of equality impact assessments
- Development of ability champions
- A review of best practice elsewhere
- Development of a behaviours framework

16.10 AD thanked TD for the presentation. NBM asked whether the Trust was ambitious enough to become an exemplar site. She suggested mandating for one member of an interview panel to have had unconscious bias training. The failings of the recruitment process were acknowledged. EL highlighted the distance the organisation would need to travel to become an exemplar and HH queried how the organisation would recognise that this ambition had been achieved. TD explained that there were multifactorial metrics to facilitate this and acknowledged that achieving this ambition was dependent on commitment from the wider organisation. JH requested there was equal focus on equality within the workforce and equity of access for the external population. KJ suggested further discussion on this topic at the June 2022 Board Seminar to consider how the gaps might be closed and what the benefits of diversity would mean for the objectives of the organisation.

Action: KMB to include EDI on the June 2022 Board Seminar agenda

16.11 AD thanked TD for the presentation and informed colleagues she was looking into associate non-executive director membership with colleagues with a view to driving the diversity agenda.

The Board **noted** the EDI update

17 Performance Report Month 10

17.1 EL reported that there were significant staffing problems in the period covered in the report (January 2022) during the third wave of the pandemic. This was no different to any other year but was exacerbated by the closure of 48% of local care homes. Weekend discharges were particularly challenging. Non-criteria to reside patients, that is, patients without a clinical reason to remain in hospital, increased to over 100 patients. On the other hand, ambulance handover times reduced consistently and the local provider, South Central Ambulance Service (SCAS), advised that the Trust

performed well compared to others. The challenging position on diagnostics had improved from the previous month but issues around MRI and staffing remained. The outpatient DNA (did not attend) rate showed an increase and sickness levels were slightly above average levels.

17.2 In response to a question from HSm over the care home situation, EL advised that the situation had improved, and the system had worked really well with only six patients waiting whilst others had in excess of 50 but there was certainly more that could be done to improve processes. She highlighted the gap within the area for double handed care.

17.3 JC highlighted the huge amount of work undertaken by EL and her team in identifying where responsibility lay for patients not meeting the criteria to reside and this was not reflected in the paper.

17.4 JH advised that the monthly trajectory review would be presented at Trust Executive Committee on Wednesday 10 March and Trust Board approval of the trajectories would be sought at the next Board Seminar.

17.5 Referencing the 62-day standards for urgent GP referrals, AD asked if there was a good understanding of the reasons where the organisation was below national levels. EL explained that the organisation benchmarked against two cancer networks and that cancer performance was good, relatively speaking, although from January to March it was influenced by the Dermatology situation which was resolving.

17.6 AD further queried whether follow up ratios included patient-initiated appointments and JB confirmed that they were. He reminded the Board that there was an expectation that follow-ups would reduce by 25% over the next year and this would be discussed at the next Board Seminar. Complaints metrics would also be discussed at that Seminar.

17.7 In response to a question from AD over how the peer group of trusts had been derived and whether it was still appropriate, it was confirmed that the group would need rebasing and refreshing post-pandemic.

17.8 LJ highlighted that the target identifiers did not match the board scorecard and JB agreed to review this.

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

18 Finance Report Month 10

18.1 TW advised that the period covered was from April 2021 to January 2022. A deficit of £1.1m was being declared which was consistent with the Trust's plan. The position covered high sickness levels in January resulting in pay pressures from pay enhancements for bank and agency which continued throughout February. The pay bill was the highest for the year, particularly for temporary staff, at £17.5m. This was broadly comparable to the previous year at the peak of the pandemic. In addition, levels of elective activity dropped off due to staff availability and reprioritisation of resources. The Trust's bonus payment would therefore be affected.

18.2 The Trust was forecasting a planned outturn of £1.1m and work was ongoing with system colleagues across the integrated care system and regional colleagues to meet the expectation that organisations would achieve their forecasted positions.

18.3 The cash position of £68m was expected to reduce to £40m by the middle of the year. An offset of around £4m against the standalone pressure of £6m had been agreed with system partners and further discussions would be taking place as positions across the system began to crystallise.

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

19 Significant Risk Register

19.1 KJ highlighted the significant amount of work being undertaken in respect of risk management which would be shared with the Board. Overdue review of incidents continued to be an area of focus. HSm asked what the risks, safety and timeframe was for these, and KJ advised that they were escalated through the monthly Risk and Compliance Board for corporate review and to Trust Executive Committee if they presented an immediate risk. She confirmed that none fell into that category at the present time.

19.2 HSm asked for a progress update on the transfer of the incident reporting system from Datix to Radar and whether the benefits were being realised yet. KJ advise that the transfer would have been imperceptible except that the change incorporated the implementation of the Learning from Patient Safety Events new way of capturing incident information. This proved much more challenging and involved a very different requirement for information and expectation from the reporter. This was fed back to NHS England on the back of which, and other iterations, KJ expected the incident reporting form to look very different by the end of the year.

19.3 KJ clarified that risk owners were expected to review their risks regularly, and monthly where the risks were significant.

The Board **noted** the Significant Risk Register

20 Board Assurance Framework (BAF)

20.1 KJ reported that there had been no significant changes to the framework within the last month. JB would ensure that a risk was drafted in response to the increased threat of cyber-attacks given the situation between Russia and Ukraine. Continuity plans would also be reviewed.

The Board **noted** the Board Assurance Framework

21.1 Summary Report for the Finance and Investment Committee Meeting – 11 January 2022

The Board **noted** the report.

21.2 Summary Report for the Finance and Investment Committee Meeting – 1 February 2022

The Board **noted** the report.

21.3 Summary Report for the Charitable Funds Committee – 27 January 2022

The Board **noted** the report.

21.4 Summary Report Workforce and Development Assurance Committee – 20 January 2022

The Board **noted** the report.

21.5 Summary Report Trust Executive Committee – 12 January 2022

The Board **noted** the report.

21.6 Summary Report Trust Executive Committee – 9 February 2022

The Board **noted** the report.

22 Use of Trust Seal

The Board **noted** the Use of Trust Seal

23 Forward Agenda Planner

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

24 Questions from Members of the Public

There were no questions from the public.

25 Any Other Business

25.1 None

26 The meeting closed at 12:41.

Updated : 27/04/22

Milton Keynes University Hospital NHS Foundation Trust

Trust Board Action Log

Action No.	Date added to log	Agenda Item No.	Subject	Action	Owner	Completion Date	Update	Status Open/ Closed
1	13-Jan-22	7.5	Incident learning and quality improvement report	A meeting to be scheduled for KJ, NBM and HH and HS to discuss monitoring and tracking of deep tissue injuries	KMB	03-Mar-22	The meeting, held on 25 April 2022, agreed that a report on the progress of actions around the management of deep tissue injuries will be submitted to the June 2022 Quality and Clinical Risk Committee meeting and then the July 2022 Trust Board meeting.	Completed
2	03-Mar-22	11.3	Maternity Self-Assessment	Executive directors to establish a means of providing patient feedback on maternity services to the Board within six months of the 2022 Maternity Survey conducted in Februray 2022	NBM	07-Jul-22		Open
	03-Mar-22	11.7	Maternity Self-Assessment	KJ to discuss maternity action plan audits with the Trust's internal auditors	KJ	05-May-22	Verbal Update	Open
	03-Mar-22	11.8	Maternity Self-Assessment	Board Seminar discussion - Reviewing patient risks (with a forcus on maternity risks) to seek/provide Board assurance	KMB	06-Jun-22		Open
	03-Mar-22	16.10	Equality, Diversity and Inclusion (EDI) Update	Board to consider in June 2022 how the gaps in equality, diversity and inclusion might be closed and what the benefits of diversity would mean for the objectives of the organisation.	KMB	06-Jun-22		Open

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: 05.05.2022**
Report Title	**Chair's Report**	**Agenda Item: 5**
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, other than routine committee attendance and matters to note to the Trust Board:

1. Our new Non-Executive Directors (NEDs)Gary Marven and Bev Messinger started with us on the 1st April and are settling into their new roles. We are delighted to have them on board and look forward to working with them.
   I would also like to acknowledge and thank our outgoing NEDs Andrew Blakeman and Nicky McLeod for their contributions and support during their terms of office.

2. We have successfully recruited to a number of consultant appointments since my last report including: Upper Limb surgery, Opthalmology, Urology, and Emergency Department.

3. I was delighted to be asked to formally open our new Outpatient Pharmacy next to the Main Entrance to the hospital, on the 21st April. It is a modern and welcoming facility and the design and layout was created directly by members of the team—great talent for interior design!
   There are ambitious plans to expand the services the Pharmacy can offer to patients and members of staff; it has a key role to play in providing advice, support and treatment options, complementary to other health service provision.

4. I took part in the Charitable Funds 'Supporter Thank You event' on the 21st April, at the Hotel La Tour. The hotel kindly sponsored the event and over 60 fundraisers, donors and supporters attended. It was a very enjoyable evening and a great opportunity to thank everyone face to face for their generosity in providing so many extra comforts, pieces of equipment and improvements to the hospital environment for the benefit of patients and staff.
   Vanessa Holmes and her team are to be thanked for the great work they do to engage with supporters and raise the profile of the hospital.
   I must also mention the Hospital Ball planned for June 24th. Tickets are available at Milton Keynes Hospital Charity launches 'A Midsummer Night's Gala Ball' | (mkhcharity.org.uk)

5. The Council of Governors have approved the reviewed MKUH Constitution after providing helpful feedback and suggestions for amendment. Approval at Trust Board will complete the Governance process.
   With the support of Lui Straccia, Governors are moving forward with plans for community/constituency engagement.
   Shirley Moon has created a presentation with discussion points and a quiz for use in schools, to encourage young people to become involved with the hospital; especially as members but also to think about careers in the health service

6. The BLMK Integrated Care System continues to prepare for Statutory status in July, with the formation of a shadow an Integrated Care Partnership group. As a Non- Executive Chair I will be a member of this, taking part in the quarterly meetings which are intended to focus on the strategy for the BLMK system to improve population health and wellbeing.
   For further details the link is BLMK (blmkpartnership.co.uk)

7. East of England Regional meetings have continued to focus on ambulance waiting times across the region, dealing with the waiting lists for treatment across all health provision and addressing inequalities in access and treatment.

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2021 NHS Staff Survey Results

Public Board - May 2022

Danielle Petch, Director of Workforce

As a teaching hospital, we conduct education and research to improve healthcare for our patients. During your visit students may be involved in your care, or you may be asked to participate in a clinical trial. Please speak to your doctor or nurse if you have any concerns.

Chief Executive: Professor Joe Harrison
Chair: Alison Davis

Milton Keynes University Hospital NHS Foundation Trust

2021 NHS Staff Survey

Benchmark Report

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise.

This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

This Presentation contains highlights of the results for the 2021 NHS Staff Survey, for MKUH.

The results are presented in the context of the highest (best), average and lowest (worst) results for similar organisations where appropriate.

2021 NHS Staff Survey

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Milton Keynes University Hospital NHS Foundation Trust

This organisation is benchmarked against:

Acute and Acute & Community Trusts

Organisation details

Completed questionnaires	1,589
2021 response rate	42%

2021 benchmarking group details

Organisations in group: **126**

Median response rate: **46%**

No. of completed questionnaires:

444,326

Survey Coordination Centre

People Promise elements, themes and sub-scores

NHS

Please note that you can navigate to the results of a particular score or question result by clicking on it in the table below.

People Promise element	Sub-scores	Question
We are compassionate and inclusive	Compassionate culture	Q6a, Q21a, Q21b, Q21c, Q21d
	Compassionate leadership	Q9f, Q9g, Q9h, Q9i
	Diversity and equality	Q15*, Q16a, Q16b, Q18
	Inclusion	Q7h, Q7i, Q8b, Q8c
We are recognised and rewarded	[No sub-scores]	Q4a, Q4b, Q4c, Q8d, Q9e
We each have a voice that counts	Autonomy and control	Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b
	Raising concerns	Q17a, Q17b, Q21e, Q21f
We are safe and healthy	Health and safety climate	Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d
	Burnout	Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g
	Negative experiences	Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c
We are always learning	Development	Q20a, Q20b, Q20c, Q20d, Q20e
	Appraisals	Q19a, Q19b, Q19c, Q19d
We work flexibly	Support for work-life balance	Q6b, Q6c, Q6d
	Flexible working	Q4d
We are a team	Team working	Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a
	Line management	Q9a, Q9b, Q9c, Q9d
Theme	**Sub-scores**	**Question**
Staff Engagement	Motivation	Q2a, Q2b, Q2c
	Involvement	Q3c, Q3d, Q3f
	Advocacy	Q21a, Q21c, Q21d
Morale	Thinking about leaving	Q22a, Q22b, Q22c
	Work pressure	Q3g, Q3h, Q3i
	Stressors	Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a
Questions not linked to the People Promise elements or themes		
Q1, Q10a, Q10b, Q10c, Q11e, Q15 (historical calculation)* , Q16c, Q22d, Q28b		

People Promise:
Elements, Sub-Scores & Questions / Themes

Milton Keynes University Hospital NHS Foundation Trust

People Promise element	Sub-scores	Questions
Promise 1: *We are compassionate and inclusive*	P1.1: Compassionate culture P1.2: Compassionate leadership P1.3: Diversity and equality P1.4: Inclusion	Q6a, Q21a-d Q9f-i Q15, Q16a-b, Q18 Q7h-i, Q8b-c
Promise 2: *We are recognised and rewarded*	[No sub scores]	Q4a-c, Q8d, Q9e
Promise 3: *We each have a voice that counts*	P3.1: Autonomy and control P3.2: Raising concerns	Q3a-f, Q5b Q17a-b, Q21e-f
Promise 4: *We are safe and healthy*	P4:1 Health and safety climate P4:2 Burnout P4:3 Negative experiences	Q3g-i, Q5a, Q11a, Q13d, Q14d Q12a-g Q11b-d, Q13a-c, Q14a-c
Promise 5: *We are always learning*	P5.1: Development P5.2: Appraisals	Q20a-e Q19a-d
Promise 6: *We work flexibly*	P6.1: Support for work-life balance P6.2: Flexible working	Q6b-d Q4d
Promise 7: *We are a team*	P7.1: Team working P7.2: Line management	Q7a-g, Q8a Q9a-d

Themes	Sub-scores	Questions
Staff Engagement	E.1: Motivation E.2: Involvement E.3: Advocacy	Q2a-c Q3c, Q3d, Q3f Q21a, Q21c, Q21d
Morale	M.1: Thinking about leaving M.2: Work pressure M.3: Stressors (HSE index)	Q22a-c Q3g-i Q3a, Q3e, Q5a-c, Q7c, Q9a

The **Workforce Race Equality Standard (WRES)** and **Workforce Disability Equality Standard (WDES)** measures will continue to be reported as previously.

People Promise and Theme result:

MKUH scored ***above*** the national average ***in all 7 elements*** of the People Promise and the ***2 themes*** of staff engagement and morale.

Milton Keynes University Hospital NHS Foundation Trust

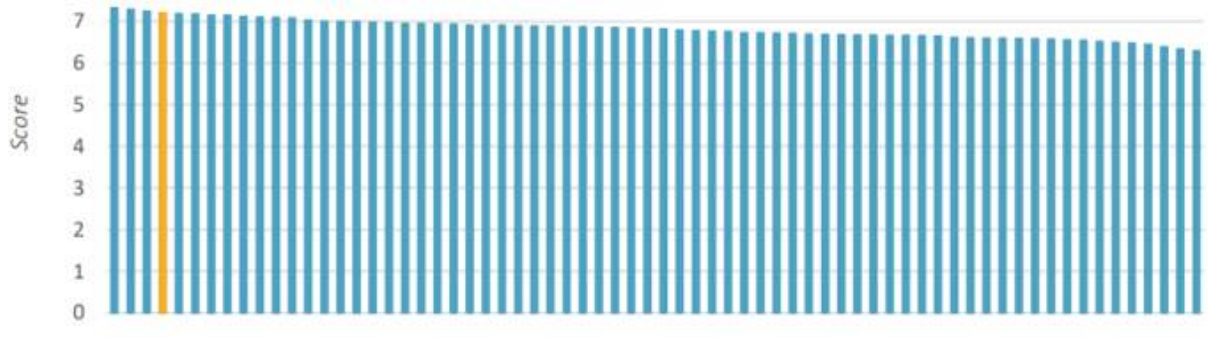
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.4	6.2	7.0	6.1	5.7	6.4	6.8	7.2	6.1
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	1,573	1,572	1,522	1,525	1,418	1,550	1,567	1,576	1,575

Executive Summary (1)

- MKUH scored well against other Trusts this year but less well when compared with previous MKUH scores
- MKUH scored **4th** for Engagement and **9th** for Morale out of the 67 Quality Health comparator Trusts
- Staff engagement scores have declined across the NHS as a whole - however - MKUH's is higher than the level identified in 2019
- MKUH has the **top** score nationally for motivation
- MKUH has scored very high nationally for 3 questions,:
  I am trusted to do my job' (***93.6%*** 'v' best national score of 93.9%)
  I look forward to going to work' (***60.8%*** 'v' best national score ***60.8%*** … ***Us !)***
  The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it? (***53.8%*** 'v' best national score 53.9%)

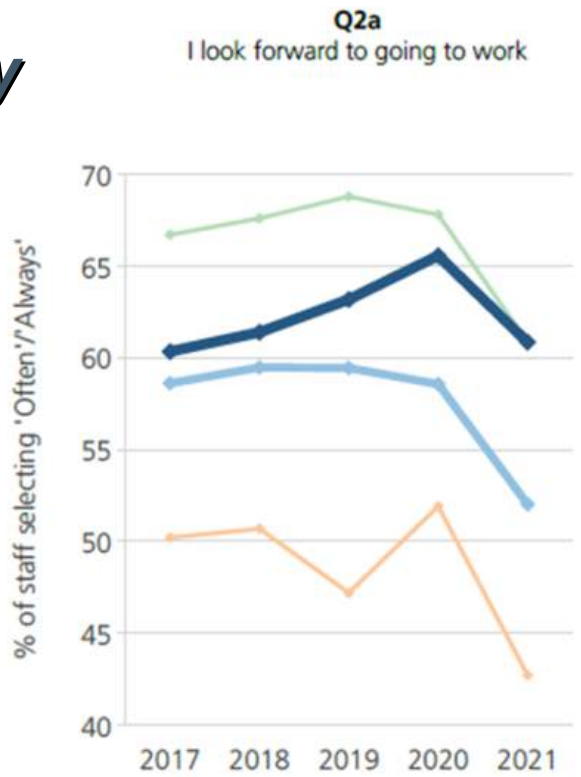
Staff Engagement

- Is measured across three subscores –
  Motivation, Involvement and Advocacy
- We are 4th in the Sector*



Our score of 7.21 is seen above in **orange** in the blue bars above.

(Quality Health sector comparator)*



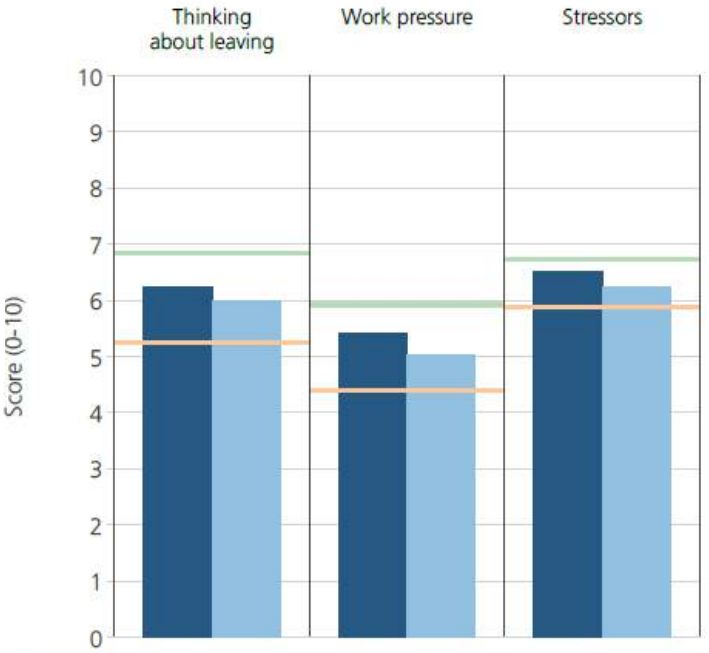
	2017	2018	2019	2020	2021
Best	66.7%	67.6%	68.8%	67.8%	60.8%
Your org	60.3%	61.4%	63.2%	65.6%	60.8%
Average	58.6%	59.5%	59.4%	58.6%	52.0%
Worst	50.2%	50.7%	47.2%	51.9%	42.7%
Responses	1,406	1,455	1,892	1,603	1,559

Morale

- Staff Morale is measured across three subscores – ***Thinking about leaving, Stressors (HSE Index) & Work pressure***
- We are 9th in the Sector *

Our score of 6.06 is seen above in **orange** bar

(Quality Health sector comparator)*



	Thinking about leaving	Work pressure	Stressors
Best	6.8	5.9	6.7
Your org	6.2	5.4	6.5
Average	6.0	5.0	6.2
Worst	5.2	4.4	5.9
Responses	1,560	1,571	1,571

Executive Summary (2)

Milton Keynes University Hospital NHS Foundation Trust

- Comparing 2021 with our 2020 results we score less well - *but …*

- MKUH has only 3 questions out of 111 where it performs 'worse' than the sector as whole.

The areas identified for improvement remain unchanged from previous surveys:

- Staff are working additional paid hours (work-life balance)
- Staff are experiencing violence from patients / service users and families
- Staff are experiencing discrimination

Overview - 21 sub-set questions across the 7 People Promise Elements and the 2 Themes

Milton Keynes University Hospital NHS Foundation Trust

- The 2 Themes of Morale and Staff Engagement are key performance indicators and MKUH's scores are significantly better than the sector scores

- The sub theme of 'Work pressure' has shown significant decline since the previous survey

At the sub-question level :

- 2 themes are significantly better
- 73 scores are significantly better than the sector
- Only 4 scores are significantly worse

Response Rate:
5 Year Comparison

Milton Keynes University Hospital NHS Foundation Trust

3,776 staff surveys were issued

1,589 usable questionnaires returned

Giving a 42.5% Trust response rate

This is slightly less than last year, where MKUH had a response rate of 45.5%.

	2017	2018	2019	2020	2021
Highest	72.6%	71.6%	76.0%	79.8%	79.9%
Your org	42.9%	43.7%	55.5%	45.5%	42.5%
Median	43.9%	43.6%	46.9%	45.4%	46.4%
Lowest	27.3%	24.6%	27.2%	28.1%	29.5%

Response Rate by Occupational Group

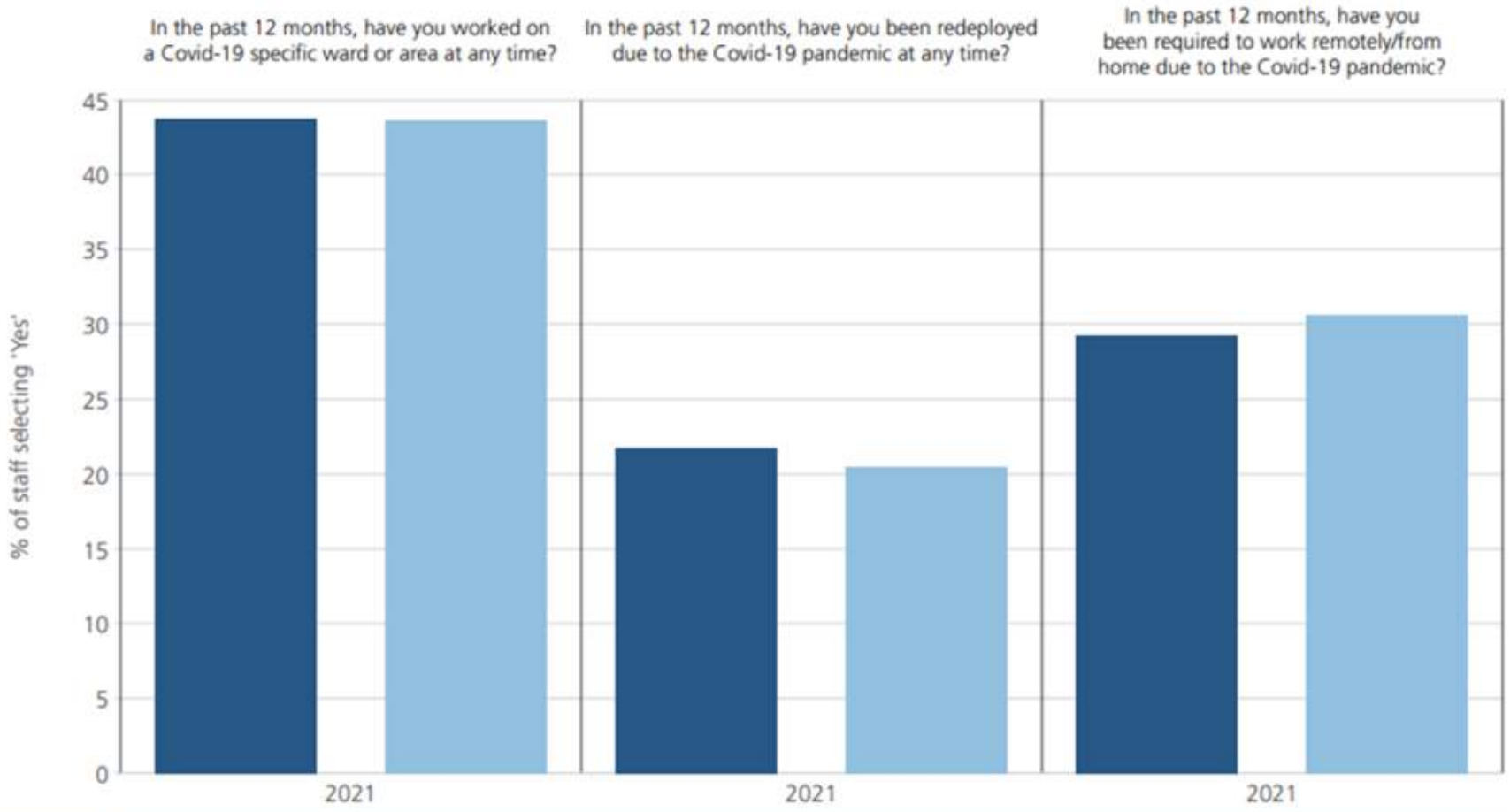
Milton Keynes University Hospital NHS Foundation Trust

Occupational Group	2021	2020
Registered Nurse and Midwives	27.3%	27%
AHP / HCS / S&T	18.6%	23%
Medical and Dental	12.5%	10%
HCA / MCA	7.4%	7%
Corporate / Maintenance	21.9%	29%
General Management	2.3%	4%

Staff Experience during Covid-19

Milton Keynes University Hospital NHS Foundation Trust

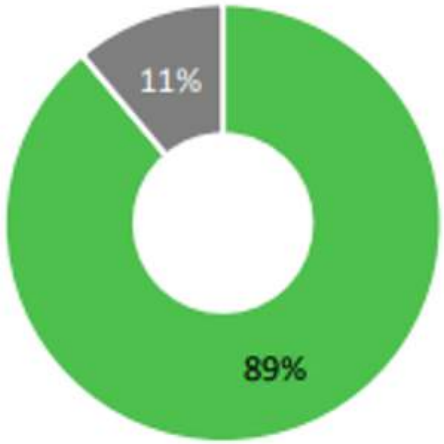
In the 2021 survey, staff were asked three classification questions relating to their experience during the Covid-19 pandemic:



	In the past 12 months, have you worked on a Covid-19 specific ward or area at any time?	In the past 12 months, have you been redeployed due to the Covid-19 pandemic at any time?	In the past 12 months, have you been required to work remotely/from home due to the Covid-19 pandemic?
Your org	43.8%	21.8%	29.2%
Average	43.6%	20.4%	30.6%
Responses	1,565	1,556	1,556

Milton Keynes University Hospital NHS Foundation Trust

Summary of the distribution of core questions and where MKUH scored against the comparator Organisations



- 8 (89%) People Promise(s)/Theme(s) scored significantly better than the sector average
- 0 (0%) People Promise(s)/Theme(s) scored significantly worse than the sector average
- 1 (11%) People Promise(s)/Theme(s) showed no significant difference in relation to the sector average or comparisons could not be drawn

Significantly Better Scores

Milton Keynes University Hospital NHS Foundation Trust

People Promise/Theme		Your Org.	Sector	Difference
People Promise 1	We are compassionate and inclusive	7.44	7.17	+0.27
People Promise 2	We are recognised and rewarded	6.23	5.81	+0.42
People Promise 3	We each have a voice that counts	7.00	6.66	+0.33
People Promise 5	We are always learning	5.72	5.23	+0.49
People Promise 6	We work flexibly	6.40	5.95	+0.46
People Promise 7	We are a team	6.82	6.56	+0.26
Theme	Staff engagement	7.21	6.81	+0.40
Theme	Morale	6.06	5.74	+0.32

Significantly Worse Scores

Milton Keynes University Hospital NHS Foundation Trust

Question		Your Org.	Sector	Difference
10b	I work additional PAID hours for this organisation, over and above my contracted hours.	48%	37%	+10.54%
13a	In the last 12 months I have personally experienced physical violence at work from patients / service users, their relatives or other members of the public.	16%	14%	+2.48%
16a	In the last 12 months I have personally experienced discrimination at work from patients / service users, their relatives or other members of the public.	9%	8%	+1.50%
16c 01	Experienced discrimination on grounds of ethnic background.	55%	48%	+7.23%

Top 10 Scores for MKUH

Milton Keynes University Hospital NHS Foundation Trust

1	13b	In the last 12 months I have personally experienced physical violence at work from managers.	0%
2	13c	In the last 12 months I have personally experienced physical violence at work from other colleagues.	2%
3	16c04	Experienced discrimination on grounds of sexual orientation.	4%
4	16c03	Experienced discrimination on grounds of religion.	4%
5	16c05	Experienced discrimination on grounds of disability.	5%
6	3b	I am trusted to do my job.	94%
7	16b	In the last 12 months I have personally experienced discrimination at work from a manager / team leader or other colleagues.	8%
8	19a	In the last 12 months, I have had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review.	92%
9	6a	I feel that my role makes a difference to patients / service users.	91%
10	16a	In the last 12 months I have personally experienced discrimination at work from patients / service users, their relatives or other members of the public.	9%

Bottom 10 Score for MKUH

1	12e	I often/always feel worn out at the end of my working day/shift.	45%
2	12a	I often/always find my work emotionally exhausting.	37%
3	12c	My work often/always frustrates me.	36%
4	5a	I have unrealistic time pressures (Never/Rarely).	23%
5	19b	The appraisal/review helped me to improve how I do my job.	26%
6	12b	I often/always feel burnt out because of my work.	33%
7	3i	There are enough staff at this organisation for me to do my job properly.	29%
8	12g	I do not have enough energy for family and friends during leisure time (often/always).	30%
9	19c	The appraisal/review helped me agree clear objectives for my work.	34%
10	19d	The appraisal/review left me feeling that my work is valued by my organisation.	35%

Next Steps

- Utilise the *Staff Survey Goes Large* approach, as rolled out in previous years to share and review department level data with each team.
- Continue the work to address staff working additional hours and violence and aggression.
- Continue work with networks and management teams to address discrimination

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Any Questions..?

As a teaching hospital, we conduct education and research to improve healthcare for our patients. During your visit students may be involved in your care, or you may be asked to participate in a clinical trial. Please speak to your doctor or nurse if you have any concerns.

Chief Executive: Professor Joe Harrison
Chair: Alison Davis

Meeting Title	**Trust Board**	**Date: April 2022**
Report Title	**Ockenden Final Report Update**	**Agenda Item: 8**
Lead Director	**Name: Nicky Burns-Muir**	**Title: Director of Patient Care and Chief Nurse**
Report Author	**Name: Melissa Davis**	**Title: Head of Midwifery, Gynaecology & Paediatrics**

Key Highlights/ Summary	**The final Ockenden Report was released on the 30th of March 2022, this report details the independent review of the maternity care of 1486 families totalling 1592 clinical incidents.** **The report details 16 overarching themes for immediate and essential safety actions including a total of 92 individual actions of which 84 are relevant to Milton Keynes maternity service for considered implementation at provider level.** **8 actions are not trust specific or relevant to the service at Milton Keynes** **84 actions are aligned with provider service provision at Milton Keynes and the current position at Milton Keynes is as follows:** **Compliant with 50** **Partially compliant with 27** **Non-compliant with 7** **This paper details the initial response to the final Ockenden Report and the planned approach to the identified actions within the Ockenden report.**			
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Noting** √	**For Review** √

Strategic Objectives Links	**Patient Safety**
Board Assurance Framework (BAF)/ Risk Register Links	

Report History	
Next Steps	
Appendices/Attachments	**Final Ockenden report initial GAP analysis**

Final Ockenden Report

Released 30th of March 2022

Board Report May 2022

Background

The Ockenden Report included an independent review of maternity cases at the Shrewsbury & Telford NHS Trust.

The initial Ockenden report containing the independent review of 250 maternity cases was released in December 2020.

This report included 7 Immediate & Essential Safety Actions and a Workforce & NICE requirement, all with individual associated safety actions. Provider trusts were required to submit evidence to demonstrate compliance with these actions.

Assessment against Ockenden Immediate and Essential Action (IEA) April 2022	
Immediate & Essential Action 1	100%
Immediate & Essential Action 2 **NED oversight of maternity services**	76%
Immediate & Essential Action 3	100%
Immediate & Essential Action 4	100%
Immediate & Essential Action 5 **Pathway for care outside of guidelines**	93%
Immediate & Essential Action 6	100%
Immediate & Essential Action 7	100%
Maternity Workforce Planning & NICE **6 monthly board reviews for ALL staff, GAP Analysis**	70%

Milton Keynes current compliance with the initial Ockenden report is above, the expected trajectory for full compliance is May 2022.

Subsequently, the final Ockenden report was released on the 30th of March 2022 and included the review of 1486 cases totalling 1592 clinical incidents.

The findings of the review included identification of 16 themes and 92 individual actions of which 84 are relevant to the maternity service at Milton Keynes.

An initial GAP analysis was conducted to identify the current trust compliance with the final Ockenden report and identify areas for focus and prioritisation, this was completed in collaboration with midwifery, obstetric, neonatal, and anaesthetic input.

An initial briefing was shared at private board in April 2022 to define the current compliance and confirm the position regarding Continuity of Carer which was defined as an immediate requirement in a letter circulated on the 4th April 2022.

This letter was released following the final Ockenden report and detailed the options available to trusts in relation to the provision of Continuity of Carer and the following options were presented:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing CoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of CoC provision.

2. Trusts that cannot meet safe minimum staffing requirements for further roll out of CoC but that can meet the safe minimum staffing requirements for existing CoC provision, should cease further roll out and continue to support at the current level of provision *['2a' – our emphasis]* **or** only provide services to existing women on CoC pathways and suspend new women being booked into CoC provision *['2b' – our emphasis]*.

3. Trusts that cannot meet safe minimum staffing requirements for further roll out of CoC and/or for existing CoC provision, should immediately suspend existing CoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in CoC teams should be safely supported into other areas of maternity provision.

Following review of the current situation at Milton Keynes, the proposed action which was accepted by the executive team was:
Option 2a - maintaining the operation of the current continuity of carer teams, continuing to support the current level of service provision but pause further roll out of CoC teams

Following completion of the GAP analysis against the 84 recommendations it was identified the Maternity Service are:

Compliant with 50 actions

Partially compliant with 27 actions

Non-Compliant with 7 actions

The breakdown of the compliance is detailed below:

Assessment against Ockenden 2 Immediate and Essential Action (IEA)	Fully Compliant	Partially Compliant	Non Compliant
Immediate & Essential Theme 1 – Workforce **4 Actions – 2 for delivery at provider level**	1	1	
Immediate & Essential Theme 2 - Training **7 Actions – 6 for delivery at provider level**	1	2	3
Immediate & Essential Theme 3 – Safe Staffing **10 actions – 10 for delivery at provider level**	7	3	
Immediate & Essential Theme 4 – Escalation & Accountability **5 actions – 5 for delivery at provider level**	4	1	
Immediate & Essential Theme 5 – Clinical Governance & Leadership **7 actions – 7 for delivery at provider level**	5	1	1
Immediate & Essential Theme 6 – Clinical Governance Incident Investigations &Complaints **7 actions – 7 for delivery at provider level**	4	2	1
Immediate & Essential Theme 7 – Learning from Maternal Deaths **3 actions – 2 for delivery at provider level**	2		
Immediate & Essential Theme 8 – MDT Training **7 actions – 7 for delivery at provider level**	5	2	
Immediate & Essential Theme 9 – Complex Antenatal Care **5 actions – 4 for delivery at provider level**	1	3	
Immediate & Essential Theme 10 – Preterm Birth **4 Actions – 4 for delivery at provider level**	3		1
Immediate & Essential Theme 11 – Labour & Birth **6 Actions – 6 for delivery at provider level – 2 not relevant to MK (MLU)**	1	3	
Immediate & Essential Safety Theme 12 – ObstetricAnaesthesia **8 Actions – 7 for delivery at provider level**		6	1
Immediate & Essential Safety Theme 13 – Postnatal Care **4 actions – 4 for delivery at provider level**	2	2	
Immediate & Essential Safety Theme 14 – Bereavement Care **4 actions – 4 for delivery at provider level**	2	2	
Immediate & Essential Safety Theme 15 – Neonatal Care **8 actions – 8 for delivery at provider level**	8		

Immediate & Essential Safety Theme 15 – Neonatal Care **3 actions – 3 for delivery at provider level**	3		

Non-Complient Actions

On initial review of the immediate and essential safety actions there are currently 8 actions which the trust is non-compliant with and is currently reviewing the response to, these include:

Newly Qualified Midwives remaining within a hospital setting for the first-year post qualification

Currently newly qualified midwives at Milton Keynes have a blended programme to enable them to gain a rounded experience and consolidation of learning.

This is supported by the newly appointed retention midwife and the preceptorship package is updated on an annual basis based on feedback directly from the yearly preceptorship co-hort.

There is an option for newly qualified midwives to enter a Continuity of Carer (CoC) team from qualification which has proved popular and been associated with positive feedback as this enables a supportive environment for preceptors to flourish.

CoC teams have a maximum of one preceptor per team to enable adequate support and as part of the programme they gain experience in each clinical area enabling a well-rounded experience.

There is no current plan to change the organisation of the preceptorship programme as a further review involving the NMC and HIE's to understand the evidence base and impact of this change is required.

Over recent years there has been a direct movement away from a model of hospital-based preceptorships to support consolidation of experience and provision of care throughout all settings. There also remains a national requirement for the implementation of CoC as the default pathway of care.

All labour ward co-ordinators attend a fully funded, nationally recognised education module

On review there appears to be one course currently available for labour ward co-ordinators and we have contacted the institution providing this course to organise places to begin the organisation of training.

We have organised contact with one of our HEI providers to explore the potential of developing an in-house co-ordinator course which would receive accreditation from the university and provide credits for those undertaking the course.

A regional discussion has identified a need for a nationally recognised course which would be beneficial to be developed at provider level to ensure provision of the required course elements and the potential options for this course moving forward will be scoped on a national platform.

All trusts develop a core team of senior midwives trained in high dependency maternity care

High dependency (HDU) courses are available for midwives to enable the provision of high dependence care within a maternity setting. These are best utilised in maternity units which have specific high dependency areas or close observation units built into their footprint.

At Milton Keynes we currently have a small co-hort of midwives who have attended the HDU course, however a period of time has elapsed since they completed their training. There is no dedicated environment in maternity to specifically support HDU care provision, therefore a skills and competency review would be required for those staff previously trained.

A review of maintenance of skills is required prior to organising HDU training for further staff to be implemented into the Training Needs Analysis (TNA). Working alongside our education team a review of the options available to enable staff to suitably maintain exposure to skills and competencies required for HDU care provision will take place.

Following this a proposed package will be organised for review and progress through the governance pathway.

A review of the plan for a HDU ad close monitoring environment within the new hospital build is required to understand the staffing establishment needed to successfully organise and support this provision of care.

Each trust requires a patient safety specialist dedicated to maternity services

The Director of Corporate Governance has been contacted regarding this action and a job description for the post has been sourced.

Following review, the proposed job description will be sent to the Director of Corporate Governance for review and approval, following which the funding for the role will be scoped to identify the proposed budget to fund the role.

If required a business case to propose the implementation of the role and proposed funding will be prepared for presentation, alternatively a budget re-allocation process may take place depending on the proposed funding source, with the required approval.

The trust to involve the MVP in developing complaint response processes

An initial meeting to scope the potential involvement of the Maternity Voices Partnership (MVP) within the organisation of complaint responses has been organised.

Following this initial contact, further review with the relevant stakeholders will take place and a proposal for MVP engagement in the complaints process will be developed and progress through the governance processes for approval.

A continuous audit process to review of all IUT's and non-transfer decisions where birth subsequently takes place in the local unit

Review of the exception report which is for mandatory completion and submission to region if a neonate outside of the accepted criteria for the level of neonatal unit at the local unit, is born in the unit. This will involve a review of the circumstances surrounding the clinical situation including the considerations for transfer to an alternative unit.

An electronic file containing details of Intra-Uterine Transfers (IUT) to be implemented and completed at the point of transfer to support a continual data collection facilitating an audit process of all IUT's.

Obstetric anaesthetic – role of consultants, SAS & training doctors in service provision and prospective cover

Previously 100% consultant anaesthetist cover was available on labour ward, this has recently dropped to approximately 80% and is potentially a result of an increased sickness absence related to COVID.

The lead obstetric anaesthetist is reviewing the organisation of staff and has identified a potential requirement for further anaesthetic staff to enable the continuous service provision.

A business case requires completion to detail the required increase of staff within the obstetric anaesthetic service, which will then be submitted for approval through the appropriate pathway.

Plan

The compliance with the Immediate and Essential Actions (IEA) following the initial and final Ockenden reports will continue to be monitored through the governance structure and escalated as required.

Financial Implications

There are several actions which will require financial investment to achieve compliance with the Final Ockenden report Immediate and Essential Safety Actions.

A financial implication to the achievement of the action is required for 7 actions, these include:

Workforce

Midwifery uplift to be re-calculated to include the previous 3 years sickness absence %, mandatory training %, annual leave % and maternity leave. This will result in an increase in the % headroom applied to each member of staff, requiring an increase in funded establishment.

Training

All labour ward co-ordinators are required to attend a fully funded specific training programme which will require funding for the programme of study, paid study leave to attend and backfill to ensure maintenance of labour ward co-ordinator cover for the service.

A core team of senior midwives trained in high dependency care is to be developed, which requires attendance at a specific training programme. This will require funding for the programme of study, paid study leave to attend, backfill to ensure maintenance of labour ward co-ordinator cover for the service and a funded annual update programme to maintain skills and competencies.

Safe Staffing

A risk assessment in trusts with no separate Obstetric & Gynaecology rota is required to be escalated to board level and if a decision is taken to implement this, funding will be required for an increase in consultant posts to support implementation.

Clinical Governance & Leadership

Every trust must ensure they have a patient safety specialist specifically dedicated to maternity, which will require funding to support implementation of this role within the midwifery establishment.

All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to engage in their responsibilities, which may require allocation of increased PA's and therefore an increase in consultants to support which will require funding to support. Currently we are not compliant with the maternity self-assessment requirement for PA's associated with roles and responsibilities. There is a current review with the RCOG to identify the expectation for allocation of PA's, the outcome of which is awaited.

Obstetric Anaesthetic Staffing

An increase in obstetric anaesthetic staff has been identified to support compliance with 100% service provision, which will require additional funding for increased consultant roles.

Milton Keynes Hospital NHS
NHS Foundation Trust

Meeting title	Trust Board (public)	5 May 2022
Report title:	Incident and Learning Report	Agenda item: 9
Lead director **Report author** **Sponsor(s)**	Kate Jarman/ Ian Reckless Tina Worth	DoCA/ Medical Director 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 Group is asked to note the contents of the report			

Strategic objectives links	Refer to main objective and link to others 1. Improve Patient Safety 3. Improve Clinical Effectiveness 4. Deliver Key Targets 7. Become Well-Governed and Financially Viable
Board Assurance Framework links	Lack of learning from incidents is a key risk identified on the BAF
CQC outcome/ regulation links	This report relates to: This report relates to CQC: Regulation 12 – Safe care & treatment Regulation 17 – Good governance Regulation 20 – Duty of Candour
Identified risks and risk management actions	Lack of learning from incidents is a key risk identified on the BAF
Resource implications	Breaches in respect of SI submission 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	Trends in graphical format

Serious Incident Report March & April 2022

There were 18 new SIs reported on STEIS in March and April 2022 (up to 25/4/22). See table below.

STEIS number	Category	Location	Details
2022/4485	Patient fall	Ward 14	Fractured neck of femur sustained
2022/4487	Medication incident	Ward 20	Patient received multiple medications prescribed on to his drug chart which were not his regular medications for several days before error was recognised
2022/4490	Patient fall	Ward 19	Impacted displaced fracture of the neck femur sustained
2022/4977	New pressure ulcer	Ward 1	Deep tissue injury (DTI) to heel
2022/4981	Medication incident	Pharmacy	Patient started on allopurinol for prophylaxis of gout. Historically they were also taking Azathioprine. This interaction was not identified by the ward pharmacist or the medical team. Patient readmitted with pancytopaenia and thrombocytopenia
2022/6166	Medication incident	Ward 4	Time critical medication to be administered to patient to stop seizure activity delayed as unable to access ecare for approximately 30 minutes
2022/6169	Medication incident	Ward 5	Ward gave expired spironolactone for a baby on discharge and provided mix strengths which led to mum administering 10 times lower dose for a number of days
2022/6172	New pressure ulcer	Ward 22	DTI to sacrum
2022/6532	New pressure ulcer	Ward 1	DTI to heel
2022/6533	New pressure ulcer	Ward 1	DTI to heel
2022/6534	New pressure ulcer	Ward 8	DTI to heel
2022/6536	New pressure ulcer	Theatres	DTI from a wrist plaster cast
2022/6537	New pressure ulcer	Ward 23	DTI to heel
2022/6990	New pressure ulcer	Ward 1	DTI to heel
2022/7641	New pressure ulcer	Ward 22	DTI to heel
2020/7632	Still birth	Labour Ward	38+4 weeks. Accepted by the Healthcare Safety Investigation Branch (HSIB) for external investigation
2022/7900	New pressure ulcer	Ward 8	DTI to heel
2022/7910	New pressure ulcer	Ward 8	DTI to heel

Trends/ Areas to Highlight

- **Paediatrics -** Risk summit approach to Paediatrics (Wards 4/5) with regards to medication incidents (SIs and on SIs) with process mapping of administration to best identify any learning

- **Deep Tissue Injuries -** 9 out of 10 cases reviewed (February to March 2022) patients were over the age of 75 years; two patients did not have mental capacity and a further patient deemed to have fluctuating capacity; all patients had multiple co-morbidities and risk factors; two patients had documented significant long lies prior to hospital admission; two patients were COVID positive during admission

  Learning themes:

  - Accuracy of waterlow assessment
  - Early validation and escalation of pressure damage
  - Timely and accurate implementation of preventative interventions

  Recommendations:

  - Holistic review of patient to identify all risk factors that may contribute to susceptibility of pressure damage
  - Information sharing of patient risk factors identified by spectrum of health professionals to be evidenced within patient assessment completion on eCare
  - Clear ward escalation process developed and shared with teams
  - Senior ward leader/Matron daily/weekly quality rounds
  - Collaboration with community partners and ambulance service contributing to holistic assessment of patient
  - Deep dive using QI methodology to review DTI incidents on ward 1
  - Workstreams to be progressed through Harm Prevention Group
  - Governance framework of Harm Prevention Group to be aligned under Patient Safety Board for quarterly reporting
  - Introduction of new bed management process
  - Training videos to promote utilization of bed profiling functions

A detailed deep dive report into DTIs will be presented at the next Quality and Clinical Risk Committee. An exception meeting to discuss action and learning to prevent DTIs was held between executive and non-executive members of the Board in April 2022.

Brief Overview of Appreciative Inquiry work (April 20221-

Embedding the CLEAR (Capturing Learning from Everyday Experience) Pathway

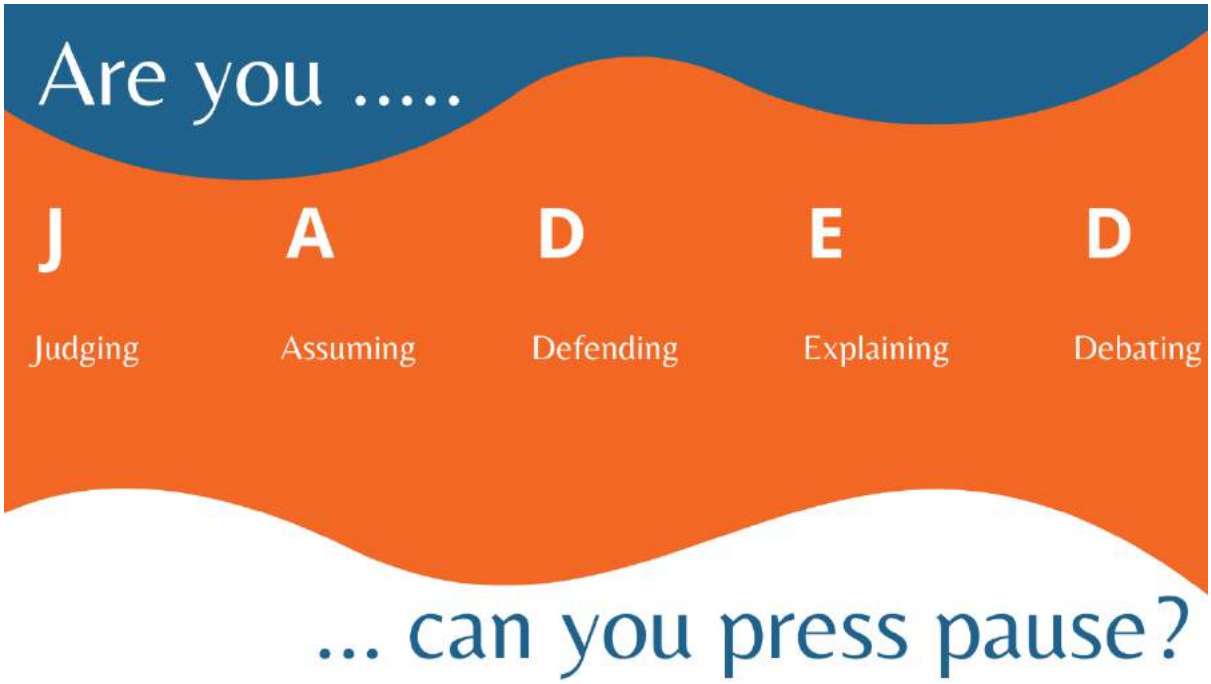
The Appreciative Inquiry team worked with 32 staff at a one-day workshops to develop skills in working with the CLEAR pathway. A range of people attended including clinical governance, research, patient experience, clinical staff. Eight of these staff were new to appreciative inquiry approach.

Introduction to self-reflective process for responding to complaints and concerns using appreciative inquiry

The Appreciative Inquiry team worked with 32 staff to introduce reflective process for responding to complaints and concerns. Captured refinements needed for resource. There is the potential to do more of these sessions.

A key finding from working with this group was that concerns and complaints is a very emotive subject that can result in responses that fall under what we call JADED (see below). Inviting people to pause and turn to curiosity. Curiosity not just about the facts but how they

themselves are feeling, how they would like to respond, who might support them. Staff acknowledged that they were not used to reflecting on themselves in this process.

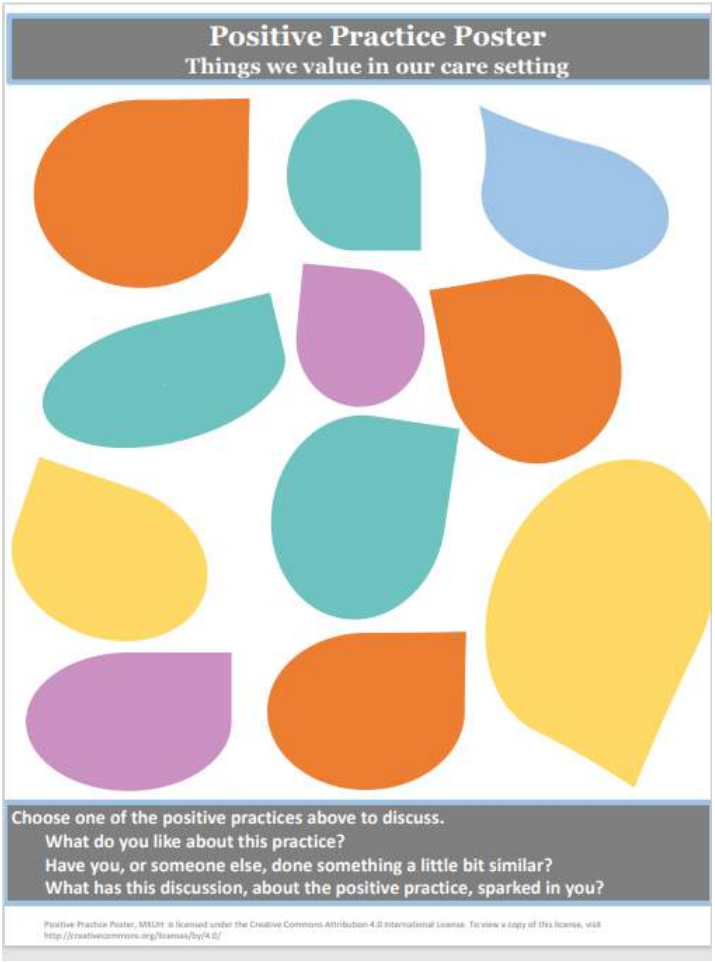


Maternity Voices Induction and Development

The Appreciative Inquiry team worked with Midwifery consultants to develop a plan to introduce a new induction programme with the Maternity Voices Partnership to enable them to have some knowledge of caring conversations in their interactions. The induction programme has already been piloted with patients, volunteers and patient safety partners.

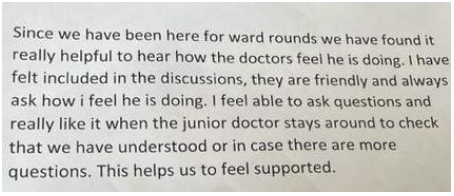
Working with GREATix Leads

There is a plan to run a short two-hour session about CLEAR pathway in September and eight one-hour in practice sessions.
We are also working on GREATix reporting to include aspects of the CLEAR pathway to help have discussions with teams about good practice.



In Practice Work with Neonatal Unit

Fiona Cook spent a day working with staff in the Neonatal Unit. She supported them to work through the CLEAR pathway and had discussions that resulted in new actions with junior doctor, staff nurses, nursery nurses and practice educators. For example:
We chose a snippet from the original story to use in a LIFE (Learning and Innovating from Everyday Experience) session. We used the following four questions to frame our responses in rounds. (1) What is there to celebrate in this story? (2) What are we wondering? Based on the discussion experienced from the first two questions, we then discussed (3) What are we hoping for moving forward and (4) What one small thing might we be doing, asking or thinking about as a consequence of the discussion?


Since we have been here for ward rounds we have found it really helpful to hear how the doctors feel he is doing. I have felt included in the discussions, they are friendly and always ask how i feel he is doing. I feel able to ask questions and really like it when the junior doctor stays around to check that we have understood or in case there are more questions. This helps us to feel supported.

There were many things to celebrate such as: the family being involved in discussions, the doctors saying how they feel the patient is doing and asking the parents what they were feeling about their son and the junior doctors staying behind to check understanding. The process has been documented by the Sister in NNU. At the end, everyone had a small action they were taking away including the junior doctor who had no idea how much the parents appreciated them staying behind and as a consequence resolved to be more intentional about doing this.

Commenced Action Learning Sets

16 people have been recruited for these six action learning sets across seven months. The sets will run as two groups. Very positive feedback from first session that took place week of 14th April.

Worked with Patient Experience Team

This work involved supporting the patient experience team to weave appreciative inquiry into all aspects and activity. Examples include:

- Development of postcards to go to all areas – a different one each day – where a story about patient/family/staff experience is illustrated with questions to open up discussions about learning from these stories.
- Development of resource based on the AEIOU of appreciative noticing. Each day of patient experience week a question related to enhancing the patient experience will go on the intranet each day such as the one detailed below.

We noticed patients and their families are calmer when the environment is quiet. We learnt that a member of staff takes care to talk calmly in low volume, not rush about even when busy and move unnecessary equipment to create more open spaces.

How do we find out what matters to each of us in relation to the ideal environment?

When the busyness of the place brings noise, what small actions can make a difference?

A lady was quite upset about visiting her husband in hospital. We noticed that the Security Guard at the front desk took the time to comfort her, walk her to the ward and introduce her to the staff.

What helps you to connect with others and notice how they are in the hospital environment?

THE A,E,I,O,U OF APPRECIATIVE OBSERVATION

TO BE ON THE LOOKOUT FOR AND NOTICE AN:

ACTION EXPERIENCE INTERACTION OUTCOME

THAT MOVES U AND/OR CREATES CURIOSITY

Future Programme

The AI work will be formally launched in June as part of the Quality Improvement Strategy.

Meeting title	Trust Board	Date: 13 April 2022
Report title:	Trust wide report – Q3 2021/22 Patient and Family Experience Report	Agenda item: 10
Lead director **Report author** **Sponsor(s)**	Nicky Burns Muir Julie Goodman	Director of Patient Care and Chief Nurse Head of Patient and Family Experience
FoI status:	Public document	

Report summary	This report provides a quarterly overview of patient experience, engagement and feedback across the Trust and actions taken to improve patient and family experience.				
Purpose *(tick one box only)*	**Information**	**Approval**	**To note**	x	**Decision**
Recommendation	The Group is asked to note the contents of the report				

Strategic objectives links	Improving patient experience with a link to: • Improving patient safety • Improving clinical effectiveness • Delivering key performance targets • Being well governed • Being innovative
Board Assurance Framework links	Lack of improvement in patient surveys is a key risk identified on the BAF
CQC outcome/ regulation links	This report relates to CQC standards: Person-centered care Good Governance Duty of candour
Identified risks and risk management actions	None
Resource implications	None
Legal implications including equality and diversity assessment	None

Report history	Trust Executive Committee April 2022
Next steps	N/A

1. Introduction and purpose

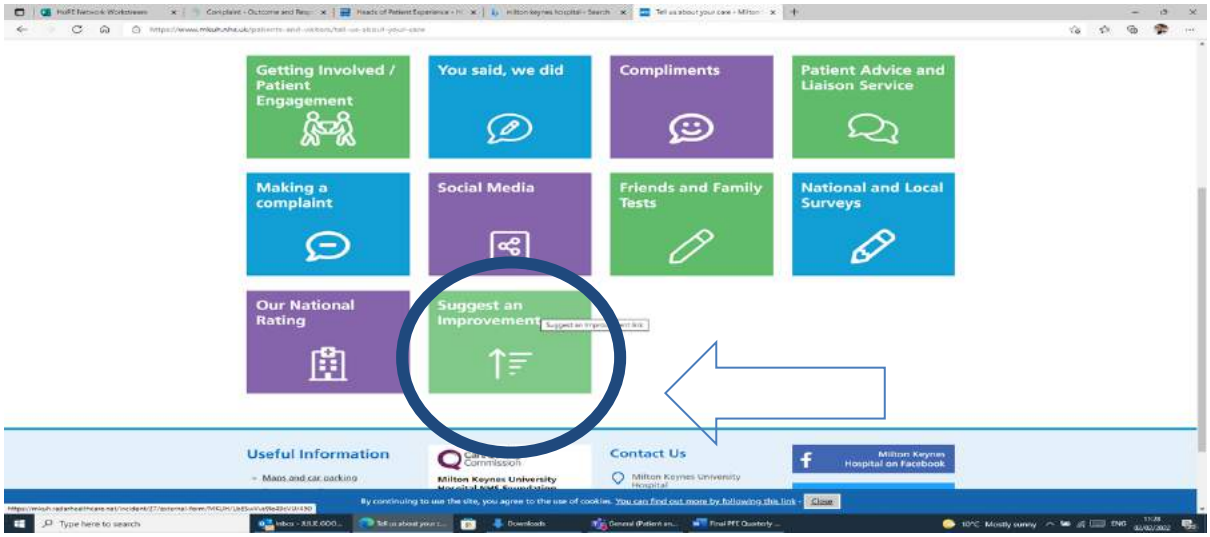
This report details the Trust's overall position regarding patient and family experience feedback and engagement activity for Q2 2021/22.

The purpose of this report is to inform the Trust of feedback received from our patients and their families through a variety of feedback mechanisms. The aim is to identify areas of good practice and areas that require support to improve their patient and family experience.

2. Achievements of the Patient and Family Experience team

'You Said, We Did' pages on the Trust Website

Towards the end the quarter the web pages were enhanced with an option for patients and families to share their suggestions. The tab is indicated on the picture below.



Compliment Project

The following individuals and teams received recognition for compliments received during the quarter.

MONTH	INDIVIDUAL COMPLIMENT	TEAM COMPLIMENT
OCTOBER 2021	Sharon Tingling, Patient Pathway Co-ordinator For being very professional and helpful and being compassionate and hard working.	Ward 24. For the kindness and care shown by the all staff. The quality of food and the cleanliness of the ward.
NOVEMBER 2021	Dr Pru Evans For her communication skills in explain everything in detail and in terms that the patient could understand.	Endoscopy For being highly professional and positive, and kind and caring for people with dignity and respect.

DECEMBER 2021	Wayne Skillen For being efficient and action as a good example to others.	Domestic team For helping patients find their way round the hospital without being asked to.

Collaborative working

The Matron for Patient and Family Experience has worked collaboratively with the Patient Safety Team using Appreciative Inquiry (AI) to explore Serious Incidents, time critical medication and recruiting patient safety volunteers.

The Time Critical medication project specifically involved the Pharmacy team and looked at Parkinson's medication. Using AI methods. feedback was gained from patients, their families, and carers in respect of taking a time critical medication and how it felt coming into hospital. Feedback was also gained from medical and nursing staff regarding prescribing and administering time critical medication. As a result, changes in practice have been put in place such as notes for prescribing on eCare, and availability of medication out of hours was reviewed and has resulted in an improvement in patient experience.

Action undertaken:

- Guidelines were developed for Parkinson's Disease (PD) management in nil by mouth or dysphagic patients – link added to eCARE alert for ease of access for doctors and pharmacists.
- Re-naming of Parkinson's medications on eCARE – examples of brands added to generic names to aid prescribing.
- Collaboration with MK community team to obtain list of patients and match with eCARE - Parkinson's Disease added as a 'Diagnosis' on eCARE to generate alerts and prioritise.
- Medicines Reconciliation Priority Alert now generate on eCARE for Pharmacy staff.
- PD medicines reconciliation alert added to eCARE for doctors and pharmacist to direct them to sources of support.
- Changes to eCARE default administration times for PD medications to meet the needs of most patients.

Actions in Progress:

- 'Parkinson's Bleep' for ED and Acute Medicine is being implemented to provide escalation route to Pharmacy to see patients urgently, collaborate with doctors and nurses to reconcile medicines and ensure timely and accurate administration.

- PD PowerPlan to be developed to include guidelines and other sources of support
- PD Clocks and other tools purchased from national support networks and will be put in place with engagements of nurses and doctors to ensure timely prescribing and administration.
- Sessions for ED – 'you said, we did' – planned to start end of February to raise awareness and assure staff that their views have been heard and acted upon

Future steps:

- Consideration of developing a PD specialist nurse role
- Self-Administration of Medicines policy development to empower patients
- Review and improve investigations of PD related incidents including the format of reports to SIRG.

Matrons Group

During this quarter, the Matron for Family and Patient Experience has acted as chairperson for the weekly Matrons meeting as the workstreams being explored were in relation to patient experience. The patient experience workstreams were:

Communication - a Standard Operating procedure will be implemented on all wards to improve communication with patients and their relatives or carers. This includes supporting the wards to set a communication standard and the effectiveness of this standard will be audited.

Listening – feedback received has highlighted that improvements are required regarding pathways for those patients attending the ED who have a learning disability and/or Autism. An ongoing project within the ED will be looking at promoting individualised care and making reasonable adjustments to improve care

3. Patient Experience data

Friends and Family Test (FFT)

During quarter 3, the use of SMS messaging, to gain the feedback of patients from the FFT, has been rolled out across all outpatient areas following the successful trial in Trauma and Orthopaedics outpatients during September 2021 (https://miltonkeynesuniversityhospital.newsweaver.com/vu32b0k3xk/1cohk6hgw1yor5srm7wl1v?email=true&lang=en&a=1&p=789530&t=197150).

The SMS messages are sent using the MyCare App. The success of this further roll out is demonstrated on the table below.

The table below details a comparison of the number of FFT responses received across the Trust for Q1, Q2 and Q3 2021/22.

Q1 2021/22	Total number of responses	Q2 2021/22	Total number of responses	Q3 2021/22	Total number of responses
April	795	July	1190	October	4855
May	1108	August	1078	November	6674

June	1234	September	1332	December	4970
TOTAL	**3137**	**TOTAL**	**3600**	**TOTAL**	**16499**

In Q3 2021/22, 93% of responses rated the Trust's services as very good or good.

Developments

Using FFT feedback, from December 2021 onwards, two posters are created by the Patient and Family Engagement team, on a bi-monthly basis. The first poster details how each area has been rated by their patients regarding the FFT categories of:

'Very Good, Good, Neither Good nor Poor, Poor and Very Poor'

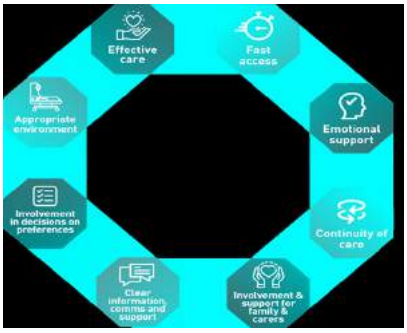
The second and new poster includes detail on some of the comments, both positive and negative, which have been made about that area.

Patient Experience Platform (PEP Health)

Since December 2021, the Trust have been working in collaboration with PEP Health, a company who specialise in analysing free text comments made through FFT, online platforms and social media sites. PEP Health use cutting-edge technology to give healthcare organisations actionable insights that are needed to have a direct and dramatic impact on patient experiences.

How does the platform work?

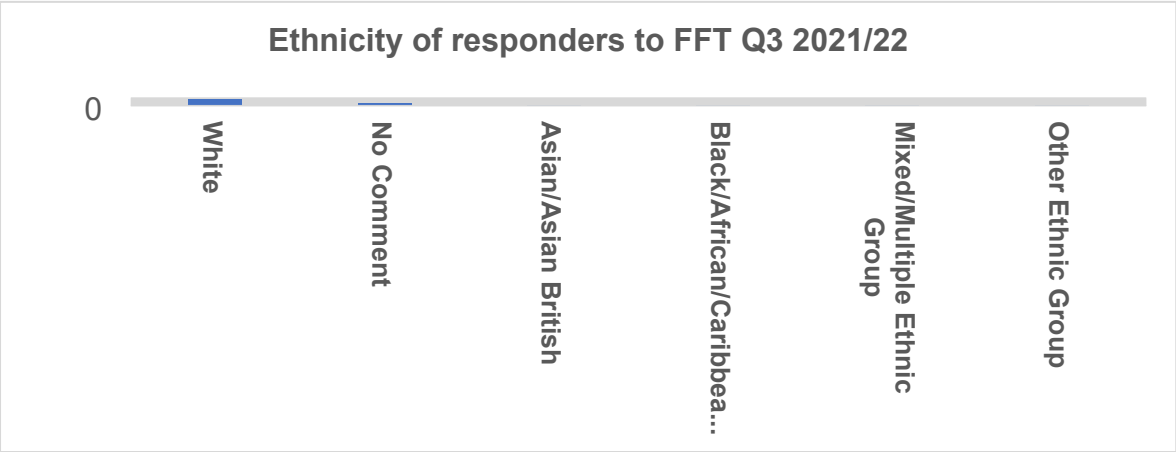
The free text comments are analysed per service and themed using 8 quality care principles as demonstrated below.



The PEP platform dashboard is accessible to all senior staff within the Trust and those staff will have received log on details directly from PEP Health. PEP Health have presented at divisional and Matron matron meetings to demonstrate the functions of the platform and how individuals can obtain up to date information regarding their specific areas of responsbility. The presentation has been recorded and available to all staff on request. On the dashboard there is also a 'help' function which explains how to get the best from the dashboard.https://www.pephealth-dashboard.ai/dashboard-manual-dec2021.pdf . A part of the dashboard is shown below.:

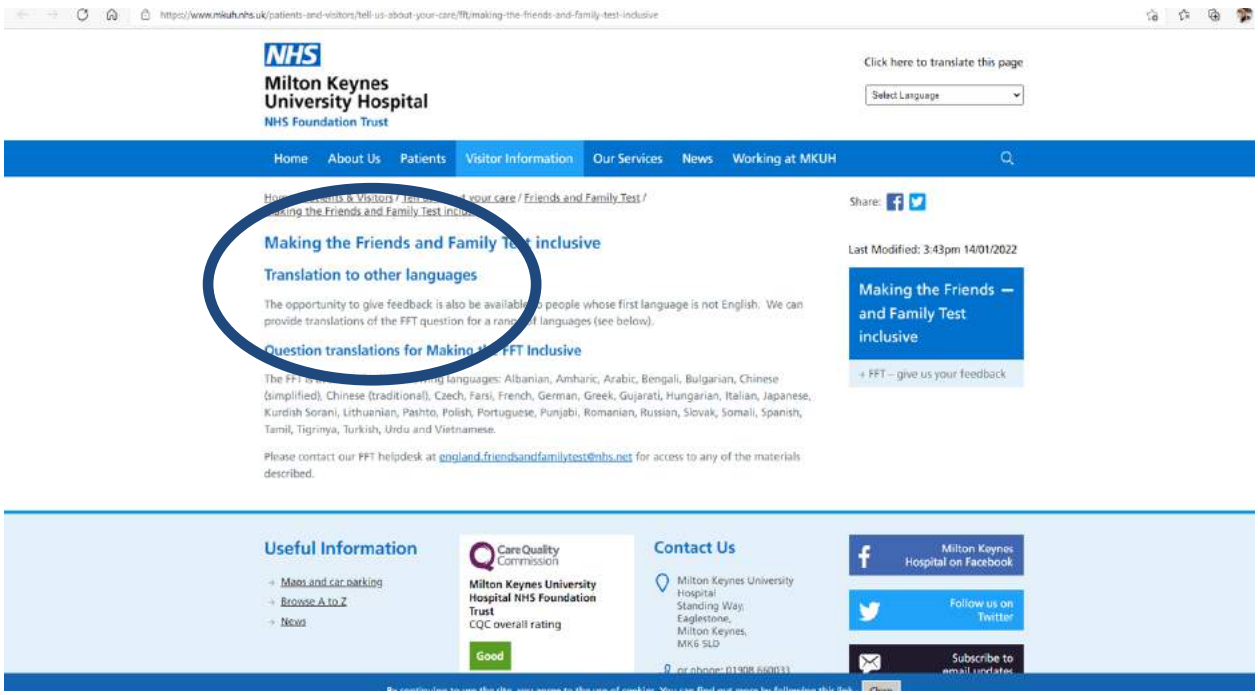
FFT- Ethnicity

The chart below details the ethnicty of those responding to the FFT, where stated.



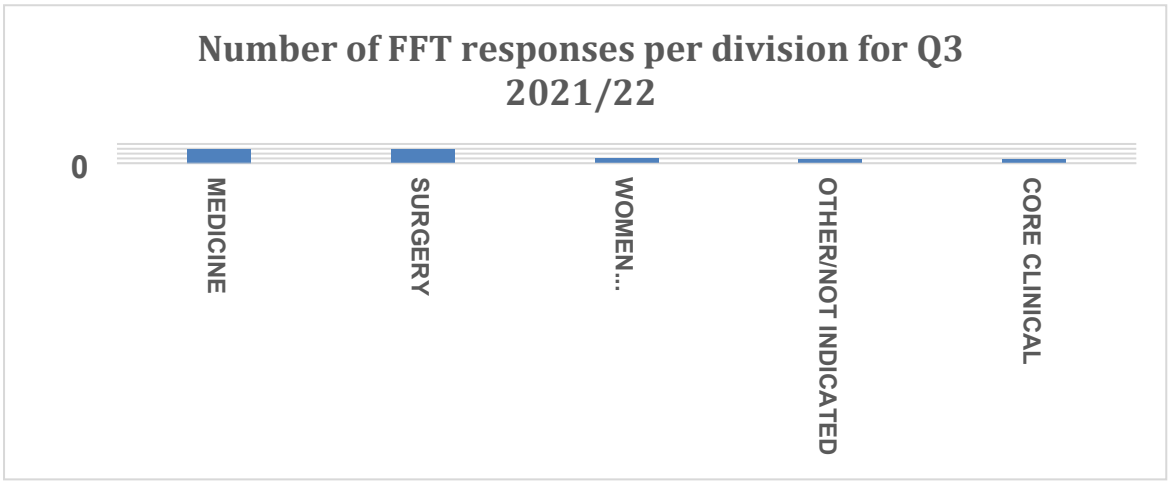
The focus for 2021/22 and into 2022/23 is to work with the Trust's Equality Diversity and Inclusion Leads to scope how the Trust can engage further with patients from ethnic minorities to obtain their valuable feedback.

The Tell Us About Your Care website pages have also been improved with regard to providing information on how to get the FFT form in a different language, if required. The availability of information on FFT in different languages and Braille is the Patient and Family Engagement team's focus for the next 6 months.



Divisonal FFT responses

The chart below deails the number of FFT responses per divison for Q3 2021/22.



FFT care principles

During Q3, the overall rating for the Trust in relation to positive comments from FFT feedback was 4.6* out of 5*.

The dashboard indicates an improvement in feedback for the following domains during this quarter:

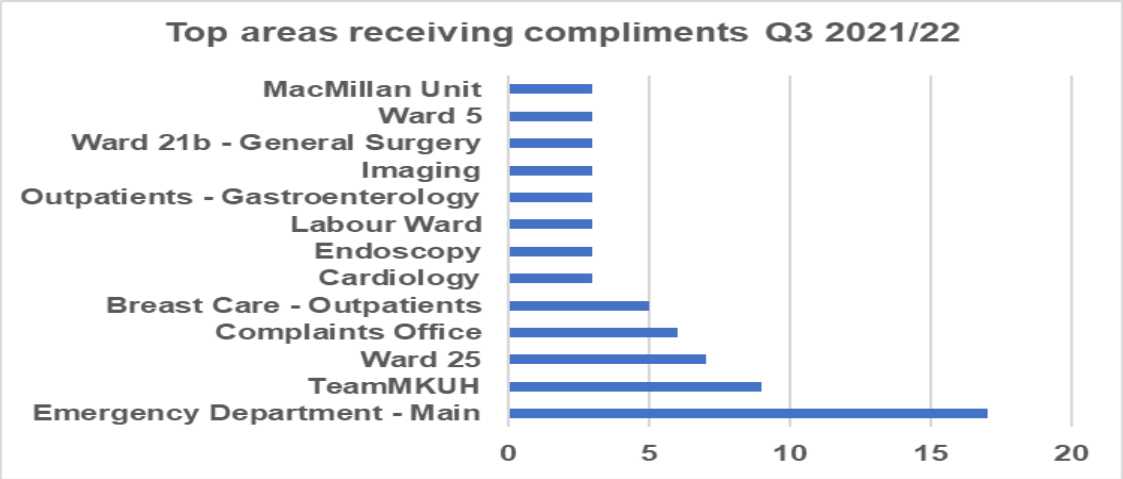
Fast access, involvement in decisions and invovlement of families.

The best perfroming units were:

Infectious diseases, neonates, paediatrics, endoscopy and physiotherapy.

Compliments

During Q3, the Trust received 122 compliments as detailed in the graph below.



Surveys

National

The 2021 Adult Inpatient patient sample will be extracted during December 2021. The survey field work will take place during January to May 2022 with results being received after this time.

The 2021 Maternity Survey patient sample will take place in March 2022. The survey field work will take place during April to August 2022 with results being received after this time.

4. Patient Experience and Engagement Activity

Volunteers

Work in ongoing to ensure the safe return of existing volunteers and consideration is being given developing bespoke roles for volunteers to support the ward staff to improve the experience of our patients.

A volunteer software package has been commissioned and currently the Volunteer team are currently receiving the training required to ensure the system is able to go live in Q4 2021/22. The software will ensure that the recruitment of volunteers into bespoke roles will be much easier and will improve communication with the volunteers and manage their individual training needs.

Bereavement

The Bereavement team have dealt with 309 deaths in Q3 2021/22 compared to 241 in Q2 2021/22. During this quarter 65 (21%) cases were referred to the coroner compared to 48 in Q2 2021/22.

During Q3, a second Medical Examiner Officer (MEO) joined the team.

The adult and child policies and leaflets have been reviewed.

Chaplaincy

During Q3, the Chaplaincy team continued to provide support to all areas across the hospital with 1160 patient contacts and 396 staff contacts.

In November 2021, a new Team Chaplain, Ali Facey, started in post. This appointment was as a result of a new partnership with Willen Hospice, providing Spiritual Care services for Willen's patients enabling better continuity of care and standardisation of services across our organisations.

During Interfaith week the team hosted an exhibition of work from pupils at Denbigh School in Bletchley. The pupils were tasked to produce work which reflected on the impact of their beliefs on their life, as well as reflecting on the impact of Climate change.

At the end of November, the team spent two weeks working with Ward 7 to trial the spiritual care box resources. The ward team were incredibly welcoming and hospitable as well and being engaged and curious. Four activities[1] were trialed with patients, after

[1] 1. Choosing a postcard and talking about why it appealed to you and seeing where the conversation led. 2. Using an ink pad to create a handprint and talking about 'what makes me unique'. 3. Using essential oils to explore the power of smell to relax and remind us of things. 4. Using sweets to reflect on 'what makes life sweet'.

gaining consent each time for undertaking the activity. After the activity the patient was asked to reflect on how helpful their experience had been, whether they felt there were any obstacles to participation and whether it had led to a meaningful conversation.

The team reflected that the activities were a stepping-stone to meaningful conversation, particularly with those who might have said that chaplaincy was not for

5. Governance and learning

Patient Experience Board

Due to a change in governance, the Board now meets monthly with set foci for each meeting in a 3 monthly cycle. The foci are:

Focus Group A - Governance
Focus Group B - Feedback
Focus Group C - Divisional Learning

Focus group A took place in October 2021, however, due to Opel 4 status within the Trust only chairman's business was heard. The meeting was attended by the Chief Nurse, the Associate Chief Nurse, and the Head of Patient and Family Experience.

Focus Group B met in November 2021 and was well attended. The agenda included a presentation by PEP Health, a patient story from the Head of Chaplaincy and Bereavement, updates on complaints and PALS; volunteer services; perfect ward; a FFT update and a presentation on the use of AI (Appreciative Inquiry) in theatres to gain feedback from patients.

6. Conclusion

There is much to celebrate during this quarter with the improvements that have been made regarding gaining valuable feedback from our patients and their families. The increase in the number of free text comments and the ability to theme these by area and division through the PEP Health platform will enhance learning and outcome from feedback across the Trust. Responsible staff are now able to see their area's feedback on an almost 'live' basis and take action/share learning accordingly in as near to real time as possible.

Meeting title	Board of Directors	**Date:** May 5th 2022
Report title:	Nursing Staffing Report	**Agenda item: 11**
Lead director **Report author** **Sponsor(s)**	**Name:** Nicky Burns-Muir **Name:** Matthew Sandham Emma Thorne	**Title:** Director of Patient Care/Chief Nurse **Title:** Associate Chief Nurse Workforce Matron
FoI status:		

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

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

Report history	To every Public Board
Next steps	
Appendices	Appendices 1

Board of Directors Report on Nursing and Midwifery staffing levels
Amalgamated report for February 2022 and March 2022

Are we safe ?

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
February	13711	4.2	2.6	6.8
March	14989	4.2	2.7	6.9

Month	**RN/RM Day % Fill Rate**	**HCA/MCA Day % Fill Rate**	**RN/RM Night % Fill Rate**	**HCA/MCA Night % Fill Rate**
February	70.6%	74.3%	100.7%	110.6%
March	71.7%	77.6%	101.0%	110.4%

- *February 2022 and March 2022 data are included in Appendix 1.*

Areas with notable fill rates

During the month of March the Trust saw a continued rise in attendance which has affected the CHPPD hours in the month. The Day % fill rate has improved also improved in March.

3. Recruitment Overview

Table below shows the latest Trusts unfilled vacancies across Nursing and Midwifery.

Division	B2 HCSW	B5 Staff Nurse	B6 Sister/Charge Nurse
Medicine	13.78	38	4
Surgery	18.5	14.81	11
Paediatrics	0	16	4.46
Maternity	0		12.7 Midwives
Total	32.28	68.8	19.46 (excluding midwives) 32.16 (including midwife vacancies)

NB: Numbers do not include the international nurse recruits.

Please note that there is a current hold on outpatient staff nurses within the Surgical Division while a workforce review is being undertaken. This equates to 4.32WTE.

The noted increase in HCA vacancies across Surgery is a result of an approved business case following the reconfiguration of Ward 21 and Ward 24.

4. Recruitment

4.1 Student Nurses to Staff Nurse Initiative

MKUH continues to offer Student Nurse undertaking their final 'sign off placement' with us the opportunity of pursuing employment with us as an organisation. The aim of the initiative is to ensure that MKUH is the students first choice of employment.

In March 2022, seven students were offered positions here at MKUH.

Table 3: Further planned Student Nurse Workshop

	Date	Number of Students
Paediatric Student Nurses	Friday 29th April 2022	11
Adult Student Nurses	Monday 6th June 2022	21

This initiative continues to provide a supply of newly registered nurses, familiar with our organisation three times a year.

4.2 Student Nurse Bank HCA opportunities

To optimise the Bank HCA workforce a process has been introduced to ensure that the Student Nurse workforce are offered the opportunity to earn while undertaking their studies.

The proactive process entails students being provided with fast-track link to join three times a year should they wish to pursue this opportunity. Outside of this time students will be directed to recruitment for processing.

4.3 International Nurse Recruitment

The Trust has now Interviewed and offered 108 International Nurses employment with us here at Milton Keynes University Hospital NHS Trust.

As outlined in previous reports the aim of the MKUH International recruitment programme is to recruit 125 nurses throughout 2022 to support current vacancies and hospital developments.

To date:

- 108 nurses have been interviewed and offered employment with the Trust subject to satisfactory pre-employment checks.
- 94 Nurses have accepted out employment offer.
- 52 have commenced in the Trust.
- Nurses continue to arrive in Cohorts of 16, every 4 weeks. Our latest Cohort (Cohort 4) arrived on Thursday 21st April 2021 with the 5th Cohort scheduled for the 19th May 2022.
- Nurses receive a bespoke induction programme and 'host ward' for their first three months, (alongside 3 of their peers) to allow for training & education, supervision, and peer support while they prepare for their OSCE examination and adjust to life in the United Kingdom.
- Interviews are being held monthly, with the next scheduled for the 6th of May 2022.
- The international nurse recruitment programme has also allowed for us to work with departments that have traditionally been difficult to recruit into, for example Theatres. 5 experienced Theatre Nurses have been offered employment and further focused interviews have been set for June 2022.
- Divisional Chief Nurses have commenced an allocation process, assigning nurses to vacancies across the Trust.

Table 1. Provides an overview of the International Nurse Recruitment Programme to date.

Stage	Element	Total
	Interviewed	113
	Offered To Date	108
	Declined Offer	14
	Accepted	94
	Started	52
	Currently Active	42

Table 2. Provides an overview of each Cohort.

Cohort	Stage of	Number of Nurses
1	Completed OSCE training. Awaiting OSCE	8
2	Completed OSCE training, Awaiting OSCE	14
3	Undertaking OSCE Training	20
4	On Induction	11
5	Commence on the 23rd May 2022.	tbc

Nurses in Cohort 1 and 2 are beginning to receive their NMC Test of Competence OSCE examination dates. Reshma Vaniya (Cohort 1), currently based on Ward 23 is our first international nurse to have successfully passed her OSCE examination.

Securing OSCE dates has been challenging due to the rise of International Nurse recruitment across Engalnd. In April/May two further test centres are due to open in Leeds and Northumbria and it is anticipated that the wait for OSCE dates will reduce as bookings open.

The Divisional Chief Nurses are leading on the allocation of International Nurses to vacancies across the organisation. Part of the devised process involves a career conversation to ensure, where possible, that the nurses existing skill set, and previous experience is acknowledged when allocating nurses to permanent wards/departments.

More experienced nurses are being offered bespoke training days to support undertaking a more senior role in the organisation which is supported by the Chief Nurse BAME Fellows and practice education team.

Are we effective?

5.0 MKUH Reservists

In view of significant operational pressures and increased staff sickness absence the Trust decided in March to mobilise the 'MKUH Reservists' to support ward teams and patients.

Reservists were asked to undertake one of two roles: Patient Care and Comfort or Ward support. A total of 19 staff volunteered to undertake the reservist roles, (mainly staff in non-patient facing administration roles), to support during busy ward periods and support during the mealtime service.

For familiarity and consistency, reservists were allocated to wards they had worked previously as part of the reservist scheme. The reservists were very well received and supported by all departments and their contribution to the wards at such a challenging time was invaluable.

6.0 SafeCare

For corporate nursing the implementation of the SafeCare system remains the objective for the year ahead. As previously explained the SafeCare 'system' allows organisations to compare their staffing with the actual acuity/dependency of its patients.

An external review undertaken in November by BLMK Workforce Lead highlighted that there was need for further education and need for accurate validation of data entry. As we return to business as usual the nursing workforce will refocus on SafeCare over the next quarter.

We celebrate.

Angela Legate, Associate Chief Nurse IPC has been selected from BLMK to attend a Buckingham Palace Garden Party in May.

Recent movement in the senior nursing team has seen the appointment five BAME Ward Managers and a focused programme is being developed to support development in these roles alongside the MK Way leadership course.

We welcomed Ben Jagger the role of Adult Safeguarding Lead Nurse and he brings extensive mental health expertise having moved across from the CNWL Psychiatric Liaison Team.

Nursing, Midwifery and Care Staff February 2022 (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	60.5%	79.8%	101.4%	103.0%	575	6.0	2.3	8.3
ICU	67.2%	23.3%	79.9%	-	162	26.5	0.4	26.9
Ward 2	63.3%	79.0%	95.5%	114.3%	675	3.7	2.5	6.2
NNU	78.6%	83.5%	95.2%	110.7%	385	10.0	1.8	11.8
Ward 14	71.1%	93.3%	99.2%	120.1%	782	2.4	2.9	5.2
Ward 10								
Ward 15	79.0%	74.2%	101.3%	105.4%	714	3.8	2.2	6.0
Ward 16	72.7%	78.1%	98.4%	117.6%	766	3.6	2.2	5.8
Ward 17	70.8%	79.6%	98.5%	121.4%	715	4.0	2.0	6.0
Ward 18	74.6%	64.9%	109.6%	128.5%	737	3.2	3.1	6.2
Ward 19	86.1%	75.9%	136.5%	128.3%	824	3.3	3.0	6.3
Ward 20	76.2%	82.7%	131.2%	109.9%	688	4.1	2.5	6.5
Ward 21	77.8%	79.9%	111.4%	107.0%	635	4.2	2.1	6.3
Ward 22	84.9%	55.4%	135.5%	105.1%	448	5.9	4.2	10.1
Ward 23	74.3%	86.3%	103.7%	110.0%	1030	3.1	3.4	6.5
Ward 24	58.5%	53.6%	97.7%	74.0%	684	3.2	2.0	5.2
Ward 3	68.9%	69.7%	109.6%	111.9%	874	2.5	2.5	5.1
Ward 5	71.7%	73.2%	105.5%	171.0%	464	6.9	2.4	9.3
Ward 7	76.5%	78.2%	100.0%	107.1%	650	3.6	3.5	7.1
Ward 8	68.7%	71.5%	104.8%	117.8%	393	5.4	4.1	9.5
Ward 9	56.0%	82.3%	61.6%	88.8%	955	2.2	1.9	4.1
Ward 25	57.2%	71.1%	96.8%	101.6%	555	3.9	3.0	6.9

Nursing, Midwifery and Care Staff March 2022(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	60.2%	99.6%	99.9%	93.5%	677	5.8	2.3	8.1
ICU	69.5%	80.1%	85.7%	-	210	23.4	1.2	24.6
Ward 2	66.5%	82.8%	106.6%	116.1%	759	3.9	2.5	6.5
NNU	68.6%	78.3%	84.6%	82.9%	325	11.4	2.0	13.4
Ward 14	72.2%	98.8%	99.4%	136.2%	706	3.1	3.9	7.0
Ward 10								
Ward 15	84.9%	83.1%	100.7%	124.2%	870	3.8	2.3	6.1
Ward 16	85.8%	94.4%	122.0%	103.2%	869	3.8	2.3	6.1
Ward 17	73.4%	79.5%	99.5%	110.9%	798	4.2	1.9	6.1
Ward 18	72.1%	78.7%	120.8%	136.6%	799	3.3	3.6	6.9
Ward 19	89.7%	72.6%	139.3%	109.7%	899	3.4	2.7	6.2
Ward 20	72.9%	65.2%	112.4%	102.3%	785	3.7	2.1	5.8
Ward 21	65.3%	103.4%	103.9%	122.6%	746	3.6	2.4	6.0
Ward 22	73.5%	70.0%	118.3%	115.2%	668	3.8	3.7	7.5
Ward 23	76.8%	87.6%	100.1%	125.1%	1157	3.0	3.6	6.6
Ward 24	64.5%	60.4%	90.6%	70.7%	342	5.6	3.7	9.3
Ward 3	75.8%	59.7%	106.4%	102.7%	798	3.4	2.7	6.1
Ward 5	72.3%	48.8%	96.4%	100.0%	455	7.5	1.7	9.2
Ward 7	87.7%	75.1%	110.8%	95.7%	740	3.8	3.2	7.0
Ward 8	67.3%	63.6%	98.9%	117.7%	652	3.5	2.6	6.1
Ward 9	59.3%	86.5%	64.8%	87.4%	1052	2.3	1.9	4.2
Ward 25	60.0%	66.4%	118.4%	118.2%	682	3.7	2.5	6.2

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: May 2022**
Report Title	**Workforce Report**	**Agenda Item: Workforce Report**
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 31 March 2022 (Month 12) and relevant Workforce and Organisational Development updates to Trust Executive Committee			
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	JCNC, May 2022
Appendices/Attachments	

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators as at 31 March 2022 (Month 12), covering the preceding 13 months.

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

Indicator	Measure	Target	03/2021	04/2021	05/2021	06/2021	07/2021	08/2021	09/2021	10/2021	11/2021	12/2021	01/2022	02/2022	03/2022
Staff in post (as at report date)	WTE		3311.6	3337.3	3304.1	3310.7	3328.5	3321.9	3328.6	3342.5	3347.7	3349.0	3390.5	3410.0	**3414.4**
	Headcount		3795	3826	3793	3797	3810	3799	3807	3823	3827	3830	3878	3904	**3900**
Establishment *(as per ESR)*	WTE		3635.4	3662.8	3677.7	3681.7	3675.1	3714.0	3724.7	3730.4	3725.7	3718.1	3722.9	3727.6	**3716.9**
	%, Vacancy Rate	10%	8.7%	8.9%	10.2%	10.1%	9.4%	10.6%	10.6%	10.4%	10.1%	9.9%	8.9%	8.5%	**8.1%**
Staff Costs (12 months) *(as per finance data)*	%, Temp Staff Cost (%, £)		11.6%	11.3%	11.3%	11.4%	11.6%	11.7%	11.9%	12.1%	12.3%	12.5%	12.7%	12.9%	**13.1%**
	%, Temp Staff Usage (%, WTE)		11.8%	11.7%	11.8%	12.0%	12.2%	12.4%	12.6%	12.7%	12.8%	12.9%	13.0%	13.1%	**13.2%**
Absence (12 months)	%, 12 month Absence Rate	4%	4.8%	4.5%	4.4%	4.5%	4.6%	4.7%	4.8%	5.0%	5.0%	5.0%	5.0%	**5.1%**	*5.3%*
	- %, 12 month Absence Rate - Long Term		*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.8%*	*2.8%*	*2.8%*	*2.9%*	*3.0%*	*3.0%*	*3.0%*	***3.0%***	*3.1%*
	- %, 12 month Absence Rate - Short Term		*2.1%*	*1.8%*	*1.8%*	*1.8%*	*1.8%*	*1.9%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	***2.1%***	*2.2%*
	%,In month Absence Rate - Total		3.6%	3.3%	4.2%	4.4%	4.6%	5.0%	5.4%	6.1%	5.5%	6.0%	6.3%	**5.4%**	*5.6%*
	- %, In month Absence Rate - Long Term		*2.4%*	*2.3%*	*2.9%*	*2.8%*	*3.3%*	*3.2%*	*3.0%*	*3.5%*	*3.3%*	*3.3%*	*3.0%*	***2.8%***	*2.4%*
	- %, In month Absence Rate - Short Term		*1.2%*	*1.0%*	*1.3%*	*1.6%*	*1.3%*	*1.9%*	*2.4%*	*2.5%*	*2.3%*	*2.7%*	*3.3%*	***2.6%***	*3.2%*
	- %, In month Absence Rate - COVID-19 Sickness Absence		0.5%	0.4%	0.4%	0.3%	0.5%	0.6%	0.6%	0.6%	0.6%	1.2%	2.3%	**1.6%**	*2.2%*
Starters, Leavers and T/O rate (12 months)	WTE, Starters		311.6	322.2	321.3	330.7	331.7	327.9	333.0	349.4	347.1	362.3	390.3	376.5	**382.0**
	Headcount, Starters		356	367	367	376	377	374	376	393	395	411	441	428	**431**
	WTE, Leavers		203.4	204.5	215.6	219.7	223.0	216.8	227.7	232.0	241.5	254.8	277.9	296.9	**329.4**
	Headcount, Leavers		241	244	255	259	264	258	271	276	289	304	332	357	**395**
	%, Leaver Turnover Rate	10%	7.1%	7.1%	7.4%	7.5%	7.7%	7.5%	7.8%	7.9%	8.3%	8.8%	9.5%	10.2%	**11.2%**
	%, Stability Index		87.8%	87.6%	87.5%	87.1%	86.6%	86.5%	86.2%	85.6%	85.2%	85.9%	85.5%	85.3%	**84.8%**
Statutory/Mandatory Training	%, Compliance	90%	97%	95%	95%	96%	96%	95%	96%	95%	96%	96%	95%	94%	**94%**
Appraisals	%, Compliance	90%	95%	95%	93%	92%	89%	90%	91%	91%	91%	91%	91%	90%	**92%**
Medical and Dental Appraisals	%, Compliance	90%	83%	97%	96%	91%	93%	94%	94%	87%	72%	85%	79%	79%	**93%**
Time to Hire (days)	General Recruitment	35	43	48	44	47	48	46	59	53	56	52	72	65	**72**
	Medical Recruitment (excl Deanery)	35	52	49	68	62	68	52	53	81	65	43	52	49	**68**
Employee relations	Number of open disciplinary cases		14	11	14	9	6	6	7	9	10	9	10	7	**9**

2.1. The Trust's **vacancy rate** (8.1%) has improved significantly through 2021/22 and the Trust is reporting the highest headcount (3414.4wte) for over a year with an additional 77.1wte in post from M1. The International Nurse Recruitment campaign is in progress and the first four cohorts arrived in M9 - M1. There are now 52 nurses in post in the Trust. The nurses that are ready are now being booked onto their OSCE and they are moving to their substantive wards from M1. OSCE booking is still a challenge and the Trust is on waiting lists for several test centres.

2.2. **Staff absence** increased in month to 5.6% with a significant proportion of this due to Covid (2.2%) due to the high community prevalence of Covid. Sickness absence figures are in line with other NHS employers in the ICS, whose figures reflect national high levels of absence. Sickness absence is currently unpredictable and the usual trends are unable to be relied upon for predicting when levels will return to what they were pre-Covid.

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 declined further in-month to 84.8%. **Staff turnover** has increased to 11.2%. The number of leavers for Q4 is in line with pre-Covid turnover trends for the organisation.

2.4. **Time to hire** overall has increased significantly in the past 3 months, with General Recruitment being well above the KPI. In Month 10 the mandatory vaccination regulations meant that the Trust needed to secure evidence of vaccination status prior to candidates starting in post. As reported previously, this resulted in candidates being moved back into 'under offer' stage in order to check their status as a condition of employment before they could be moved to 'unconditional offer' and then 'start date booked'. This impact is likely to continue to have an effect but it likely to start returning to normal levels again shortly.

2.5. The number of **open disciplinary cases** remains low, however the team are experiencing a high number of absence management cases as well as an increase in grievances. A detailed Employee Relations case report is produced monthly to JCNC and on a quarterly basis for Workforce Board.

2.6. **Statutory and mandatory training** compliance is at 94% and **appraisals** compliance at 92% as the Trust's reporting period enters the winter period. Divisions are addressing any underperformance against these KPIs locally.

3. Continuous Improvement, Transformation and Innovation

3.1. The Trust reached out to all staff to advise them that the caps for banking annual leave into their lifetime account and selling leftover leave had been lifted. All department managers were contacted to ensure the accuracy of annual leave records on health roster to automate the banking of leave where appropriate upon commencement of the new leave year.

3.2. The HR Services Team are currently exploring **e-Expenses** software to support the digital agenda within HR. Demonstrations and software reviews were held in M12 and options are being presented to Execs in M1.

3.3. The HRBPs are supporting divisions with business cases for **overseas recruitment**, identifying vacancies that could be filled from overseas and looking at the pathways for professional registration and support.

4. Culture and Staff Engagement

4.1. The **Staff Survey** results have shown that the Trust is the top-scoring hospital to work for in the East of England. The team are sharing the high level results across the Trust in M1 with local deep dives down to directorate and department level being carried out in M2. Highlights are as follows:

- The Trust has made improvements in staff feeling personally discriminated against by other staff at work
- MKUH has scored significantly better than the sector average for staff engagement and morale, higher than its score from 2019
- There were score improvements in staff feeling the organisation acts fairly with regards to career progression /promotion
- There were significant score improvements for staff feeling that they have a voice that counts
- MKUH has outperformed the vast majority of the comparator Trusts with only 4 questions out of 111 where we perform 'worse' than the sector as whole
- 73 scores are significantly better than the sector comparators

4.2. The **People Pulse Survey** opens in Q1 and is open to all employees for completion to check the pulse of the organisation, measuring our employees' current feelings, experiences at work, and wellbeing.

5. Current Affairs & Hot Topics

5.1. Consultation commenced on moving some administrative teams from the hospital site to Witan Gate House. This will be completed in M1 with the teams starting to move over in M2.

5.2. The Business Partnering and OD Teams are working together to look at our benefits offering to night workers. This is an engagement project to understand whether some staff groups are adversely impacted or disadvantaged by working predominantly nights.

6. Recommendations

Members are asked to note the report.

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: May 2022**
Report Title	**FTSU Annual Report**	**Agenda Item: 13**
Lead Director	**Name: Danielle Petch**	**Title: Director of Workforce**
Report Author	**Name: Philip Ball**	**Title: Lead FTSU Guardian**

Key Highlights/ Summary	This report provides a summary of FTSU activities between January 2021 and December 2021			
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	TEC, JCNC, WFB, WDAC, Trust Intranet & Internet sites
Next Steps	
Appendices/Attachments	

Freedom to Speak Up Guardian Annual Report 2021

Executive Summary

This annual report to the Trust Board on Freedom to Speak Up (FTSU) in the Trust is for the period January 2021 to December 2021. The Freedom to Speak Up Guardian (FTSUG) is a role that has been in place across NHS Acute Trusts since 2016. Philip Ball is Lead Guardian and Lead Nurse Palliative and End of Life Care.

The National Guardian's Office (NGO) recommends Guardians report twice a year to the Trust Board in person.

In the year under consideration, 21 concerns have been raised.

- 10 were reported as having some element of bullying and harassment involved – mainly through incivility when dealing with other departments, or a line manager.
- Five reported as detriment – where when the witness has already spoken about an issue, and they feel they have an experience they describe as detrimental.
- Six were about patient safety – mainly concerning the misuse of PPE, though two were about the pressures on teams and groups of staff where low numbers and low morale were having an impact.
- At the time of writing most cases were dealt with through intervention with line managers or workforce department assistance. Some witnesses took their own action, and others decided that no further action was required.
- No ongoing investigations have been required.
- All 3 current Guardians have acted to support witnesses.

The increase in reported concerns is noted. It is hoped that this indicates increasing confidence in the FTSU service. When provided the feedback about the service has been positive.

There have been some changes in the people acting as Guardians during this time. COVID-19 restrictions led to the closure of the main office of the National Guardian Office (NGO), and a lack of face-to-face training. This was rectified by the provision of introductory training provided online by the NGO.

The current Trust FTSU Guardians are Angela Legate, Lizzie Taylor, and Philip Ball. These are supported by seven FTSU Champions who act as first points of contact and signpost to Guardians where required. The Champions and Guardians have met where possible during 2021 to keep in touch with developments.

Protected time for Guardians is stipulated in the Protected Working Time policy.

This is an Annual Report. This report has been presented at Board and other Trust committees and groups. The report is also published on the Trust's internal intranet and on the external webpage.

Developing the Role and profile of the Freedom to Speak Up Guardian in MKUH

The Freedom to Speak Up Guardian is not part of the management structure of the Trust and is able to act independently in response to the concerns being raised. The Guardian reports directly to the Chief Executive, and this gives them access to the executive directors of the Trust. The Guardian is usually supported by an Executive and Non-Executive Director. There are two key elements to the role:

- To give independent, safe, and confidential advice and support to members of staff who wish to raise concerns that could have an impact on patient safety and experience.
- To promote a culture where members of staff feel safe to raise concerns and do not fear adverse repercussions as consequence.

There is a dedicated email address freedomtospeakup@mkuh.nhs.uk for staff to contact the Guardians, and there is a mobile phone number 07779 986470 that is a direct route to contact a Guardian. This way of contacting the Guardians is particularly useful for staff who do not normally use email. This has a drawback in that the caller can be anonymous, making feedback and changes difficult. There are plans to implement a web-based form to report concerns.

The NGO has encouraged the development of the FTSU Champion role – mainly as a way of signposting staff either to the Guardians, or to other support systems within the organisation, where their concerns may be more appropriately addressed. 7 Champions were identified. This willingness to become engaged in FTSU activity is a testament to the openness of the Trust.

Freedom to Speak Up activities in the Trust – working on the Culture

Philip Ball, MKUH Lead FTSU Guardian, has been participating in East of England Guardians network meetings and attending web-based events delivered by the NGO. October is the Speak Up Month and in 2021 limited activity took place despite the wishes to do more. Operational and COVID-19 pressures, and a clash with black history month, limited the resources available for communications, for example.

One of the aims of the introduction of FTSU was to help establish a culture of openness within the NHS. The MKUH Lead Guardian, supported by the Director of Workforce as executive lead, is helping to achieve this in several ways including:

Raising awareness: All new staff are given information in a presentation about Freedom to Speak Up as part of corporate induction and presentations have been given to student nurses and medical students. The NGO has provided a short web-based training package that all staff can access, via https://www.e-lfh.org.uk/programmes/freedom-to-speak-up/ and it is planned to embed this in mandatory training requirements. A training package for Executives at Board level is

expected to be rolled out during 2022. The postcard we developed to assist with raising awareness is featured at the start and end of this report.

An improved intranet page is in place. Posters with details of FTSU service and reminders of ways to speak up are kept up to date and are in place across the Trust. Communications about staff support include references to FTSU, which are helpful.

The Lead Guardian plans to set up a programme whereby Guardians and or Champions attend departmental/team meetings to deliver short presentations to promote FTSU. The Guardians have been invited to attend staff network meetings and be involved in discussions about staff health and well-being.

Staff Development: Unregistered care staff can often find it harder to raise concerns but spend the most time in direct contact with patients. There is a need to develop opportunities to engage with professional groups and within leadership development training to empower staff to feel confident about speaking up, and to prepare managers to receive feedback from their staff when they have concerns. The development of the Nursing and Midwifery Strategy provided an opportunity to encourage speaking up and speaking out, through the work of Strategy Ambition 1.

Influencing cultural change: Continued collaborative working with HR and the EDI team to raise awareness about bullying and harassment and how to address and combat this behaviour.

Plans for 2022 -

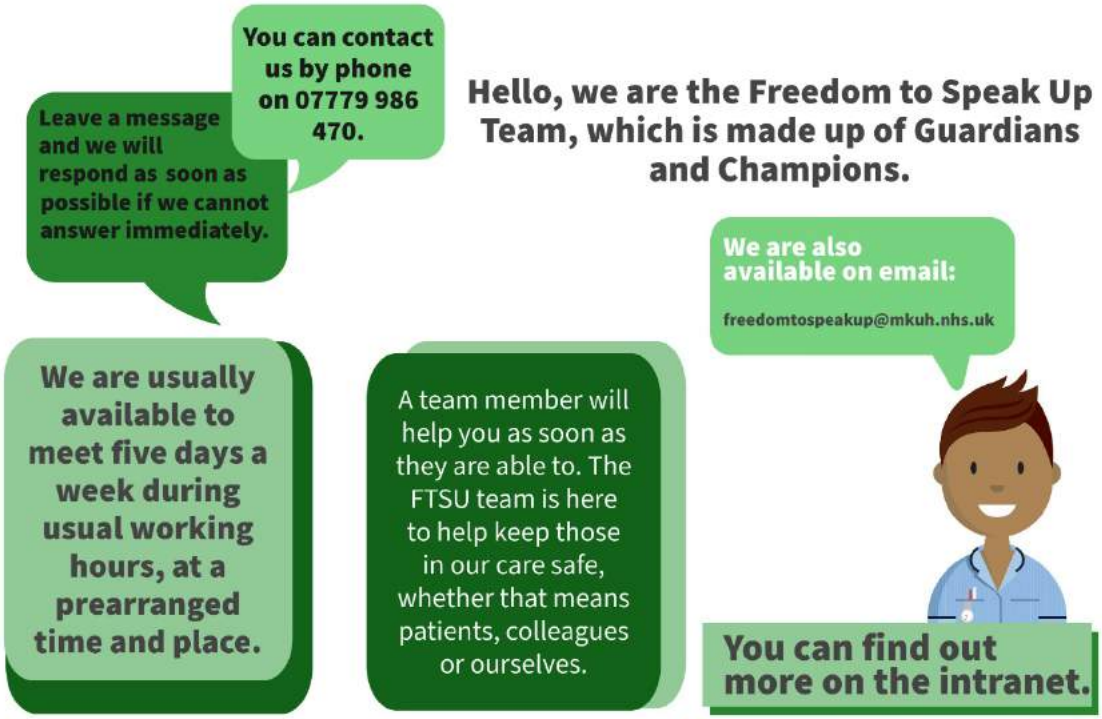
- The Lead Guardian is increasing dedicated time working in the Guardian role to one day per week from April 2022.
- The approach to FTSU will be re-launched during 2022 aiming for more activity in October 2022, as it is the ‘Speak Up’ month.
- Questions will be included in exit questionnaires about awareness of the FTSU Guardians and whether the leaver had used the service.
- The Trust will continue to participate in the development of the role of the FTSU Guardian and continue to be active in the East of England regional group, through the quarterly meetings and WhatsApp.
- The Lead Guardian will attend the virtual NGO Annual Conference on 29th March 2022.
- Evaluation of the effectiveness of the Freedom to Speak Up Guardian role in the Trust will take place through the use of feedback to the Guardian about how well the use of the service has worked.
- FTSU Guardians and Champions will become regular contributors to team, departmental and divisional meetings; engaging with networks such as the Ability and BAME networks which are developing at MKUH.
- The Trust will implement a web-based form that can be accessed by MKUH staff to report concerns.

- The Trust will promote the use of the postcards developed about the FTSU service. These will be provided to all new starters as well as current staff, with a version available in the Trust Intranet.

Recommendation

The Trust Board is asked to note the contents of this annual report by the Freedom to Speak Up Guardian.

Philip Ball, FTSU Guardian, 15th March 2022



Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board of Directors**	**Date: May 2022**
Report Title	2021-22 Executive Summary M12	**Agenda Item: 14**
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: M12 (March 2022)

1.0 Summary

This report summarises performance in March 2022 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%**
4.5	RTT Patients waiting over 52 weeks	**0**
4.6	Diagnostic Waits <6 weeks	**99%**
4.7	All 2 week wait all cancers %	**93%**
4.8	Diagnosis to 1st Treatment (all cancers) - 31 days %	**96%**
4.9	Referral to Treatment (Standard) 62 day %	**85%**

Given the impact of COVID-19, the performance of certain key constitutional NHS targets for March 2022 have been directly impacted. To ensure that this impact is reflected, the monthly trajectories for 2021/22 are in place to ensure that they are reasonable and reflect a level of recovery for the Trust to achieve.

2.0 Sustainability and Transformation Fund (STF)

Performance Improvement Trajectories

March 2022 and year-end 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%	83.9%	80.5%	×		×	
4.2	RTT Incomplete Pathways <18 weeks		92%	92%		52.5%	×	▼		
4.9	62 day standard (Quarterly)		85%	85%		62.0%	×	▼		

In March 2022 the ED performance was 80.5%, remaining the same as performance in February 2022. MKUH performance remains significantly higher than both the national overall performance of 71.6% and the majority of its Peer Group (see Appendix 1 for details).

The 2021/22 annual ED performance was 83.9%, below the 95% target and a decline in performance when compared to the 2020/21 ED performance of 93.1% and the 2019/20 ED performance of 88.7%.

The Trust's RTT Incomplete Pathways <18 weeks performance stood at 52.5% at the end of March 2022. This was a deterioration in performance for the third consecutive month and represents an overall trend of declining performance since the Trust recorded 69.3% in July 2021.

The Trust has put in place robust activity recovery plans, which will support further improvement in RTT performance and actively 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 Q3 2021/22, the Trust's provisional 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) was 62.0% against a national target of 85%.

The provisional performance of the percentage of patients who started treatment within 31 days of a decision to treat was 96.6%, above the 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 86.7% against a national target of 93%.

3.0 Urgent and Emergency Care

In March 2022, three of the six key performance indicators measured in urgent and emergency care showed a month-on-month 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%	0.84%	0.49%	✓	▲	✓	
3.2	Ward Discharges by Midday		25%	25%	15.3%	15.2%	✗	▼	✗	
3.4	30 day readmissions		7%	7%	7.2%	6.9%	✓	▲	✗	
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		53			104	✗	▼		
3.9	Ambulance Handovers >30 mins (%)		5%	5%	13.1%	17.0%	✗	▲	✗	
4.2	RTT Incomplete Pathways <18 weeks		92%	92%		52.5%	✗	▼		

Cancelled Operations on the Day

In March 2022, there were 12 operations cancelled on the day for non-clinical reasons as detailed below:

Cancellation Reason	Number of Cancellations
Staff Availability	6
Bed Availability	3
Insufficient time	2
Emergency Priority	1

Readmissions

The Trust's 30-day emergency readmission rate in March 2022 was 6.9% (please note that the readmission rate in March 2022 may include patients that were readmitted with Covid-19).

Performance showed an improvement compared to the February 2022 rate of 7.5%.

The Trust's 30-day emergency readmission rate for the 2021/22 financial year was 7.2%, which was an improvement in performance when compared to both the 2020/21 30-day re-admission rate of 8.5%, and the 2019/20 30-day re-admission rate of 7.9%.

Delayed Transfers of Care (DTOC)

The number of DTOC patients reported at midnight on the last Thursday of March 2022 was 30 patients: 25 in Medicine and five in Surgery.

This was an improvement compared to performance in February 2022 when 39 DTOC patients were reported on the last Thursday of the month.

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 104. This was an increase for the third consecutive month and is the highest volume of super stranded patients reported since April 2019 (106).

This was also an increase on the number of super stranded patients reported at the end of March 2021 (77) and March 2020 (41).

Ambulance Handovers

In March 2022, the percentage of ambulance handovers to the Emergency Department taking more than 30 minutes was 17.0%.

This was a slight improvement in performance compared to 18.0% recorded in February 2022.

The percentage of ambulance handovers taking more than 30 minutes across the 2021/22 financial year was 13.1%, which was a significant deterioration when compared to 4.7% in 2020/21 and 8.6% in 2019/20.

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%	88.9%	93.0%	✓	▼	✓	
3.5	Follow Up Ratio		1.5		1.28	1.29	✓	▼	✓	
4.2	RTT Incomplete Pathways <18 weeks		92%	92%		52.5%	✗	▼		

Overnight Bed Occupancy

Overnight bed occupancy was 93.0% in March 2022. This is the highest level recorded during 2021/22 and equals the threshold.

The Trust's 2021/22 overnight bed occupancy for the whole financial year was 88.9%, which was a deterioration when compared to the 2020/21 overnight bed occupancy of 78.4%. However, when comparing to the Trust's 2019/20 overnight bed occupancy of 89.1%, this was a slight improvement.

Follow up Ratio

The Trust outpatient follow up ratio in March 2022 was 1.29 which was a decline in performance when compared to the February 2022 ratio of 1.17.

The Trust's 2021/22 outpatient follow up ratio for the whole financial year was 1.28, which was an improvement in performance when compared to both the 2020/21 ratio of 1.68 and the 2019/20 ratio of 1.58.

RTT Incomplete Pathways

The Trust's RTT Incomplete Pathways <18 weeks at the end of March 2022 was 52.5% and the number of patients waiting more than 52 weeks without being treated was 916. These patients were in Surgery (849 patients), Medicine (30 patients), and Women and Children (36 patients). *Note, the remaining one patient does not yet have a division recorded in the data.*

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 March 2022, with a performance of 64.5%.

This was a slight decline from 67.2% recorded in February 2022.

5.0 Patient Safety

Infection Control

In March 2022 there was one reported case of E-Coli, which occurred in Medicine (Ward 19). There were also two reported cases of C.Diff, both in Medicine (Ward 14). There were no reported cases of MRSA or MSSA.

Three of the four metrics have breached their annual thresholds, with E-Coli being the exception.

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/).

January 2022 to March 2022 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	Jan-22	Feb-22	Mar-22
Homerton University Hospital NHS Foundation Trust	86.5%	87.4%	83.9%
Milton Keynes University Hospital NHS Foundation Trust	83.2%	80.5%	80.5%
Southport And Ormskirk Hospital NHS Trust	76.0%	75.3%	74.9%
The Hillingdon Hospitals NHS Foundation Trust	77.5%	76.9%	71.9%
Buckinghamshire Healthcare NHS Trust	73.2%	73.0%	69.7%
North Middlesex University Hospital NHS Trust	67.3%	66.8%	68.2%
Northampton General Hospital NHS Trust	68.3%	66.2%	64.9%
Barnsley Hospital NHS Foundation Trust	77.4%	69.0%	64.8%
Oxford University Hospitals NHS Foundation Trust	70.2%	66.0%	64.3%
The Princess Alexandra Hospital NHS Trust	69.1%	65.1%	63.8%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	64.4%	60.0%	57.3%
Mid Cheshire Hospitals NHS Foundation Trust	60.9%	58.4%	56.2%
Bedfordshire Hospitals NHS Foundation Trust	-	-	-
Kettering General Hospital NHS Foundation Trust	-	-	-

Board Performance Report 2021/22
March 2022 (M12)

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) ★		97.6	97.6		101.1	✗	▲		
1.2	Mortality - (SHMI)		100	100		107.94	✗	▲		
1.3	Never Events		0	0	1	0	✓	▬	✗	
1.4	Clostridium Difficile		10	10	13	2	✗	▲	✗	
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	0.21	✗	▲	✗	
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	48.15	48.53	✗	▲	✗	
1.9	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▬	✓	
1.10	E-Coli		18	18	15	1	✓	▲	✓	
1.11	MSSA		5	5	10	0	✓	▬	✗	
1.12	VTE Assessment		95%	95%	97.6%	96.1%	✓	▼	✓	

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%	77.8%	78.6%	✗	▲	✗	
2.4	Cancelled Ops - On Day		1%	1%	0.84%	0.49%	✓	▲	✓	
2.5	Over 75s Ward Moves at Night		1,800	1,800	1,341	162	✗	▼	✓	
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%	88.9%	93.0%	✓	▼	✓	
3.2	Ward Discharges by Midday		25%	25%	15.3%	15.2%	✗	▼	✗	
3.3	Weekend Discharges		70%	70%	59.8%	58.0%	✗	▼	✗	
3.4	30 day readmissions		7%	7%	7.2%	6.9%	✓	▲	✗	
3.5	Follow Up Ratio		1.5		1.28	1.29	✓	▼	✓	
3.6.1	Number of Stranded Patients (LOS>=7 Days)		184			263	✗	▼		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		53			104	✗	▼		
3.7	Delayed Transfers of Care		20			30	✗	▲		
3.8	Discharges from PDU (%)		15%	15%	8.3%	11.3%	✗	▲	✗	
3.9	Ambulance Handovers >30 mins (%)		5%	5%	13.1%	17.0%	✗	▲	✗	

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%	83.9%	80.5%	✗	▬	✗	
4.2	RTT Incomplete Pathways <18 weeks		92%	92%		52.5%	✗	▼		
4.4	RTT Total Open Pathways		33,715	33,715		32,134	✓	▲		
4.5	RTT Patients waiting over 52 weeks		1,252	1,252		916	✓	▼		
4.6	Diagnostic Waits <6 weeks		99%	99%		64.5%	✗	▼		
4.7	All 2 week wait all cancers (Quarterly) ✎		93%	93%		86.7%	✗	▲		
4.8	31 days Diagnosis to Treatment (Quarterly) ✎		96%	96%		96.6%	✓	▲		
4.9	62 day standard (Quarterly) ✎		85%	85%		62.0%	✗	▼		

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		91,054	6,637	Not Available	▼	Not Available	
5.2	A&E Attendances		103,529	103,529	100,429	9,037	✗	▼	✓	
5.3	Elective Spells (PBR)		24,474	24,474	23,828	2,031	✓	▲	✗	
5.4	Non-Elective Spells (PBR)		39,224	39,224	31,524	2,526	✗	▼	✓	
5.5	OP Attendances / Procs (Total)		392,098	392,098	404,766	34,298	✓	▲	✓	
5.6	Outpatient DNA Rate		6%	6%	6.6%	6.9%	✗	▲	✗	

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	316,858	327,223	36,069	✓	▲	✓	
7.2	Pay £'000		(203,273)	(203,273)	(207,283)	(18,409)	✗	▼	✗	
7.3	Non-pay £'000		(96,446)	(96,446)	(105,248)	(17,446)	✗	▼	✗	
7.4	Non-operating costs £'000		(18,239)	(18,239)	(15,844)	306	✓	▲	✓	
7.5	I&E Total £'000		(1,100)	(1,100)	(969)	131	✓	▲	✗	
7.6	Cash Balance £'000		25,668	25,668		57,975	✓	▼		
7.7	Savings Delivered £'000		6,850	6,850	1,758	142	✗	▼	✗	
7.8	Capital Expenditure £'000		50,799	50,799	31,830	11,009	✗	▼	✓	

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%		8.1%	✓	▲		
8.2	Agency Expenditure %		5%	5%	4.2%	5.4%	✗	▲	✓	
8.3	Staff Sickness % - Days Lost (Rolling 12 months) ✎		4%	4%		5.1%	✗	▼		
8.4	Appraisals		90%	90%		92.0%	✓	▲		
8.5	Statutory Mandatory training		90%	90%		94.0%	✓	▬		
8.6	Substantive Staff Turnover		9%	9%		11.2%	✗	▼		

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%	72.8%	82.4%	✗	▼	✗	
O.4	Overdue Incidents >1 month		0	0		279	✗	▲		
O.5	Serious Incidents		20	20	96	8	✗	▼	✗	

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
★	There was a notable increase in the value of Mortality (HSMR) in January 2022 due to the baseline being rebased. Further, from February 2022, the HSMR threshold may change on a monthly basis as we will be using the monthly peer value to compare MKUH performance against.

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: 14/04/2022

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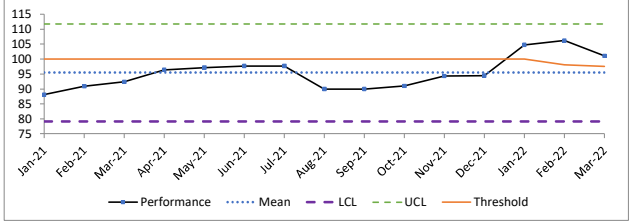
OBJECTIVE 1 - PATIENT SAFETY

Milton Keynes University Hospital NHS Foundation Trust

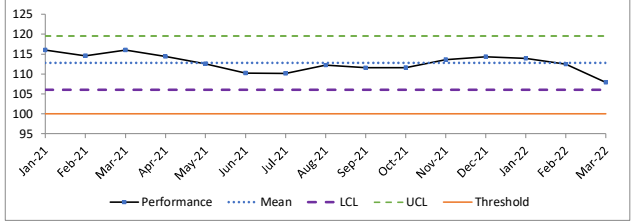
SD=3

1.1 Mortality - HSMR (Rolling 15 months)

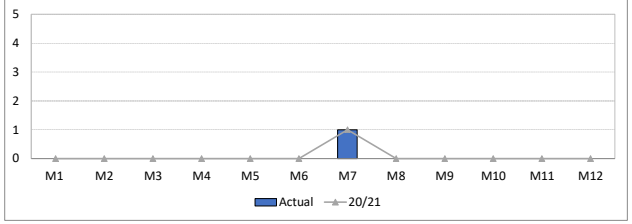


SD=3

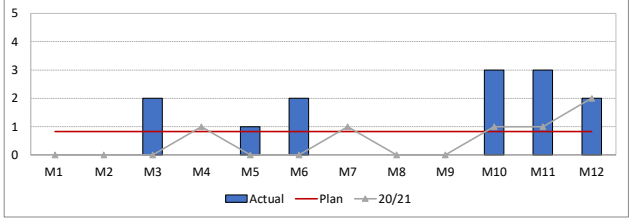
1.2 Mortality - SHMI (Rolling 15 months)



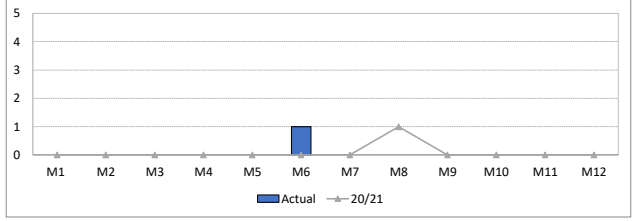
1.3 - Never events



1.4 - C.Diff Infections

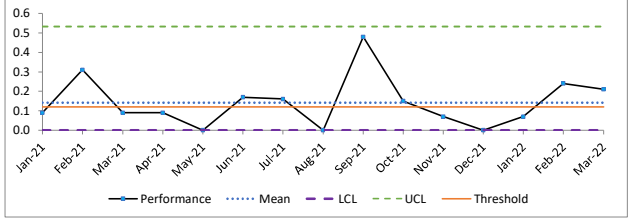


1.5 - MRSA Bacteraemia



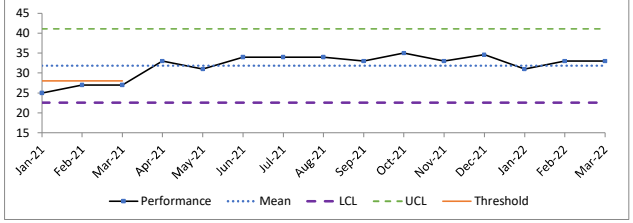
SD=3

1.6 - Falls with harm (per 1,000 bed days)



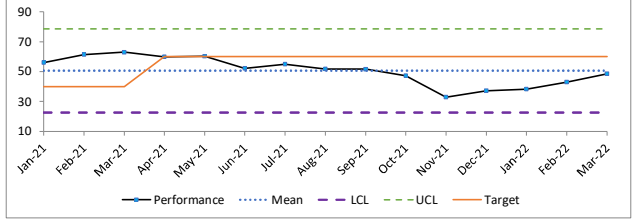
SD=3

1.7b - Midwife to birth ratio (Actual for Month)

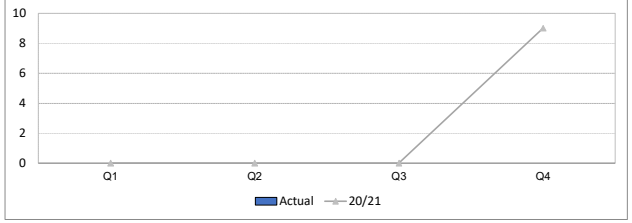


SD=3

1.8 - Incident Rate (per 1,000 bed days)



1.9- Duty of Candour Breaches



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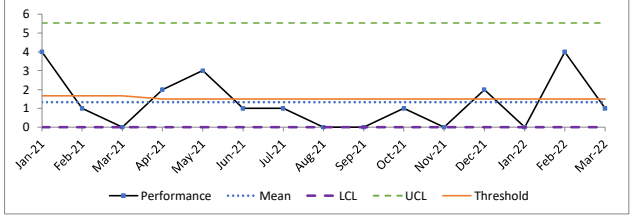
1.10 - E-Coli



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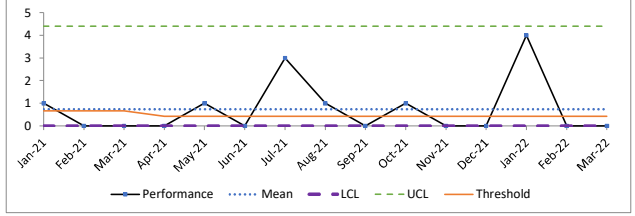
1.11 - MSSA



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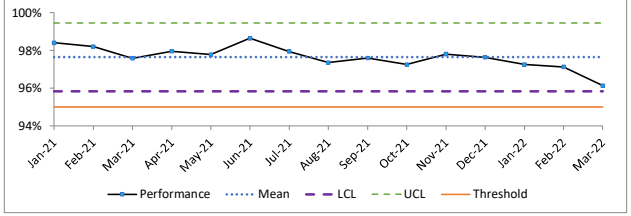
1.12 - VTE Assessment



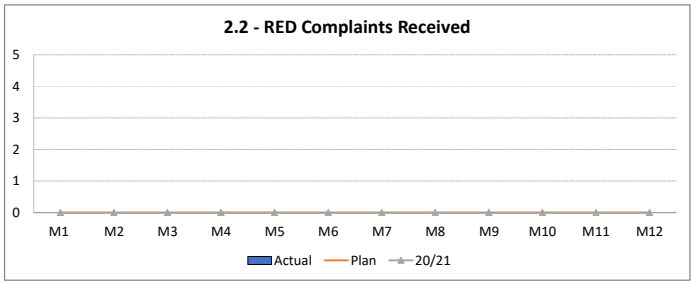
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

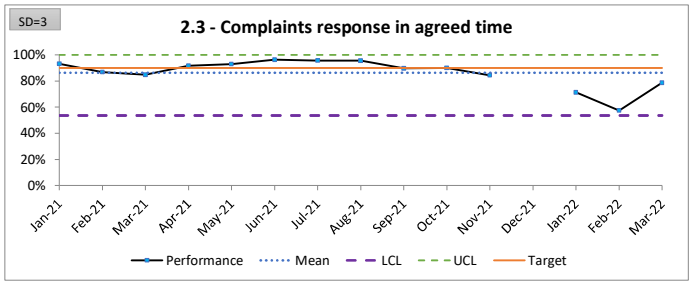
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

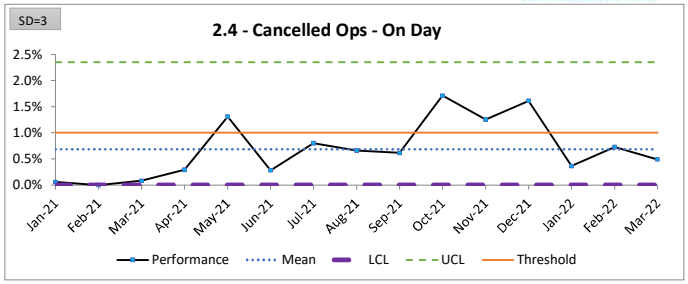
Board Performance Report 2021/22

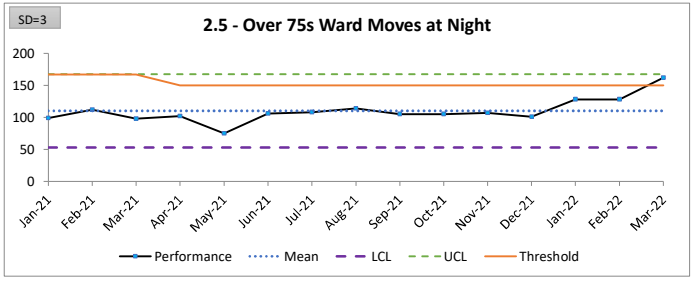
OBJECTIVE 2 - PATIENT EXPERIENCE

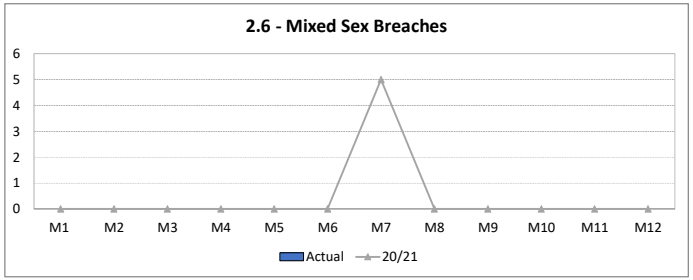
Milton Keynes University Hospital NHS Foundation Trust











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Performance activity on a rolling 15 months/quarterly
Average on a rolling 15 months/quarterly
Lower Control Limit (LCL)
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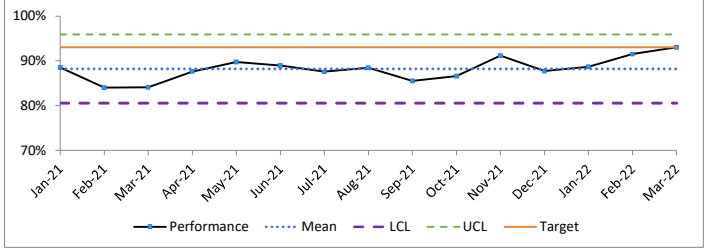
Board Performance Report 2021/22

OBJECTIVE 3 - CLINICAL EFFECTIVENESS

Milton Keynes University Hospital NHS Foundation Trust

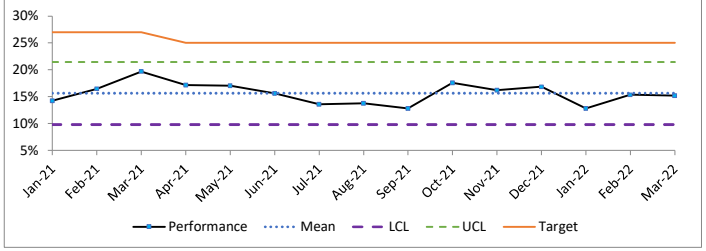
SD=3

3.1 - Overnight bed occupancy rate



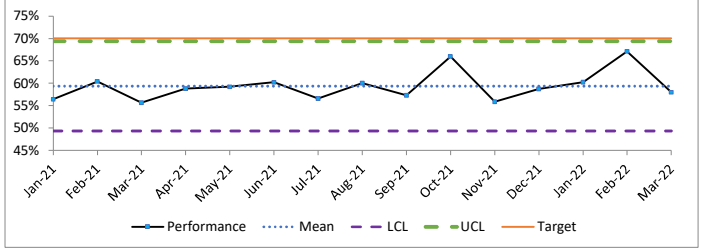
SD=3

3.2 - Ward Discharges by Midday



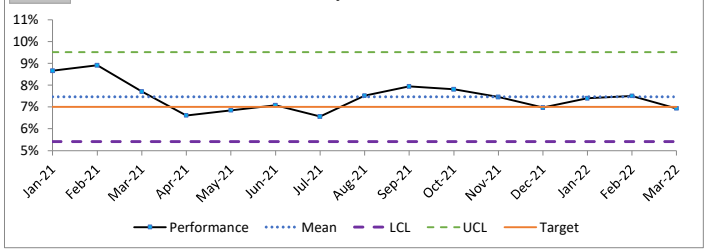
SD=3

3.3 - Weekend Discharges



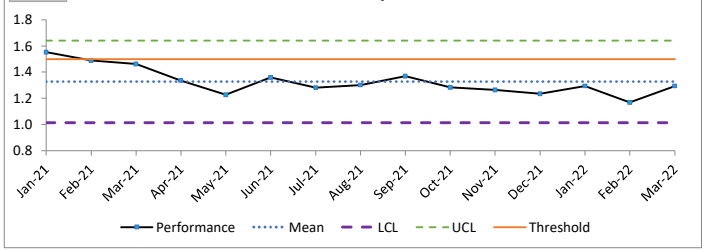
SD=3

3.4 - 30 Day Readmissions



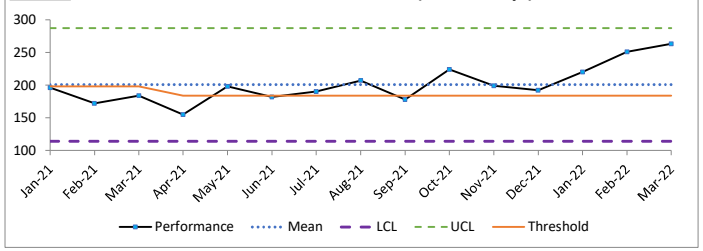
SD=3

3.5 - Follow-up Ratio



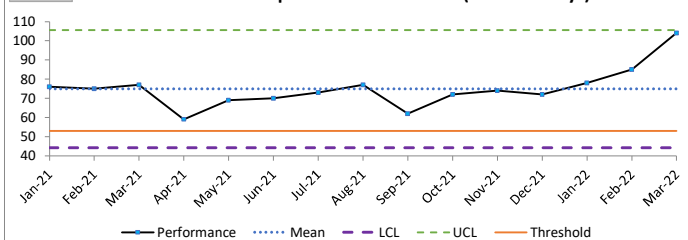
SD=3

Number of Stranded Patients (LOS>=7 Days)



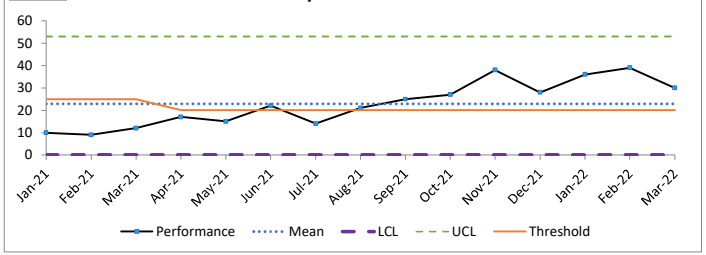
SD=3

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



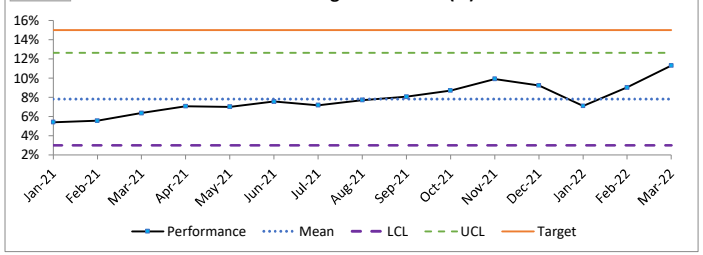
SD=3

3.7 - Delayed Transfers of Care



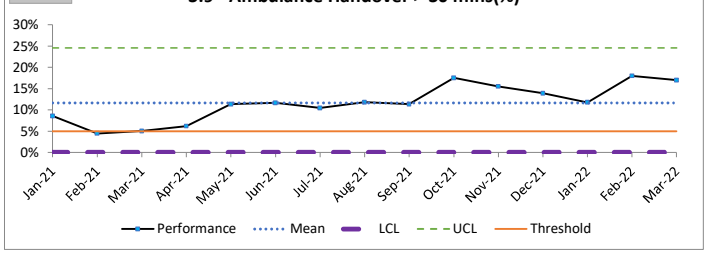
SD=3

3.8 - Discharges from PDU (%)



SD=3

3.9 - Ambulance Handover > 30 mins(%)



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- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
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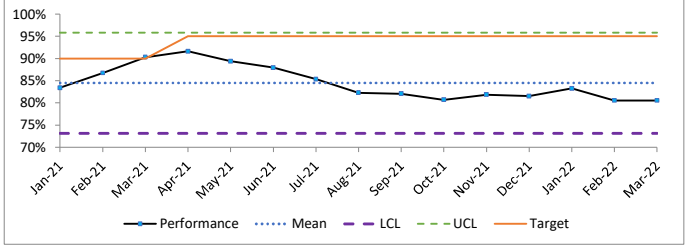
Board Performance Report 2021/22

OBJECTIVE 4 - KEY TARGETS

Milton Keynes University Hospital NHS Foundation Trust

SD=3

4.1 - ED Hour Target (includes UCS)



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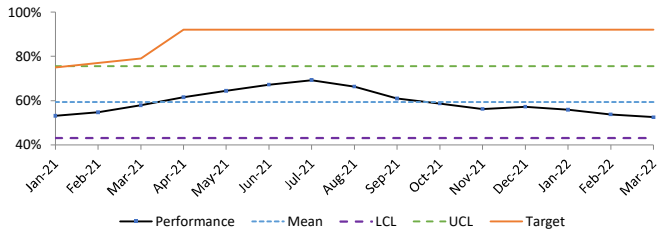
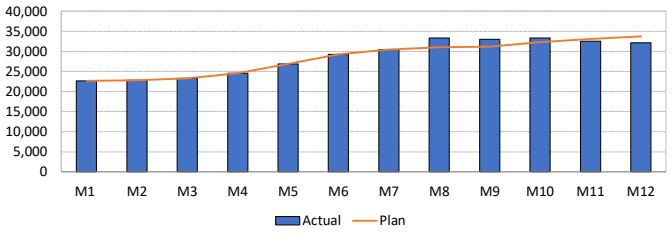
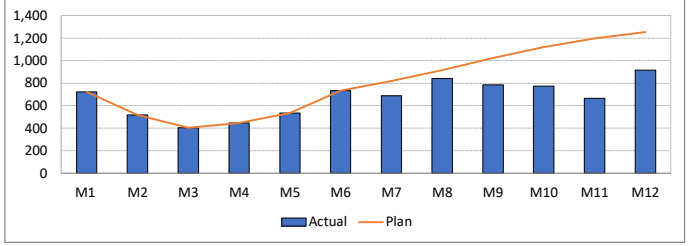
4.2 - RTT Incomplete Pathways <18 weeks



4.4 - RTT Total Open Pathways



4.5 - RTT Patients Waiting Over 52 weeks



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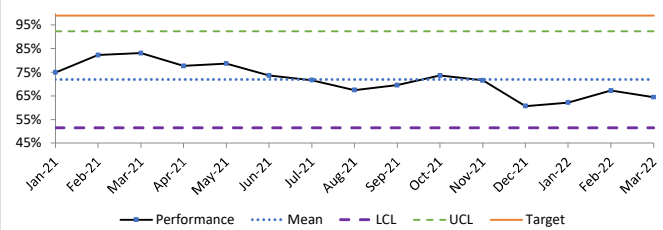
4.6 - Diagnostic Waits < 6 weeks



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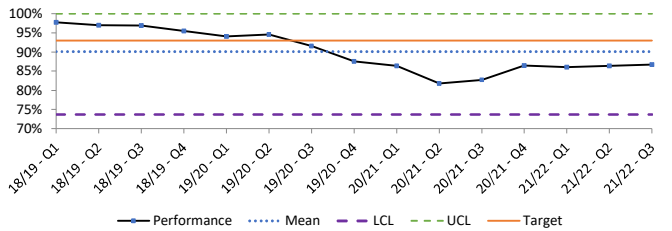
4.7 - 2 Week Wait - Cancer



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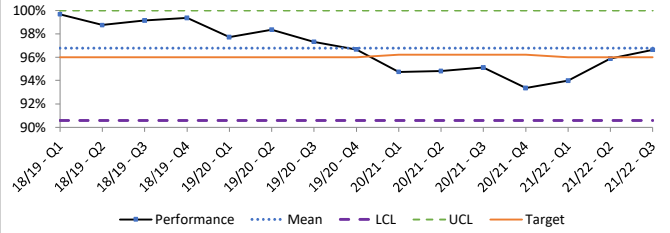
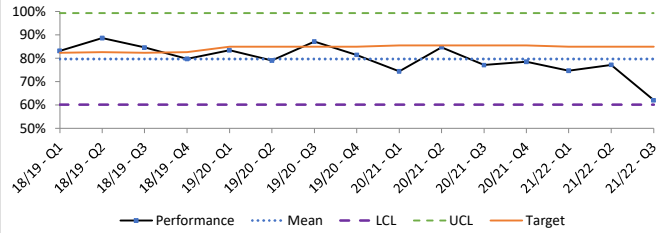
4.8 - 31 day diagnosis to treatment - Cancer



SD=3

4.9 - 62 day standard - Cancer



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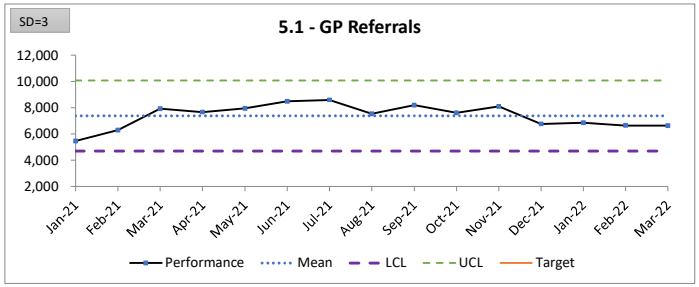
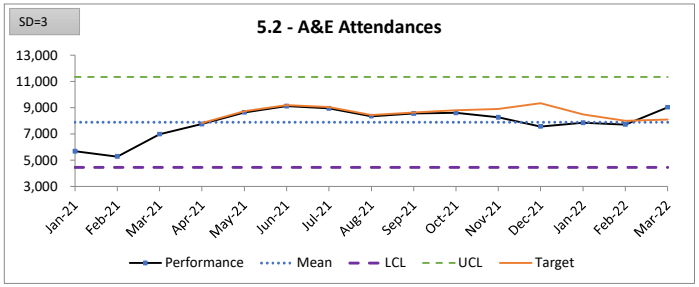
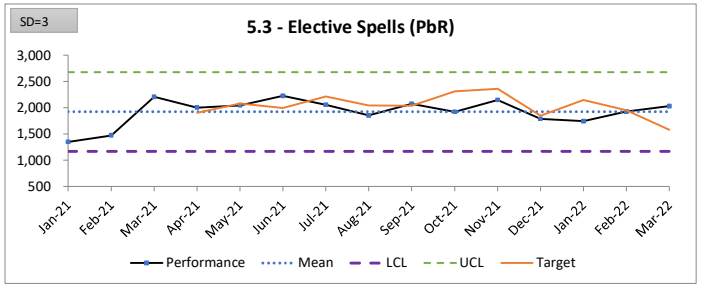
Board Performance Report 2021/22

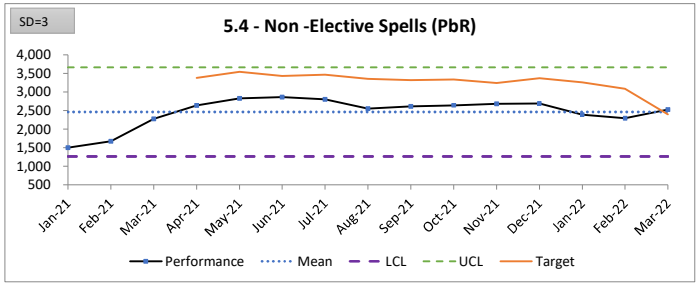
OBJECTIVE 5 - SUSTAINABILITY

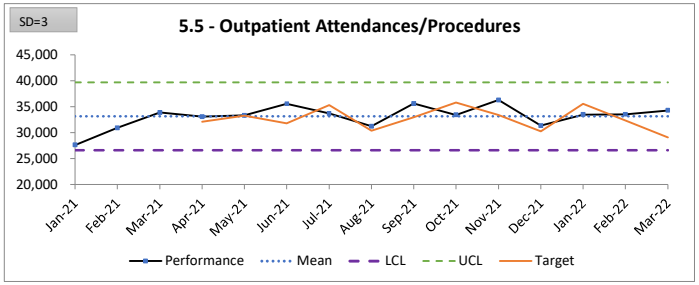
Milton Keynes University Hospital NHS Foundation Trust

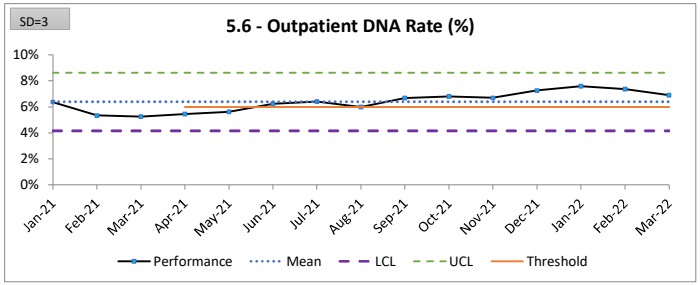












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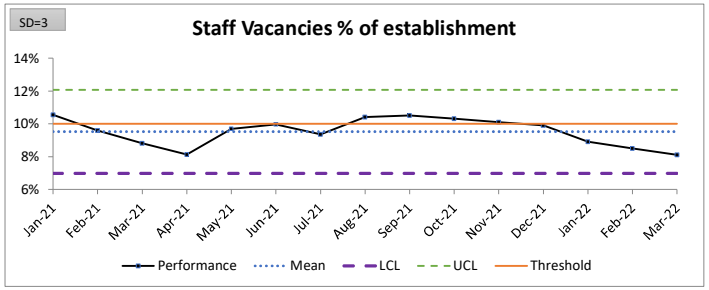
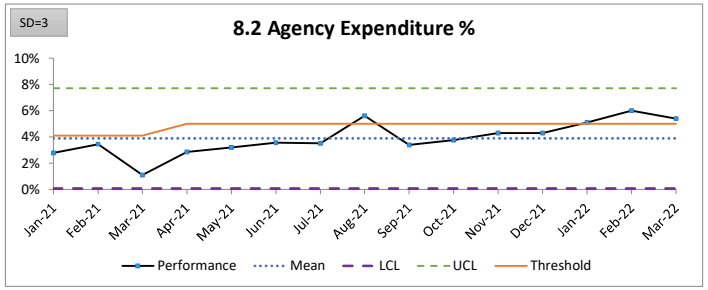
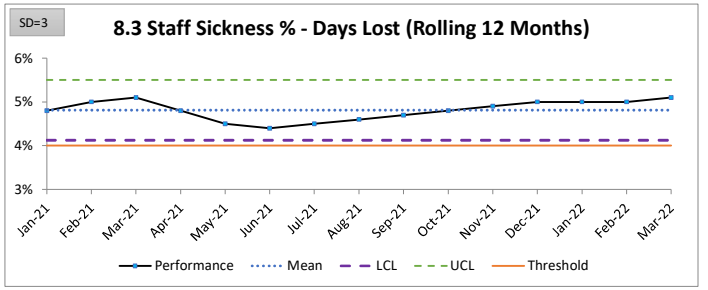
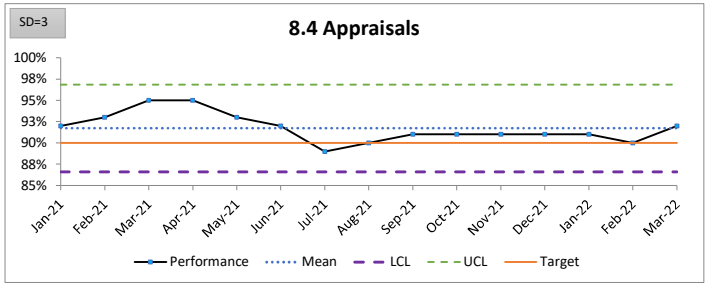
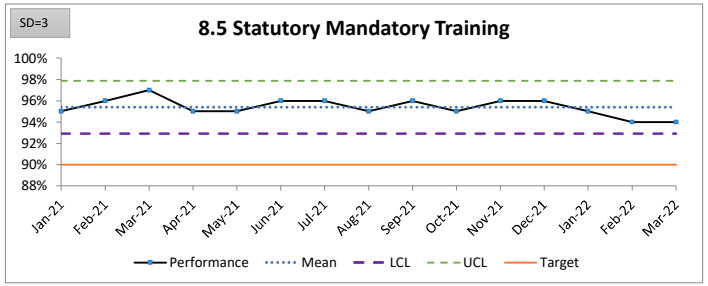
OBJECTIVE 8 - WORKFORCE PERFORMANCE

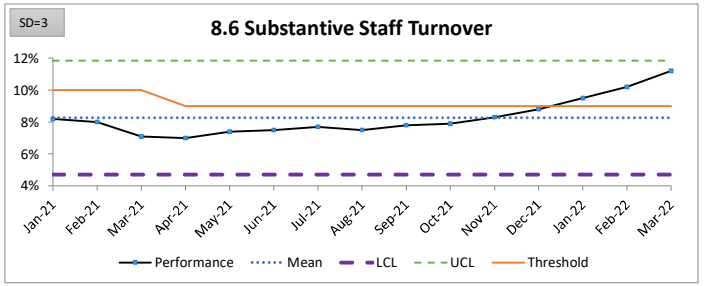












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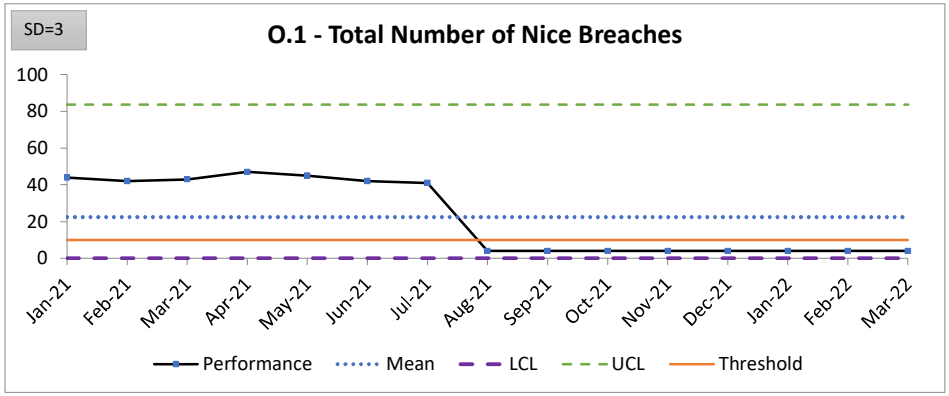

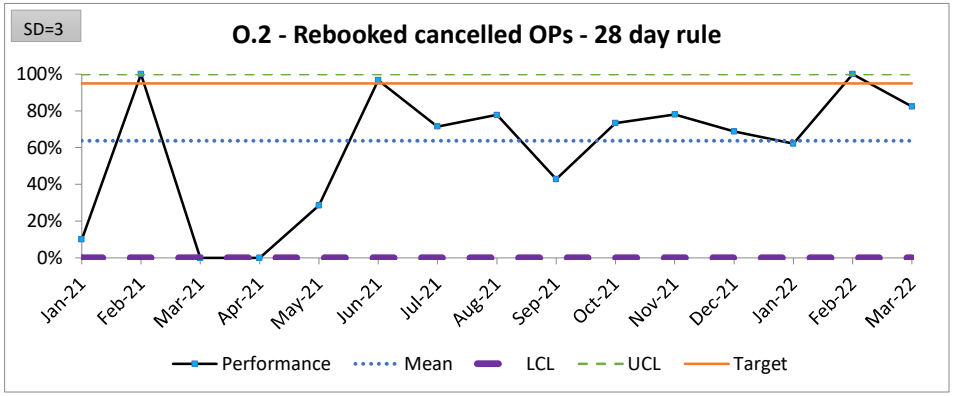

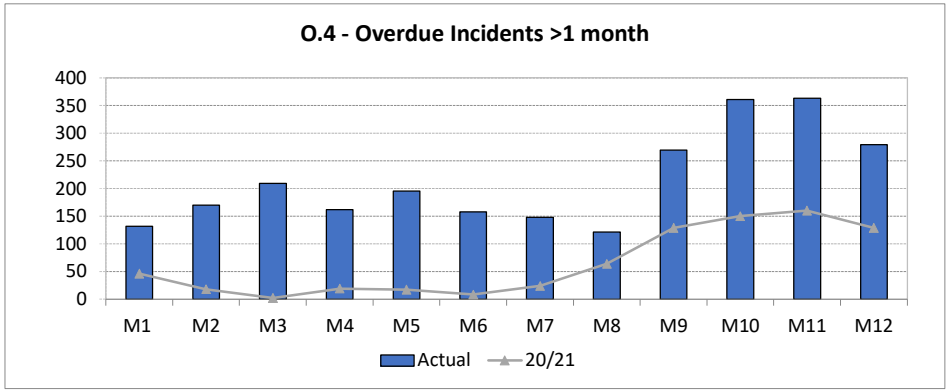

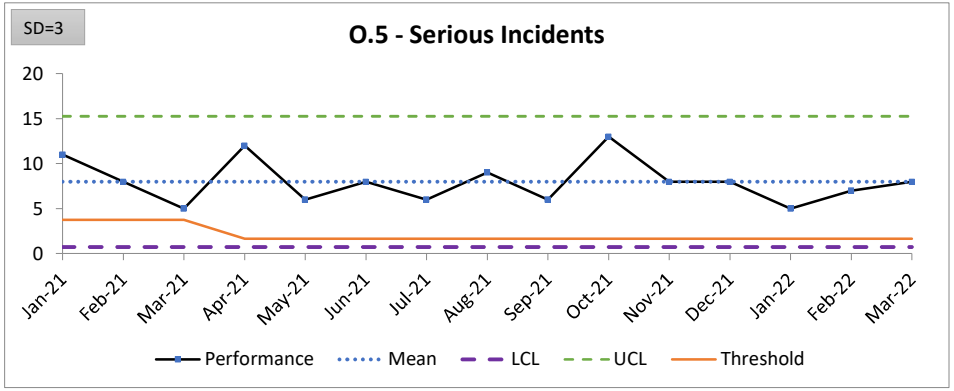

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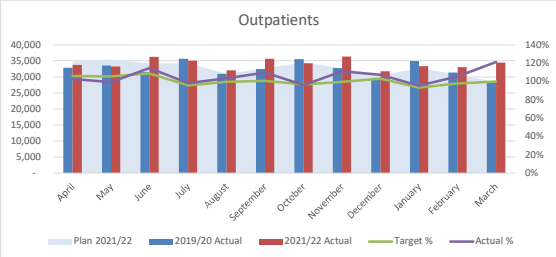
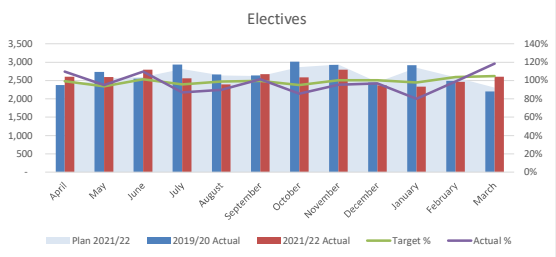
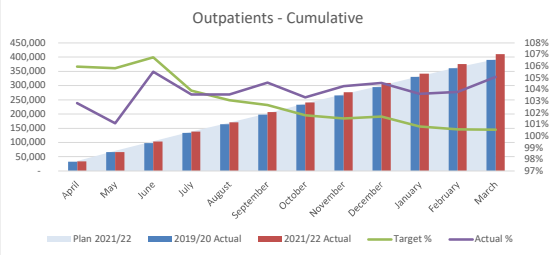
Accelerator Comparison

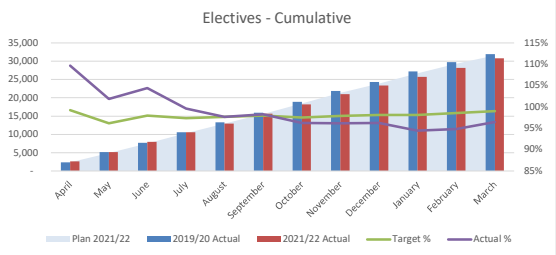
Elective and Outpatient Plan Vs Actual Accelerator Comparison

Include	Month	April	May	June	July	August	September	October	November	December	January	February	March
Outpatients	2019/20 Actual	32,883	33,528	31,522	35,693	31,035	32,479	35,585	32,779	29,587	34,908	31,329	28,386
	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%	103%	94%	98%	100%
	2021/22 Actual	**33,815**	**33,315**	**36,212**	**35,063**	**32,114**	**35,654**	**34,238**	**36,422**	**31,741**	**33,338**	**33,090**	**34,481**
	Actual %	103%	99.4%	114.9%	98.2%	103.5%	109.8%	96.2%	111.1%	107.3%	95.5%	105.6%	121.5%
Electives	2019/20 Actual	2,378	2,732	2,551	2,935	2,667	2,638	3,011	2,926	2,444	2,920	2,492	2,203
	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%	100%	98%	104%	105%
	2021/22 Actual	**2,608**	**2,596**	**2,795**	**2,559**	**2,393**	**2,672**	**2,583**	**2,795**	**2,367**	**2,333**	**2,462**	**2,607**
	Actual %	110%	95.0%	109.6%	87.2%	89.7%	101.3%	85.8%	95.5%	96.8%	79.9%	98.8%	118.3%





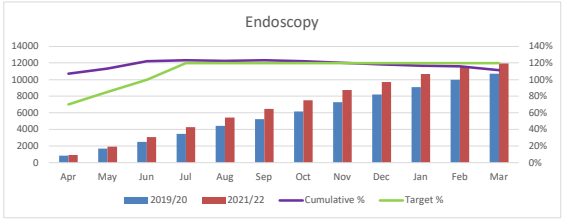


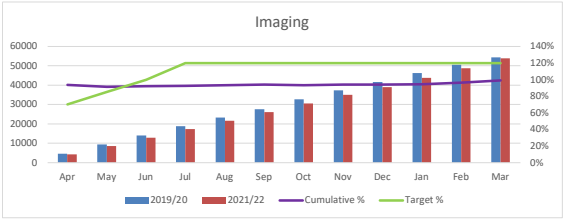


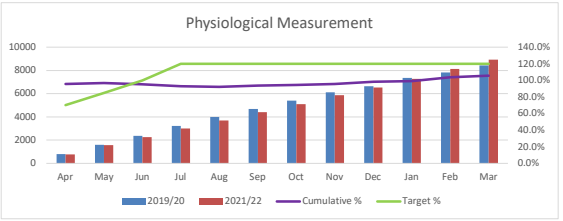
Key:
2019/20 Actual - represents the actual activity associated with FY 2019/20
Plan 2021/22 - represent the divisional planned activity that have been provided by each of the clinical divisions for FY 2021/22
Target % - represents that anticipated "Target Percentage" based on the divisional planned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

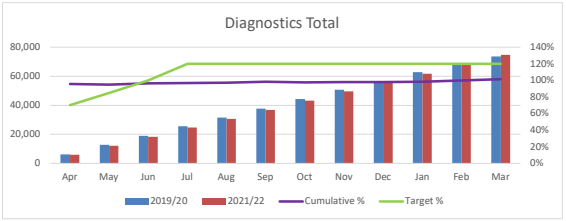
Diagnostics Accelerator Comparison

Include	Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Endoscopy	Colonoscopy	355	409	473	411	408	392	417	446	359	428	355	83
	Cystoscopy	168	190	268	286	269	277	221	316	230	174	206	190
	Flexi sigmoidoscopy	87	85	104	122	106	78	81	119	80	92	89	22
	Gastroscopy	299	311	329	379	347	328	323	351	283	265	271	53
	Total	**909**	**995**	**1,174**	**1,198**	**1,130**	**1,075**	**1,042**	**1,232**	**952**	**959**	**921**	**348**
	Total as % of 2019/20	**107.1%**	**119.6%**	**140.1%**	**125.7%**	**120.0%**	**127.1%**	**115.6%**	**109.4%**	**105.0%**	**104.1%**	**104.2%**	**47.8%**
	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	972	1,403	1,382	1,445
	Magnetic Resonance Imaging	460	497	592	651	643	556	619	537	541	456	575	577
	Non-obstetric ultrasound	3,007	2,846	2,891	2,922	2,647	3,069	2,900	2,957	2,495	2,839	3,056	3,087
	Total	**4,317**	**4,283**	**4,279**	**4,461**	**4,257**	**4,421**	**4,466**	**4,500**	**4,008**	**4,698**	**5,013**	**5,109**
	Total as % of 2019/20	**93.5%**	**89.3%**	**93.2%**	**93.6%**	**97.1%**	**99.5%**	**88.0%**	**98.3%**	**93.0%**	**99.2%**	**116.9%**	**134.4%**
	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	133	105	169	153
	Cardiology - echocardiography	303	409	355	413	336	383	323	364	346	442	450	402
	Cardiology - electrophysiology	211	174	174	176	177	144	179	183	144	159	173	196
	Respiratory physiology - sleep studies	56	22	44	32	64	63	56	71	48	38	46	29
	Urodynamics - pressures & flows	17	16	13	4	-	4	4	3	-	8	11	7
	Total	**767**	**787**	**714**	**731**	**684**	**717**	**695**	**762**	**671**	**752**	**849**	**787**
	Total as % of 2019/20	**95.9%**	**97.6%**	**92.0%**	**86.3%**	**89.6%**	**103.6%**	**96.9%**	**105.7%**	**129.0%**	**106.2%**	**176.9%**	**129.2%**
	Target	70%	85%	100%	120%	120%	120%	120%	120%	120%	120%	120%	120%
Grand Total	Grand Total	5,993	6,065	6,167	6,390	6,071	6,213	6,203	6,494	5,631	6,409	6,783	6,244
	Grand Total as % of 2019/20	95.6%	94.2%	99.4%	97.3%	99.7%	103.9%	92.7%	101.1%	98.1%	100.7%	120.0%	121.5%
	Target	70%	85%	100%	120%	120%	120%	120%	120%	120%	120%	120%	120%



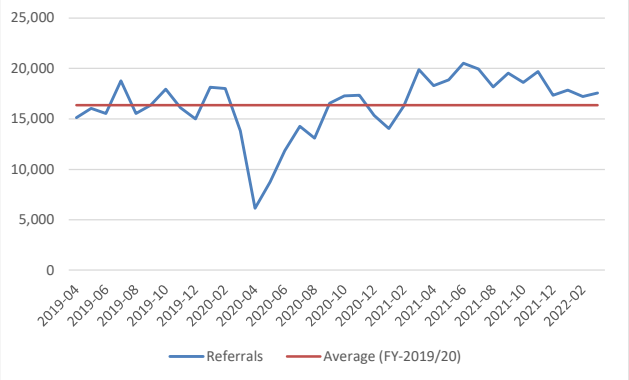




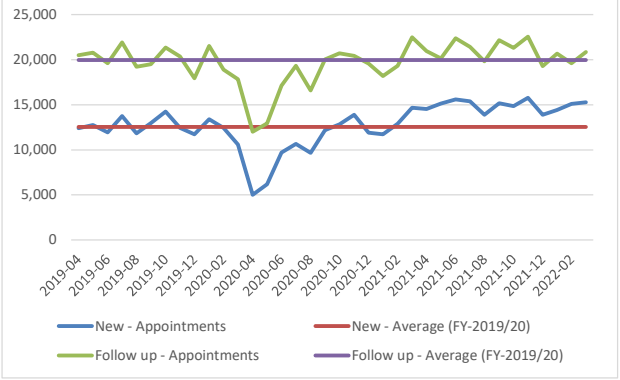


Recovery Plan Graphs

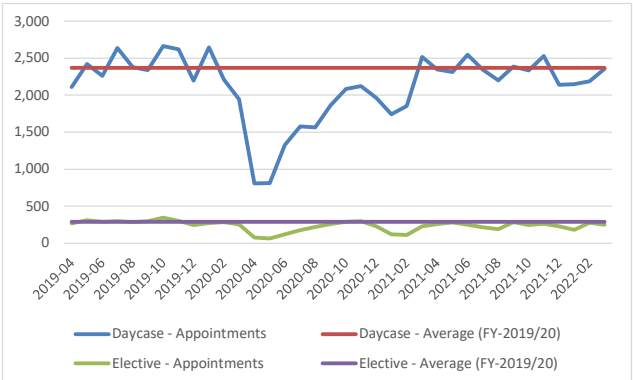
Referrals



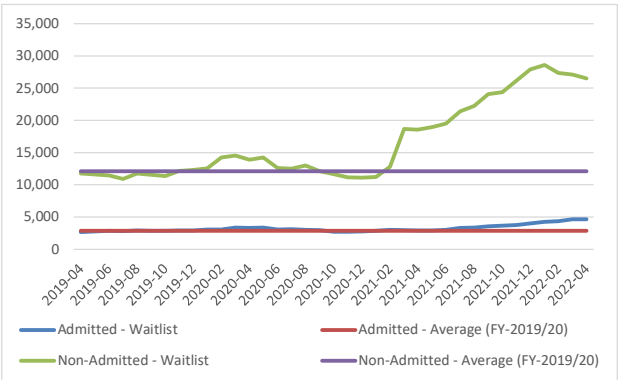
Outpatients



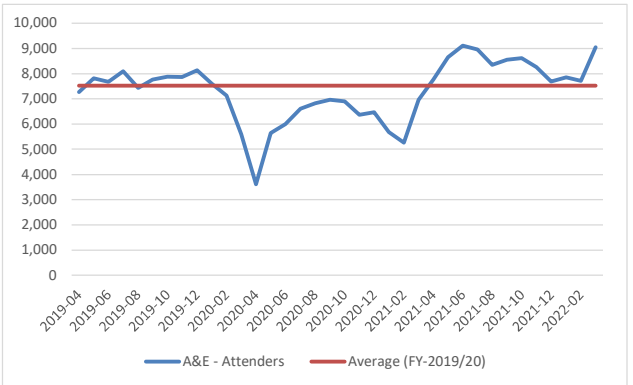
Elective



Waiting List



A&E Arrivals



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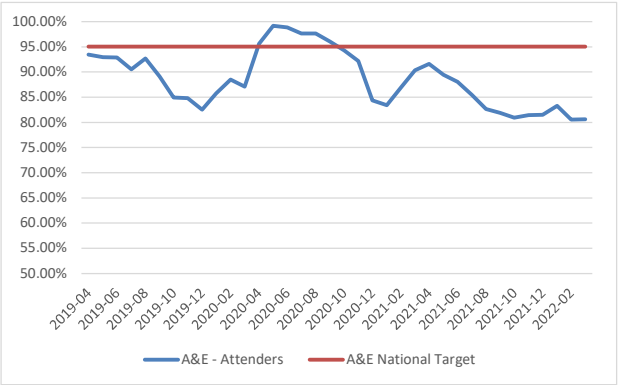
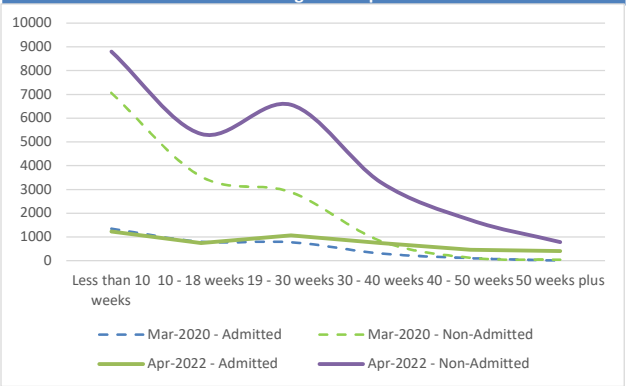
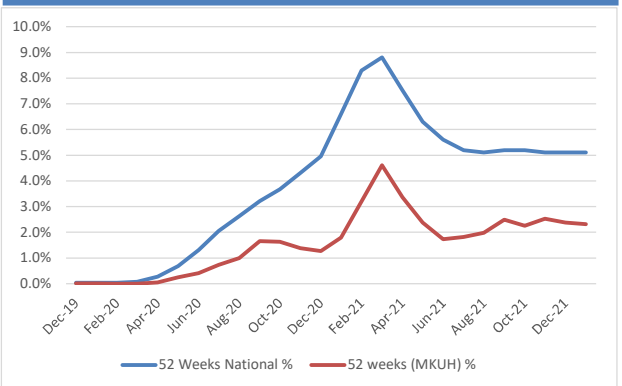


Waiting List Shape



% 52+ weeks waiters



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NHS
Milton Keynes University Hospital
NHS Foundation Trust

Meeting title	**Public Board**	**Date:**
Report title:	**Finance Paper Month 12 2021-22**	**Agenda item: 15**
Lead director **Report authors**	Terry Whittle Sue Fox Cheryl Williams	Director of Finance Deputy Head of Financial Management Financial Controller
FoI status:	Private document	

Report summary	An update on the financial position of the Trust at Month 12 (March 2022)			
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 31st March 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	See Appendix
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 31st MARCH 2022

TRUST BOARD

CONTENTS

EXECUTIVE SUMMARY

(1. & 2.) Revenue – Clinical revenue is paid as part of a block contract. Clinical revenue is above plan due to additional income for elective recovery. Non-clinical revenue is above plan due to income received for NHS pension contributions which is offset by pay.

(3. & 4.) Operating expenses – Pay is above plan with higher temporary staffing costs. Non-pay also above plan due to internally funded non-recurrent project spend.

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

(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 £58m, equivalent to 69 days cash to cover operating expenses. Balances include £9.1m for capital schemes.

(12.) Capital – The Trust is £7.8m higher than plan excluding the New Hospital Programme (NHP). However the plan doesn't include £5.9m of additional in year funding from the National Capital schemes. The Trust's final (Capital Departmental Expenditure Limit) CDEL is a breach of £1.9m which is the residual b/fwd. capital commitments for FY21 which has been agreed to be covered of at an ICS level

(13.) Elective Recovery Fund– Higher than planned levels of ERF were recorded up to Month 12 (March). This is due to the change in the calculation against completed pathways in 2019/20.

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

Ref	All Figures in £'000	Month 12 YTD Plan	Month 12 YTD Actual	Month 12 YTD Var	Full Year Plan	Full Year Forecast	Full Year Var	RAG
1	Clinical Revenue	297,314	297,531	216	297,314	297,531	217	
2	Other Revenue	19,542	29,691	10,149	19,542	29,691	10,149	
3	Pay	(203,271)	(207,282)	(4,011)	(203,271)	(207,282)	(4,011)	
4	Non Pay	(96,446)	(105,249)	(8,803)	(96,446)	(105,249)	(8,803)	
5	Financing & Non-Ops	(18,634)	(15,956)	2,678	(18,634)	(15,956)	2,678	
6	Surplus/(Deficit)	(1,494)	(1,266)	229	(1,495)	(1,266)	229	
7	Control Total Surplus/(Deficit)	(1,101)	(722)	380	(1,102)	(722)	380	
8	Inc. COVID expenditure	(10,966)	(7,177)	3,789	(10,966)	(7,177)	3,789	
9	High Cost Drugs	(18,900)	(21,842)	(2,942)	(18,900)	(21,842)	(2,942)	
10	CIP Delivery	6,960	6,960	-	6,960	6,960	-	
11	Cash	25,668	57,975	32,307	25,668	57,975	32,307	
12a	Capital Plan (excluding NHP)	22,290	30,080	7,790	22,290	30,080	7,790	
12b	Capital Plan (including NHP)	50,290	31,060	(19,230)	50,290	31,060	(19,230)	
13	ERF Delivery	9,532	12,180	2,648	9,532	12,180	2,648	
14	ICS Financial Position	-	-	-	-	-	-	

Key message

The Trust is reporting a £0.7m deficit for the period April to March, this position is favourable to plan. The Trust had income surety based on a block contract supplemented by significant additional Covid related income (for elective recovery and operational pressures). Funding was 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 excluding the NHP and additional national funding is a £1.9m Capital Departmental Expenditure Limit (CDEL) breach however it has secured £1.9m CDEL from its ICS partners.

FINANCIAL PERFORMANCE- OVERVIEW MONTH 12

2. **Summary Month 12**

For the month of March 2022, financial performance (on a Control Total basis) is a 0.4m surplus, this is favourable to plan.

3. Clinical Income
Clinical income shows a negative variance of £0.7m which is due to deferred ERF funding.

4. Other Income
Other income shows a favourable variance of £10.6m. This is principally due to an in-month adjustment for pension contributions of £7.8m which is offset by an equal and opposite adjustment in pay.

5. Pay
Pay spend is above plan with additional temporary staffing costs partly offset by substantive vacancies. An adjustment of £7.8m for pensions contributions was also made in month. Further detail is included in Appendices 1 and 4.

6. Non-Pay
Non pay is above plan due to internally funded non-recurrent project spend. Further detail is included in Appendices 1 and 5.

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

All Figures in £'000	Month 12 Plan	Month 12 Actual	Month 12 Var	Month 12 YTD Plan	Month 12 YTD Actual	Month 12 YTD Var	Plan Plan	Plan Forecast	Plan Var
Clinical Revenue	19,984	19,321	(663)	244,958	245,175	216	244,958	245,175	217
Other Revenue	1,378	12,002	10,624	19,051	29,130	10,079	19,051	29,130	10,079
Total Income	21,362	31,324	9,961	264,010	274,305	10,295	264,009	274,305	10,296
Pay	(16,577)	(18,409)	(1,832)	(203,271)	(207,282)	(4,011)	(203,271)	(207,282)	(4,011)
Non Pay	(7,921)	(17,446)	(9,525)	(96,446)	(105,249)	(8,803)	(96,446)	(105,249)	(8,803)
Total Operational Expenditure	(24,498)	(35,855)	(11,357)	(299,717)	(312,531)	(12,814)	(299,717)	(312,531)	(12,814)
EBITDA	(3,136)	(4,531)	(1,396)	(35,707)	(38,226)	(2,519)	(35,708)	(38,226)	(2,518)
Financing & Non-Op. Costs	(1,464)	550	2,014	(17,750)	(14,851)	2,899	(17,750)	(14,851)	2,899
Control Total Deficit (excl. top ups)	**(4,600)**	**(3,982)**	**618**	**(53,457)**	**(53,078)**	**380**	**(53,458)**	**(53,078)**	**380**
Adjustments excl. from control total:									
National Top up	3,430	3,430	0	41,160	41,160	0	41,160	41,160	0
COVID Top up	933	933	0	11,196	11,196	0	11,196	11,196	0
Control Total Deficit (incl. top ups)	**(237)**	**381**	**618**	**(1,101)**	**(722)**	**380**	**(1,102)**	**(722)**	**380**
Donated income	293	382	89	491	561	70	491	561	70
Depreciation	(71)	(78)	(7)	(834)	(840)	(6)	(834)	(840)	(6)
Impairments & Rounding	0	(217)	(217)	(50)	(265)	(215)	(50)	(265)	(215)
Reported deficit/surplus	**(15)**	**468**	**483**	**(1,494)**	**(1,266)**	**229**	**(1,495)**	**(1,266)**	**229**

Key message
For the month of March 2022, the position on a Control Total basis is 0.4m surplus, which is favourable to plan. Overspends in-month are offset by higher clinical income and reduced depreciation costs.

FINANCIAL PERFORMANCE- OVERVIEW YTD

8. **Summary Year to Date**

Cumulative financial performance (April to March) on a Control Total basis is a deficit of £0.7m. This is slightly better than plan. The incremental cost of elective care backlog recovery is offset by ERF. The Trust utilised ERF margin to support additional expenditure during Q4.

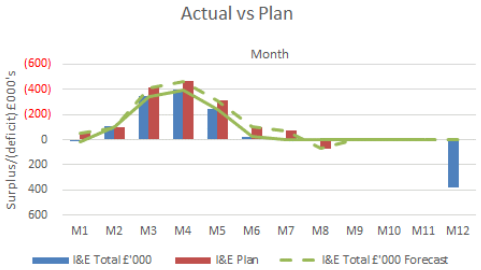
9. Clinical Income YTD
Clinical income shows a positive variance of £0.2m YTD, the Trust has recognised £12.1m related to ERF and £3m of accelerator income. Further detail is included in Appendix 1.

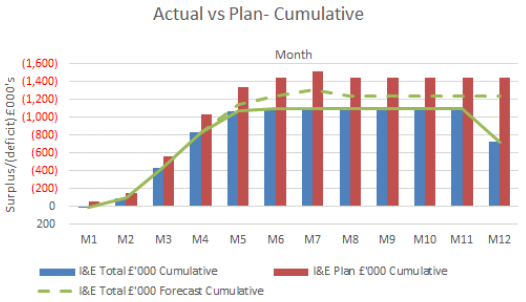
10. Other Income YTD
Other income is £10m above plan YTD. Additional Pension contributions of £7.8m were paid in month 12.

11. Pay YTD
Pay is overspent by 4m YTD. Additional pensions contributions of £7.8m were paid in month 12 which was offset by income. Increased bank and agency spend is offset by substantive vacancy savings. Further detail is included in Appendices 1 & 4.

12. Non-Pay YTD
There is a negative variance YTD of £8.8m. This is driven by spend on internally funded non-recurrent projects. Further detail is included in Appendices 1 & 5.

13. Non-Operating Expenditure YTD
Non-operating expenditure is £1.1m under plan YTD due to reduced depreciation charges.





Key message
Up to March 2022, the position on a Control Total basis is a deficit of £0.7m. This is slightly better than plan. Overspends on pay and non-pay relate to the delivery of additional clinical activity which is offset by additional income (ERF).

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 experienced a reduction in delivery during 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 was further 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>

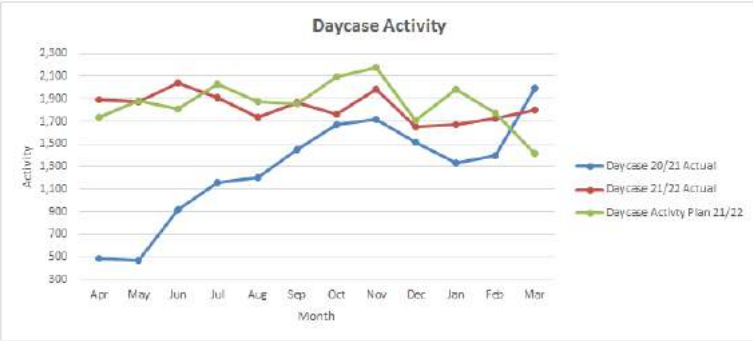
Day case activity-
Day cases have increased in the month, keeping them up the 21/22 plan but below March 2021.

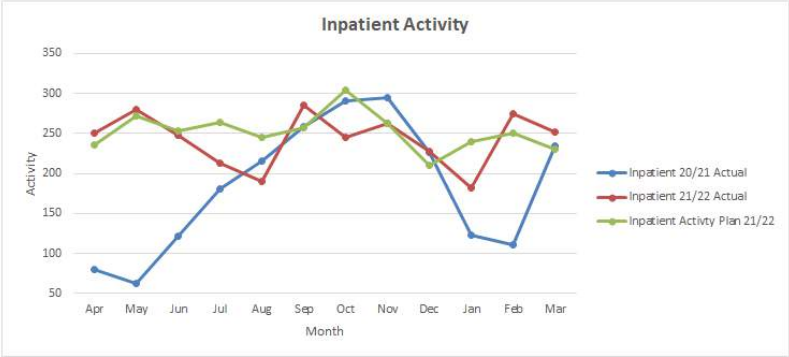
Elective Inpatient Activity-
Inpatient activity has decreased in month but remains higher than the 21/22 plan. It is also higher than M12 20/21 activity.

Outpatient Activity-
Outpatient activity has increased in March compared to the previous month. Actuals are above the 21/22 plan, and marginally below 20/21 activity.

Non-Elective Spells-
Non elective activity has increased against the previous month and is now above the 21/22 plan, and higher than 20/21 activity.

A&E activity-
A&E activity has increased in the month, coming in above the plan for March. It continues to remain high compared to 20/21 activity.





Key message
During Month 12 there were higher levels of elective day case, A&E, outpatient and non-elective activity. Further detail can be seen in Appendices 2 & 3.

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. Over the second half of the year the Trust has recognised an additional £4.9m bringing the total to £12.1m.

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 has been recognised in-line with the additional expenditure in Q4.

Key message
Day case and outpatient care activity increased in March. Due to the change in calculation and payment of ERF and the impact on planned care recovery from the Covid-19 Omicron variant, for prudency some income was deferred as it may need to be paid back to NHSE/I when the final clock stop information is calculated.

EFFICIENCY SAVINGS

20. As of March, the Trust has reported a breakeven position to plan, included within this position is £7m 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. Moving into the new financial year (2022-23) the Trust is increasing the focus on financial efficiency through the Better Value programme. The Trust has identified £3.5m from schemes submitted to date.

Key message
YTD the Trust has delivered its £7m efficiency requirement. This has been achieved through transactional saving schemes and managing the cost of operations within available resources. Work is progressing through the Trust 'Better Values' programme to identify schemes in line with the efficiency target for 2022/23.

CAPITAL- OVERVIEW YTD

22. The YTD spend on capital after accounting for donated assets and derecognised assets is £30.08m, which is above the Trust's capital plan (excluding the New Hospitals Programme (NHP) by £7.8m. However there was additional in year funding of £5.87m resulting in a £1.93m above the Trusts CDEL allocation. This is due to strategic schemes are brought forward from prior year with no CDEL. The £1.93m CDEL breach has been covered of by an agreed ICS transfer.

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 (£0.34m) and Imaging (£0.54m) 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	0.41				
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				0.34	
Digital Diagnostics Capability - Imaging				0.54	
Diagnostics Workforce - Echo cardiology				0.07	
Sub Total CDEL	**14.01**	**0**	**36.3**	**15.27**	**0.0**
CDEL Allocation Approved	**29.28**				**0.0**
Total Planned CDEL	**50.29**				

Capital Item	**YTD Plan up to end of Mar 22** £m	**Actual up to end of Mar 22** £m	**Actual vs CDEL Allocation** £m	**Status**	**Comments** Status
CBIG Allocation	**5.12**	**5.78**	**0.66**		Slippage on other schemes re-allocated to CBIG
Pre commitments					
Finance Leases	0.30	0.20	-0.10		Slippage on finance lease
Capitalised Staffing - IT and Estates	0.27	0.21	-0.06		Staff costs lower than expected
IT equipment	1.50	0.50	-1.00		Reallocated some spend under TIF Digital
Cerner Phase C	0.45	0.34	-0.11		Lower than expected due to VAT
LIMS (Pathology IT System)	0.02	0.11	0.09		Staffing costs not included in org plan
HR IT system	0.10	0.13	0.03		Slightly higher than forecast due to inflation
Mammography Installation for 2 machines	0.39	0.38	-0.01		
Breast Unit Building Works	0.50	0.01	-0.49		Slippage for Building Works re-allocated to CBIG, pre-commitment for 22/23
Sub Total Pre-commitments	***3.53***	***1.88***	**-1.65**		
Donated Assets (are excluded from CDEL)					
Baby Leo 3 incubators	0.08	0.08	0.00		Fully committed
Pathlake	0.43	0.29	-0.14		Balance now not expected until 22/23
COVID Donated assets	0.00	0.05	0.05		No impact on capital allocation
Other donated assets	0.00	0.14	0.14		renovations
Sub Total Donated	***0.51***	***0.56***	**0.05**		
Strategic Schemes					
Staff Room Refurbishment	0.20	0.05	-0.15		Delay due to access to areas, will be a pre-
CT Scanner (prior year COVID funding)	0.53	0.00	-0.53		Now supported by TIF funding
Endoscopy (prior year COVID funding)	0.23	0.08	-0.15		Not a priority for 21/22
Xray Interventional	1.20	0.00	-1.20		Now supported by TIF funding
Angio Interventional	1.40	0.00	-1.40		Now supported by TIF funding
Other strategic schemes allocation	2.83	0.70	-2.13		Schemes costs reallocated to Nationally Approved schemes
Radiotherapy	*0.00*	*0.74*	0.74		Additional radiotherapy costs
South Site Infrastructure	*0.00*	*1.84*	1.84		Monitoring forecast
Bed replacement	*0.00*	*1.47*	1.47		New scheme approved in year
Sensyne	0.00	2.50	2.50		No confirmed CDEL
Prior year schemes not allocated CDEL					
Endoscopy Fit Out (Whitehouse)	0.00	0.13	0.13		Supported by ICS CDEL Transfer
MRI installation	0.00	0.61	0.61		Supported by ICS CDEL Transfer
Flat roofs	0.00	2.20	2.20		Supported by ICS CDEL Transfer
HIP2 Infrastructure schemes	0.00	1.94	1.94		Supported by ICS CDEL Transfer
Sub Total Strategic Schemes	***6.38***	***12.26***	**5.88**		
Less Donated Assets	***- 0.51***	***- 0.56***	**-0.05**		
Derecognition of assets	**0.00**	**-2.86**	**-2.86**		Includes Cancer centre final agreement
Total ICS CDEL	**14.01**	**15.94**	**1.93**		Above CDEL allocation but within ICS CDEL Allocation
Other National Approved funding approved					
Maple Unit	8.28	8.28	0.00		
TIF (ERF Diagnostics)	0.00	3.00	0.00		
TIF (IT Digital)	0.00	1.92	0.00		
Digital Diagnostics - Pathology	0.00	0.33	0.00		
Digital Diagnostics - Imaging	0.00	0.54	0.00		
Diagnostics workforce - Echo Cardiology	0.00	0.07	0.00		
Total Capital (excluding NHP)	**22.29**	**30.08**	**0.00**		Above CDEL allocation but within ICS CDEL Allocation
New Hospital Programme (NHP)	28.00	0.98	0.00		
Total Capital (including NHP)	**50.29**	**31.06**	**1.93**		
ICS CDEL Transfer					
Revised CDEL after CDEL Transfer	**50.29**	**31.06**	**0.00**		

Key message
Capital expenditure is above plan by £1.93m , after excluding NHP but including the additional in year funding.

CASH

25. Summary of Cash Flow

The cash balance at the end of March was £58m, this was £32m higher than the planned figure of £26m. This is a decrease on last month's figure of £79m. (see opposite).

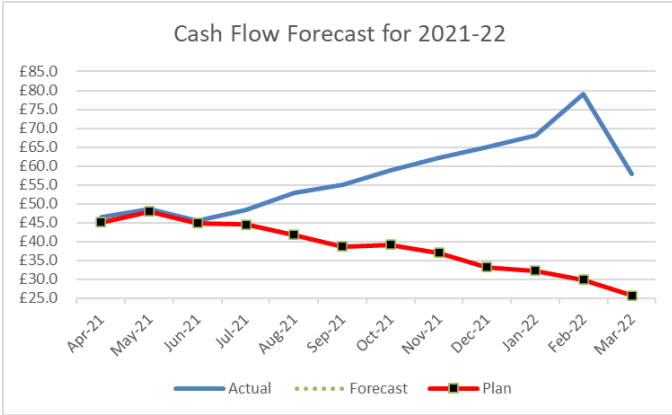
See appendices 6-8 for the cashflow detail.

26. Cash arrangements 2022/23

The Trust will receive block funding for FY23 which will include an uplift for growth plus any additional incentive funding linked to activity delivery and funding for high-cost drugs on a pass-through basis.

27. Better Payment Practice

The Trust has fallen below the national target of 95% of all bills paid within the target timeframe. This is mainly due to the repatriation of SBS AP services. Payment performance of NHS bills also requires 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 M12 YTD Number	Actual M12 YTD £'000	Actual M11 YTD Number	Actual M11 YTD £'000
Non NHS				
Total bills paid in the year	62,923	171,825	55,767	146,383
Total bills paid within target	57,461	162,037	51,084	138,050
Percentage of bills paid within target	**91.3%**	**94.3%**	**91.6%**	**94.3%**
NHS				
Total bills paid in the year	2,124	7,553	1,877	6,373
Total bills paid within target	1,590	4,124	1,430	3,798
Percentage of bills paid within target	**74.9%**	**54.6%**	**76.2%**	**59.6%**
Total				
Total bills paid in the year	**65,047**	**179,378**	**57,644**	**152,756**
Total bills paid within target	**59,051**	**166,160**	**52,514**	**141,849**
Percentage of bills paid within target	**90.8%**	**92.6%**	**91.1%**	**92.9%**

Key message

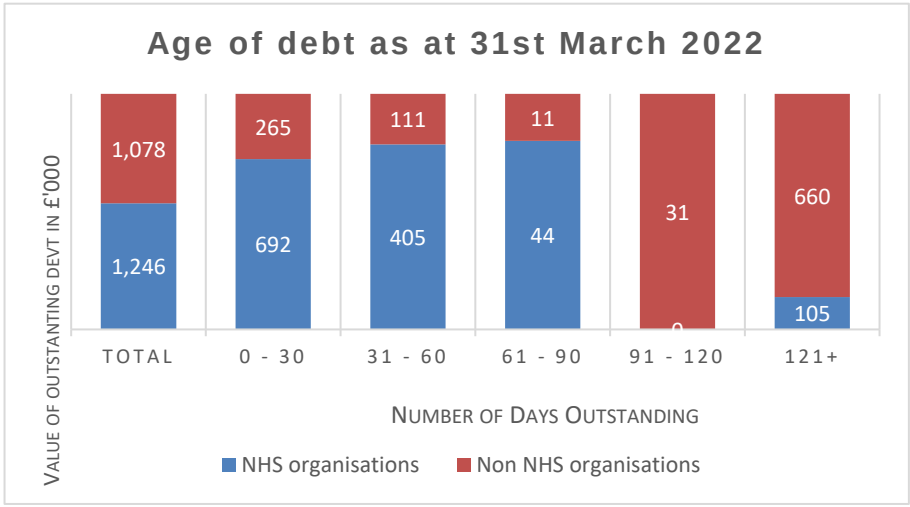
Cash is above plan by £32m, and the Trust has fallen below the 95% target for BPPC, mainly due to issues experience by SBS during their repatriation of AP services.

BALANCE SHEET

28. Statement of Financial Position

The statement of financial position is set out in Appendix 9. The key movements include:

- Non-Current Assets have increased from March 21 by £16.1m; this is driven by additions in year.
- Current assets have increased by £0.1m, this is mainly due to the increase in cash 9.2m and inventories £0.3m offset by a reduction in receivables (£9.4m).
- Current liabilities have increased by £6.3m, this is mainly due to the increase in Deferred Income £9.3m offset by decreases in Trade Payables (£2.5m) and Provisions (£0.5m)
- Non-Current Liabilities have decreased from March 21 by £0.1m, this is due to the movement in long term borrowings £0.2m offset by an increase in provisions (£0.1m)



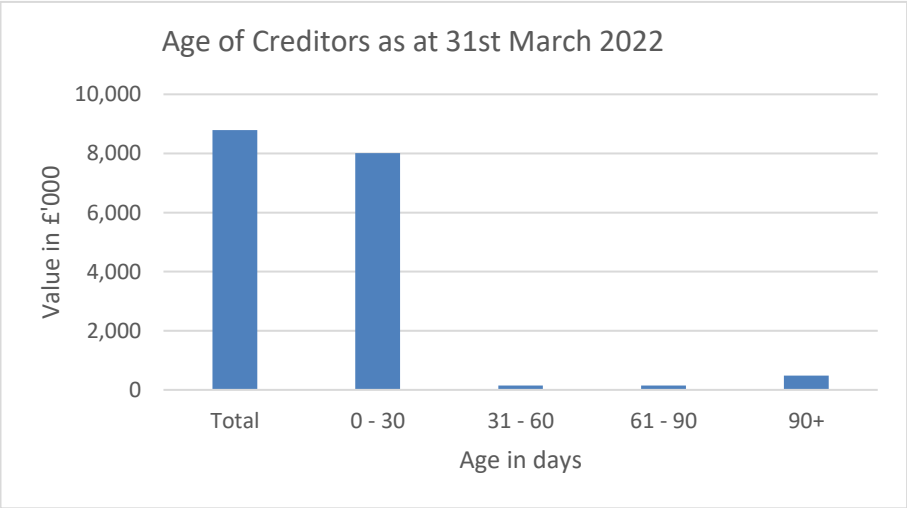
29. Aged debt

The debtors position as of 31st March is £2.3m, which is a decrease of £0.1m from the February position. Of this total £0.7m is over 121 days old, the detail is shown in Appendix 10.

The three largest NHS debtors are Bedford Hospitals NHS Foundation Trust £0.04m for salary recharges, NHS England £0.02m for Diabetic Retinopathy and training recharges amd Oxford University Hospitals NHS FT £0.02m relating to Renal recharges. The largest non-NHS debtors include £0.2m for overseas patients, £0.2m with Bedfordshire and Northamptonshire councils for sexual health, £0.1m with University of Buckinghamshire Ltd for utilities recharges. Further details of the aged debtors are shown in Appendix 11.

30. Creditors

The creditor's position is £8.8m, which is a decrease of £3.8m from the February 22 position. Of this £0.8m is over 30 days, with £0.6m approved for payment. The breakdown of creditors is shown in Appendix 12.



Key message

Main movements on the statement of financial position related to net capital additions in year £16m and increase in deferred income £9.3m; 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 31st March and the proposed actions and risks therein.

APPENDICIES

Appendix 1

Statement of Comprehensive Income
For the period ending 31st March 2022

	FY22	M12 CUMULATIVE			M12			PRIOR MONTH	
	Annual Budget	Budget	Actual	Variance	Budget	Actual	Variance	M11 Actual	Change
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME									
Outpatients	53,716	53,716	57,388	3,671	4,033	5,121	1,088	4,598 ▲	523
Elective admissions	26,165	26,165	24,636	(1,528)	1,729	2,079	351	2,115 ▼	(36)
Emergency admissions	77,583	77,583	75,419	(2,163)	5,460	6,713	1,253	6,123 ▲	591
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	16,398	16,994	596	1,017	1,513	496	1,299 ▲	214
Other Admissions	2,674	2,674	1,992	(682)	210	140	(71)	153 ▼	(13)
Maternity	21,670	21,670	21,243	(428)	1,772	1,572	(200)	1,552 ▲	20
Critical Care & Neonatal	7,001	7,001	7,025	24	602	583	(19)	540 ▲	43
Imaging	5,643	5,643	5,885	242	406	498	92	541 ▼	(43)
Direct access Pathology	4,818	4,818	4,651	(166)	300	457	157	393 ▲	64
Non Tariff Drugs and Devices (high cost/individual drugs)	18,900	18,900	21,842	2,942	1,541	1,995	455	1,580 ▲	415
Other (inc. home visits and best practice tariffs)	6,467	6,467	18,122	11,656	530	239	(291)	3,261 ▼	(3,022)
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	56,279	42,333	(13,947)	6,748	2,774	(3,975)	4,342 ▼	(1,568)
MKCCG Block adj	0	0	0	0	0	0	0	0 ▲	0
Clinical Income	**297,314**	**297,314**	**297,531**	**216**	**24,347**	**23,684**	**(663)**	**26,497 ▼**	**(2,812)**
Non-Patient Income	19,051	19,051	29,131	10,079	1,378	12,002	10,624	441 ▲	11,561
PSF Income	0	0	(0)	(0)	0	0	0	0 ▲	0
Donations	491	491	561	70	293	382	89	38 ▲	344
Non-Patient Income	**19,542**	**19,542**	**29,691**	**10,149**	**1,671**	**12,384**	**10,713**	**479 ▲**	**11,905**
TOTAL INCOME	**316,857**	**316,857**	**327,222**	**10,365**	**26,018**	**36,069**	**10,050**	**26,976 ▲**	**9,093**
EXPENDITURE									
Pay - Substantive	(174,597)	(174,597)	(168,020)	6,577	(14,729)	(8,822)	5,908	(14,635) ▲	5,813
Pay - Bank	(16,419)	(16,419)	(18,708)	(2,289)	(1,118)	(1,930)	(812)	(1,734) ▼	(196)
Pay - Locum	(4,493)	(4,493)	(3,672)	821	(304)	278	583	(366) ▲	645
Pay - Agency	(7,373)	(7,373)	(8,463)	(1,090)	(596)	(249)	346	(1,067) ▲	817
Pay - Other	0	0	(8,419)	(8,419)	182	(7,687)	(7,869)	(75) ▼	(7,611)
Pay CIP	(389)	(389)	0	389	(16)	0	16	0 ▲	0
Vacancy Factor	0	0	0	(0)	4	0	(4)	0 ▲	0
Pay	**(203,271)**	**(203,271)**	**(207,282)**	**(4,011)**	**(16,577)**	**(18,409)**	**(1,832)**	**(17,877) ▼**	**(532)**
Non Pay	(77,545)	(77,545)	(83,406)	(5,861)	(6,380)	(15,451)	(9,070)	(6,015) ▼	(9,436)
Non Tariff Drugs (high cost/individual drugs)	(18,900)	(18,900)	(21,842)	(2,942)	(1,541)	(1,995)	(455)	(1,580) ▼	(415)
Non Pay	**(96,446)**	**(96,446)**	**(105,249)**	**(8,803)**	**(7,921)**	**(17,446)**	**(9,525)**	**(7,595) ▼**	**(9,850)**
TOTAL EXPENDITURE	**(299,717)**	**(299,717)**	**(312,531)**	**(12,814)**	**(24,498)**	**(35,855)**	**(11,357)**	**(25,473) ▼**	**(10,382)**
EARNINGS BEFORE INTEREST, TAXATION, DEPRECIATION AND AMORTISATION (EBITDA)	**17,140**	**17,140**	**14,691**	**(2,449)**	**1,520**	**214**	**(1,307)**	**1,503 ▼**	**(1,289)**
Interest Receivable	0	0	36	36	(1)	23	24	9 ▲	14
Interest Payable	(290)	(290)	(267)	23	(26)	(22)	4	(22) ▼	(0)
Depreciation, Impairments & Profit/Loss on Asset Disposal	(12,739)	(12,739)	(10,438)	2,301	(1,062)	(168)	894	(710) ▲	542
Donated Asset Depreciation	(834)	(834)	(840)	(6)	(71)	(78)	(7)	(69) ▼	(9)
Profit/Loss on Asset Disposal & Impairments	(48)	(48)	(48)	(0)	0	0	0	0 ▲	0
DEL Impairments	0	0	(320)	(320)	0	0	0	(320) ▲	320
AME Impairments	0	0	(27)	(27)	0	(27)	(27)	(0) ▼	(27)
Unwinding of Discounts	0	0	0	0	0	0	0	0 ▲	0
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**3,229**	**3,229**	**2,786**	**(442)**	**361**	**(59)**	**(420)**	**390 ▼**	**(449)**
Dividends Payable	(4,723)	(4,723)	(4,052)	671	(376)	528	903	(422) ▲	949
OPERATING SURPLUS/(DEFICIT) AFTER DIVIDENDS	**(1,494)**	**(1,494)**	**(1,266)**	**229**	**(15)**	**468**	**483**	**(32) ▲**	**500**

Appendix 2

Statement of Cash Flow
As of 31st March 2022

	Unaudited Mth 12 £000	Mth 11 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	3,065	3,126	61
Operating (deficit)	**3,065**	**3,126**	**61**
Non-cash income and expense:			
Depreciation and amortisation	11,278	11,031	(247)
Impairments	348	0	(348)
(Gain)/Loss on disposal	(48)	(48)	0
Non-cash donations/grants credited to income	0	0	0
(Increase)/Decrease in Trade and Other Receivables	9,285	7,357	(1,928)
(Increase)/Decrease in Inventories	(375)	(7)	368
Increase/(Decrease) in Trade and Other Payables	9,435	10,659	1,224
Increase/(Decrease) in Other Liabilities	9,215	9,138	(77)
Increase/(Decrease) in Provisions	(338)	(303)	35
NHS Charitable Funds	(561)	(178)	383
Other movements in operating cash flows	(1)	(4)	(3)
NET CASH GENERATED FROM OPERATIONS	**41,303**	**40,771**	**(532)**
Cash flows from investing activities			
Interest received	36	13	(23)
Purchase of financial assets	(2,500)	0	2,500
Purchase of intangible assets	(2,948)	(2,314)	634
Purchase of Property, Plant and Equipment, Intangibles	(37,385)	(19,585)	17,800
De-recognition of PPE	0	0	0
Net cash generated (used in) investing activities	**(42,797)**	**(21,886)**	**20,911**
Cash flows from financing activities			
Public dividend capital received	15,273	13,897	(1,376)
Capital element of finance lease rental payments	(200)	(197)	3
Interest element of finance lease	(267)	(245)	22
PDC Dividend paid	(4,663)	(2,412)	2,251
Receipt of cash donations to purchase capital assets	561	178	(383)
Net cash generated from/(used in) financing activities	**10,704**	**11,221**	**517**
Increase/(decrease) in cash and cash equivalents	**9,210**	**30,106**	20,896
Opening Cash and Cash equivalents	**48,765**	**48,765**	
Closing Cash and Cash equivalents	**57,975**	**78,871**	**20,896**

Appendix 3

Statement of Financial Position as of 31st March 2022

	Audited Mar-21	Mar-22 YTD Actual	YTD Mvmt	% Variance
Assets Non-Current				
Tangible Assets	169.5	185.3	15.8	9.3%
Intangible Assets	22.0	22.3	0.3	1.4%
Other Assets	1.0	1.0	0.0	0.0%
Total Non Current Assets	**192.5**	**208.6**	**16.1**	**8.4%**
Assets Current				
Inventory	3.7	4.0	0.3	8.1%
NHS Receivables	7.3	5.0	(2.3)	(31.5%)
Other Receivables	12.5	5.4	(7.1)	(56.8%)
Cash	48.8	58.0	9.2	18.9%
Total Current Assets	**72.3**	**72.4**	**0.1**	**0.1%**
Liabilities Current				
Interest -bearing borrowings	(0.2)	(0.2)	0.0	0.0%
Deferred Income	(14.9)	(24.2)	(9.3)	62.4%
Provisions	(2.9)	(2.4)	0.5	(17.2%)
Trade & other Creditors (incl NHS)	(58.5)	(56.0)	2.5	(4.3%)
Total Current Liabilities	**(76.5)**	**(82.8)**	**(6.3)**	**8.2%**
Net current assets	**(4.2)**	**(10.4)**	**(6.2)**	**147.6%**
Liabilities Non-Current				
Long-term Interest bearing borrowings	(5.6)	(5.4)	0.2	(3.6%)
Provisions for liabilities and charges	(1.7)	(1.8)	(0.1)	5.9%
Total non-current liabilities	**(7.3)**	**(7.2)**	**0.1**	**(1.4%)**
Total Assets Employed	**181.0**	**191.0**	**10.0**	**5.5%**
Taxpayers Equity				
Public Dividend Capital (PDC)	259.9	275.1	15.2	5.8%
Revaluation Reserve	50.1	48.7	(1.4)	(2.8%)
Financial assets at FV through OCI reserve	0.2	(2.3)	(2.5)	(1250.0%)
I&E Reserve	(129.2)	(130.5)	(1.3)	1.0%
Total Taxpayers Equity	**181.0**	**191.0**	**10.0**	**5.5%**

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 Research & Development (R&D) Strategy

January 2022-December 2025

Executive Summary & Strategic Aims

There is robust evidence that taking part in research is good for patients and good for hospitals. Milton Keynes University Hospital (MKUH) has had a successful three years in 2018-2021 as one of the top recruiting small hospitals in England of participants to National Institute for Health Research (NIHR) portfolio studies. Furthermore, we have risen to the challenge of the COVID-19 pandemic, recruiting patients to key national studies such as ISARIC, RECOVERY and REMAP-CAP among others. This strategy document allows us to build on our 2018-2021 strategy and to formally set out the current activities of the Research & Development (R&D) Department and our ambitions for the next 3 years.

Our strategic aims for R&D are to:

- Build on and develop our current activities at MKUH
- Develop our staff, relationships and facilities
- Raise the profile of R&D and enhance clinician, patient and public engagement
- Take advantage of any new opportunities and create them where possible

At its heart this strategy is about ensuring that we have the 'basics' right to maximize our involvement in NIHR portfolio studies to the highest standards whilst also creating an environment in which we can take advantage of opportunities for innovation and 'own account' research and development as and when they arise.

The MK Way

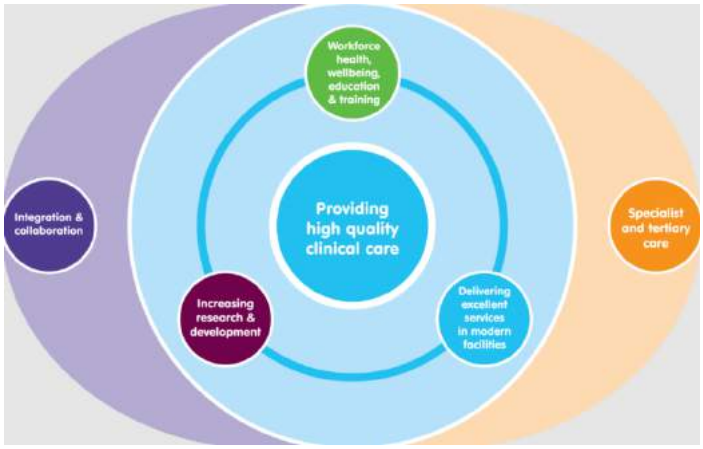
The MK Way is our refreshed vision, values, strategy and objectives for Milton Keynes University Hospital and have been developed in collaboration with our staff. These are all important as they provide the framework in which we operate, and our values particularly outline what we all believe is important in how we work.

All members of #TeamMKUH have a huge part to play in contributing to our goal of providing exceptional patient care and experience and through creating our new strategy, values and objectives, each and every staff member will understand how they can support the organization in delivering our vision.

Our Purpose, Vision, Values, Strategy and Objectives
Our Purpose*:* High quality care for everyone we serve.
Our Vision: for Milton Keynes University Hospital NHS Foundation Trust is to be an outstanding acute hospital and part of a health and care system working well together.
Our Values: We CARE, We COMMUNICATE, We COLLABORATE, We CONTRIBUTE
Our Strategy: has five key priorities which will help us to be an outstanding acute hospital and part of a health and care system working well together.
Our Objectives: Improving patient safety, Improving patient experience, Improving clinical effectiveness.

R&D Vision:

To deliver high quality patient care through robust and innovative research, development and innovation



Introduction

Milton Keynes University Hospital (MKUH) is committed to delivering high quality clinical care. Patients who are cared for in a research-active hospital have better overall healthcare outcomes (1), lower overall risk-adjusted mortality rates following acute admission (2) and better cancer survival rates (3,4). Furthermore, health economic data shows that interventional cancer trials are associated with reduced treatment costs benefitting the NHS financially (5). These benefits may result from a culture of quality and innovation associated with research active institutions. There is a reasonable further assumption that departments and clinicians within the Hospital, who are research active, provide better care. In turn, this suggests that it is desirable to encourage as many clinicians and departments to become research active as is practicable.

COVID-19

COVID-19 led to a near-complete interruption of existing research studies in the UK during 2020 and a rapid replacement by studies directed at tackling COVID-19. MKUH participated in a number of national studies delivered through Urgent Public Health including RECOVERY, REMAP-CAP, Genomicc, PRIEST, FALCON and ISARIC and were among the highest recruiting Trusts for our size. In addition, we facilitated Department of Health studies into COVID-19 antibody testing. From mid-2021 non-COVID research has restarted and barring an unexpected setback, eg from a vaccine resistant variant, we expect to continue to actively deliver COVID-19 and non-COVID-19 research according to NIHR priorities over the next 3 years.

National Priorities and the National Institute for Health Research (NIHR)

The NHS is committed to research through its Constitution and through its operational plans, policy frameworks and planning guidance. The main organization delivering research in the NHS is the National Institute for Health Research (NIHR). The NIHR's budget in 2020-2021 is £285,852,633, made up of £226,023,878 of fixed funding, £56,505,968 of variable funding, £2,070,141 of top-sliced funding and £1,252,646 of excess treatment costs.

Fifteen Local Clinical Research Networks (LCRNs) support the delivery of NIHR adopted portfolio research, to ensure patient access to research across England. MKUH is a member of the Thames Valley and South Midlands (TVSM) LCRN, hosted by Oxford University Hospitals NHS Foundation Trust. The 2020-2021 funding allocation for TVSM LCRN is £16,017,123. MKUH will receive £755,000 of this in 2020-2021. Our assumption is that overall NIHR funding and the proportion allocated to MKUH is likely to be broadly similar over the next 3 years. (https://www.nihr.ac.uk/documents/nihr-local-clinical-research-network-funding-allocations-202021/11735

NIHR high level objectives:
The NIHR CRN measures its effectiveness against a set of High Level Objectives which we will embed into the MKUH R&D strategic and operational plans wherever practicable. These objectives include:

- Increasing the proportion of CRN Portfolio studies that deliver in line with the study's planned delivery time and participant recruitment targets
- Increasing the number of research participants
- Reducing the time it takes for a study to set up and start at each research site
- Increasing the number of life-sciences studies supported by the CRN
- Increasing the number of health and care organisations active in research
- Increasing the number of participants involved in research into dementias
- Demonstrating to research participants that their contribution is valued

https://www.nihr.ac.uk/about-us/our-contribution-to-research/research-performance/clinical-research-network-performance.htm

National Institute for Health Research http://www.nihr.ac.uk/
Heath Research Authority (HRA) http://www.hra.nhs.uk/

Build on and develop our current activities at MKUH

NIHR LCRN funding provides most of MKUH R&D income. This supports the salaries of R&D staff in exchange for MKUH clinicians recruiting participants to NIHR portfolio studies, thereby providing benefit to patients, clinicians and to MKUH. In the last three years Milton Keynes University Hospital NHS Foundation Trust has delivered significant achievements in R&D, increasing research activity and engaging clinicians across most speciality areas.

In the financial year 2015/2016, 2018/19 and 2019/2020 we were the top recruiting small acute hospital for NIHR LCRN Portfolio studies in England. We plan to deliver a sustainable R&D budget

that manages risks associated with income and expenditure variation from year to year whilst living within our means. In 2020-2021 total R&D income was £933k very close to our target of £1M which we expect to reach within the next 3 years.

Increase recruitment to NIHR LCRN Portfolio Studies:
To maintain our position as a high recruiting small acute hospital over the next 3 years, to increase the number of participants recruited into NIHR LCRN Portfolio studies according to both NIHR and MKUH strategic priorities whilst delivering a sustainable budget. In addition, wherever practicable, we aim to increase the breadth of recruiting studies across teams and specialties at MKUH.

Increase our commercial research studies:
Commercial studies offer patients access to new treatments, diagnostic tools and/or devices which may otherwise be unobtainable. For some patients, e.g. those under cancer care, commercial research may present a last option when all avenues of standard care are exhausted. Commercial Research also brings in additional revenue for the Trust, for us to reinvest further into research. Our focus is on phase II-IV. We have no phase I programme (first in man). We aim to increase the number of commercial NIHR LCRN research studies performed at MKUH over the next 3 years.

Develop investigator led 'own account' research and external grant income:
'Own account' investigator-led research provides an opportunity for clinicians to develop their own ideas, individually or in partnership with external partners, to bring in grant income and to offer new approaches to clinical assessment or therapy for patient benefit and thereby enhancing the reputation of the Trust. In order to support this, we provide general advice/signposting and R&D expertise (eg in protocol and grant writing, completing Research Ethics Committee applications, trial design, data management and analysis, quality assurance and pharmacovigilance), to research-active clinicians who wish to develop their 'own account' investigator led research. We will offer this support directly wherever possible or through networking/signposting to external support where we do not have this expertise in house. Wherever possible we will encourage 'own account' research to be delivered through external grant funding and study registration on the NIHR research portfolio. Examples of 'own account research at MKUH include **VECTRA-ECG** (Validation study to assess the utility of a cardiac electrical biomarker (CEB) in patients with chest pain and **CHESS** (ChroniSense National Early Warning Score Study of a wearable wrist device to measure vital signs in hospitalized patients). Over the next 3 years we will continue to offer R&D support and advisory services for clinicians at MKUH to develop their own account research and apply for external grant funding

Maintain high standards of governance and reporting
The R&D Department and R&D Steering Committee is responsible through the Quality and Clinical Risk Committee to the Medical Director and Trust Board and meets regularly to review R&D activities and advise the Medical Director. The Steering Committee includes clinical staff as well as public/patient representation.

Most research studies are LCRN adopted with nationally determined approvals and monitoring processes that MKUH R&D facilitates locally. For studies where MKUH is acting as sponsor the same level of assessment and quality assurance is in place through Trust based Standard Operating

Procedures underpinned by sound financial processes. The R&D Steering Committee is responsible for maintaining and monitoring the R&D risk register.

Develop our Staff, Relationships and Facilities

Research active clinicians are more likely to deliver high quality patient care. The R&D Department will therefore continue to encourage staff to engage in research and to ensure that staff have the necessary knowledge, skills, and confidence to carry out high-quality research. We will request that information about the R&D department is included in departmental induction packs and facilitate the completion of Good Clinical Practice training by staff members involved in, or wanting to become involved in research. We will raise awareness of and promote completion of other core research training offered by the NIHR for research active staff, for example, Principal Investigator oversight training, research awareness, fundamentals of clinical research. A number of doctors have also completed MSc/PhD/DPhil qualifications at MKUH. We are committed, therefore, to support and develop a sustainable workforce with the skills to deliver high quality research at MKUH.

We will encourage and support the recognition of research activity in appraisals, revalidation and job plans for existing research active staff. We aim to work with divisional research leads to promote and increase the understanding by all MKUH staff of the importance of research and innovation in high quality clinical care. Research offers the opportunity for nurses and other AHP's to gain many additional governance, logistical and technological skills leading to a more knowledgeable, adaptable, and flexible workforce.

We will encourage the Trust to include research roles and responsibilities into job descriptions for new appointments where appropriate. We will explore the potential for this to include trainee medical and non-medical staff undertaking research projects and education as well as service (eg as Clinical Fellows), together with their Clinical/Educational Supervisors. Where appropriate we will engage external partners in developing these roles.

We will explore the potential for clinical nurses to gain a better understanding of the research nurse role with an option to have hybrid roles spanning both research and clinical work. We will also promote research as a specialty area with clearly defined career progression and opportunities for growth, with the potential incorporation of an Advanced Research Nurse Practitioner role. We aim to make involvement in research accessible to all through the promotion of equal opportunities, non-nursing degree entry into the Clinical Research Practitioner role, potential secondment opportunities for nursing and other health care professionals and the potential to develop nurse and administration apprenticeships in R&D

We intend to support and encourage nurse and other AHPs with an appropriate interest and ability to do practice -based research Master Level or PhD qualifications. And encourage participation of staff more generally in developing research and practice development projects.

Networks

A major strength of Milton Keynes University Hospital NHS Foundation Trust is that we are based in 'the golden triangle' between Oxford, Cambridge and London with existing or developing relationships with several Universities.

1. The University of Buckingham
2. The Open University
3. The University of Bedford
4. Cranfield University
5. University of Oxford
6. University of Warwick
7. Other interested academic centres (overseas)

Milton Keynes has the 2nd fastest growing economy in the UK. It will have an estimated population of 310,000 by 2026. MKUH already has a strong partnership with the University of Buckingham through the medical school. There is also a longstanding agreement to teach University of Oxford medical students as well as attending careers events in local schools and Academies. As clinical research at MKUH develops we are committed to strengthening existing partnerships and building new ones to develop innovative research and we will respond to new opportunities as they arise. We also have strong relationships with the Oxford Academic Health Sciences Network and through this with the Milton Keynes Chamber of Commerce. We also have useful and ongoing engagement with the TVSM CRN primary care research team and the Applied Research Collaboration Lead. We aim to expand our existing relationships with Universities, and health sector commercial organizations and to develop innovative approaches to healthcare through clinical studies. We are currently in discussion with the University of Buckingham to develop closer working relationships with a planned exemplar in Cardiology, which has been an active research group in receipt of external recognition and funding.

Innovation

MKUH has a reputation as an IT-focused organization and early adopter of new technologies eg the CMR Surgical Robot in urological, gynaecological and colorectal surgery. A number of our clinicians are developing new technologies e.g. in orthopaedic surgery, the use of delivery drones, artificial intelligence in analysing radiological images and cardiac monitoring. We will support these activities where they involve NHS research to obtain NHS ethics approval and assist in signposting to other resources/support wherever we can. The R&D department is actively moving towards paperless activity and incorporating digital tools into the delivery of research to enable cloud storage rather than the storage of paper documents. This aligns with the Trusts work towards reducing its carbon footprint whilst making the department more efficient.

R&D Nursing Capacity & Pharmacy Support

Capacity is an issue throughout NHS R&D in relation to pharmacy and nurse specialist/administrative support for research studies. We will work with Oxford and Thames Valley LCRN and the Pharmacy Department at MKUH to operate efficiently and maximize the number of studies that we are able to do at MKUH given these capacity limitations.

Developing Research Facilities

In order to efficiently deliver the increasingly complex research studies, the R&D team frequently physically see and assess research participants. It is a long-term goal for the research team to secure a dedicated facility including consulting rooms, a waiting area, and an area for storage of clinical trials equipment, centrifuges, consumables, a fridge, freezer and appropriate safety level hoods for processing of samples. We aim to develop a business plan for this as and when the opportunity arises for further hospital site development.

Raise the Profile of R&D and enhance clinician, patient and public engagement

Over the past 3 years R&D at MKUH has increased the profile of research within the Trust, TV&SM LCRN and nationally through various activities. These have ranged from meetings with research participants and research champions to training and teaching sessions and task group sessions. We have continuously expanded our interactions and contributions. Members of the R&D team regularly participate in radio interviews, publish patient's stories with support from the LCRN communications team and we are planning to continue, develop and grow these activities over the next 3 years.

R&D team members at MKUH actively participate in a number of the Trust's Boards such as the Clinical Quality Board, the Patient and Family Experience Board, Nursing, Midwifery and Therapies Board and in external Boards such as that of the Allied Health Sciences Network.

We will continue to raise the profile of R&D at MKUH internally and externally and develop an improved web presence on the MKUH internet and intranet pages to inform and engage patients and the public as well as staff and other clinicians about research taking place at MKUH.

Take advantage of any new opportunities and create them where possible

Milton Keynes is likely to double in size of population to c500,000 residents over the next 30 years if not before. It is planning to develop a new University MK:U (Project Two - MK:U a new University | MK Futures 2050). As it does, MKUH will also expand substantially over this period to meet the health needs of its population. It has an innovative and well-connected leadership team. It has a relatively discrete population with good integration between primary and secondary care. It is equidistant between London, Oxford and Cambridge with growing transport links. We cannot predict what opportunities will arise to create partnerships with health and health-IT companies, whether they be small and local or large global multinationals. Given the above developments, we will take advantage of these, as they arise, to further R&D activities at MKUH and better deliver our strategic aims.

Strategy Development, Monitoring and Reporting

This strategy was developed through discussions at the R&D Governance Committee and with individual members of this Committee which includes patient and public representation In addition a

stakeholders meeting including key Trust Leadership and external representation including from the Thames Valley and South Midlands LCRN was held in October 2021. This strategy will be reviewed annually by the R&D Steering Committee reporting to the Quality and Clinical Risk Committee along with an annual report underpinned by detailed financial management.

References

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Meeting title	**Trust Board of Directors**	**Date: 16 March 2022**
Report title:	**Quality Priorities 2022/23**	**Agenda item: 17**
Lead director **Report author**	**Kate Jarman** **Kate Jarman**	**Director of Corporate Affairs** **Director of Corporate Affairs**
FoI status:	**Public**	

Report summary	The Trust is required to set three 'quality priorities' in the annual Quality Account which, as required, have been approved by the Council of Governors.			
Purpose *(tick one box only)*	**Information** **Yes**	**Approval**	**To note** **Yes**	**Decision**
Recommendation	**There are three options for setting the quality priorities for 2022/23:** 1. Continue with the same priorities for a third year, as the pandemic continued throughout 2021/22 2. Realign 2021/22 priorities continuing aspects of some for a third year as they particularly (two and three for example) align with the Trust's operational priorities and wider national ambitions and select a safety priority based on current safety data# 3. Select entirely new priorities **Option 2 is recommended.**			

Strategic objectives links	Patient safety, patient experience, clinical effectiveness, well governed
Board Assurance Framework links	
CQC regulations	All domains
Identified risks and risk management actions	
Resource implications	
Legal implications including equality	Pursuant to individual risks

and diversity assessment	

Report history	Quality and Clinical Risk Committee March 2022 and Council of Governors March 2022
Next steps	N/A
Appendices	Papers follow

Quality Priorities for 2022/23

The Trust agreed the below three priorities for improvement in 2021/22, forming the three 'quality priorities' in the annual Quality Account, which must be agreed and approved by the Council of Governors.

- **Priority 1:** Improvements in the management of medication and outcomes for admitted patients with diabetes.
- **Priority 2:** Improvements in Outpatients efficiency.
- **Priority 3:** We will reduce length of stay for our older patients

The priorities for 2021/22 were continued from 2020/21 because the delivery of the 2020-21 priorities were significantly impacted by the operational challenges of the Trust's response to COVID-19. The Trust has deemed it appropriate to continue with these priorities for 2021-22, refreshing the metrics and objectives, and considering ongoing COVID-19 priorities. A summary narrative on the priorities is included at Appendix A.

The Trust has always selected the priorities to cover the three domains of quality (safety, experience, effectiveness), which also aligns with the organisation's three core strategic objectives.

There are three options for setting the quality priorities for 2022/23:

4. Continue with the same priorities for a third year, as the pandemic continued throughout 2021/22
5. Realign 2021/22 priorities continuing aspects of some for a third year as they particularly (two and three for example) align with the Trust's operational priorities and wider national ambitions and select a safety priority based on current safety data
6. Select entirely new priorities

Recommendation

The recommendation is to realign 2021/22 priorities continuing aspects of some for a third year as they particularly (two and three for example) align with the Trust's operational priorities and wider national ambitions and select a safety priority based on current safety data.

It is proposed therefore the 2022/23 qualities would be:

- Reduction in deep tissue injuries (pressure ulcers)
- Improvements in (elective care) to reduce long waiting times
- Reductions in discharge delays

Appendix A

The ***first priority, improvements in the management of medications and outcomes for admitted patients with diabetes***, is an area that has the potential to provide significant improvements in patient safety.

The ***second priority, which is a continuation of one of last year's priorities around reducing high Did Not Attend (DNA) rates, focuses further on improving efficiency in the Outpatients Department*** –this will improve operational effectiveness.

The ***third priority–on reducing the length of inpatient stay for some patients***, focuses on improving patient experience by ensuring that patients only stay in hospital as long as they medically need to do so.

Priority 1: Improving Care for Inpatients with Diabetes
Reduce harm from failure to recognise and respond appropriately to both high and low glucose levels. Improve the experience of patients with diabetes and empower them to be self-managing whenever possible.

Why have we selected this Priority?
Failure to act or recognise and respond to both high and low glucose levels can have serious implications for patients with diabetes and can result in patient harm. Our monitoring of patient safety incidents show that a significant number of incidents are related to delays and poor management of hypoglycaemia episodes following glucose monitoring and medication administration errors related to the administration of insulin. Approximately 1 in 6 people admitted as inpatients to our hospital have diabetes. The majority of our patients are admitted for a variety of medical reasons rather than specifically for the management of their diabetes which adds to the complexity of delivering excellent patient centred care for patients with diabetes.

Priority 2: Improvements in Outpatients Efficiency.
This is a continuation of one of the priorities for 2020/21, including efforts to reduce high Did Not Attend (DNA) rates which weren't necessarily the patients' fault as other metrics were involved, e.g. timing of letters, changing of appointment dates.

Outpatient activity has grown faster than all other hospital activity in the last 10 years. Due to the significant impact of the COVID-19 pandemic in 2020/21,there were 313,363 outpatient attendances from 383,764 outpatient attendances in 2019/20and 383,036 in 2018/19. With the growth of the town and the decline of COVID-19 infections however, outpatient activity is predicted continue its upward trajectory year on year.

There continues to be scope for improvement in outpatients which will make the experience better for both the patients and staff and will greatly improve the efficiency of how the service operates. The work is effectively split into 2 key areas – digital advancement and operational efficiency. The digital road map continues to make great progress with developments in eCare, Synertec and MyCare which are transforming communication into paperless processes. The operational efficiency is

focussed on developing robust metrics and dashboards to better understand efficiency and improved utilisation.

Why have we selected this as a priority?
We have continued to focus on Outpatients' efficiency as a priority because we know there is greater opportunity to be captured to improve patient experience and be more efficient across processes and our interfaces with patients and the public. Patient feedback tells us there is more to be done.

Priority 3: We will reduce length of stay for our older patients.
There are many reasons why a hospital discharge for an older person is not straight forward. We have introduced a programme of work to understand and address these 11issues with the aim that we reduce the number of patients still in hospital once they are medically fit for discharge. We also want to reduce the number of beds occupied by patients with a length of stay of 21 days or more.

Why have we selected this as a Priority?
Long stays in hospital introduce the risk of functional decline in people over the age of 70. Patients in this age group occupy around 56% of the beds in our medical and surgical wards. Functional decline can be caused by inactivity and sleep deprivation, and increases the risk of falls and fracture, prolonged episodes of acute confusion and hospital acquired infections. For this reason, we need to work with patients and their families so that people only stay in hospital until they are medically fit for discharge. National audits looking at reasons for longer lengths of stay typically show that up to half the reasons why patients are not discharged earlier are under the direct control of the hospital itself. We are therefore supporting wards to adopt and embed proactive approaches to managing patient pathways and are looking for real-time data highlighting local constraints so we may capture the system issues that need to be addressed. By reducing long lengths of stay for medically fit patients we will not only improve the experience for patients and reduce the risk of harm, functional decline and/or loss of independence; we will aim to keep patients on their speciality wards, remove the need for escalation beds and reduce 'on the day' cancellation of inpatient surgery.

Meeting Title	Trust Executive Committee	**Date:** 5th May 2022
Report Title	Risk Report	**Agenda Item: 18**
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 28th April 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	*Public Board*
Appendices/Attachments	*Significant Risk Register – as of 28th April 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 32 significant risks identified on Risk Registers across the Trust, and of these risks, 4 are overdue their review dates (a reduction of 2). The 4 overdue risks have been escalated for corporate review.

- There was 1 new significant risk added since the last report in March 2022:

  RSK-331 - IF Medicine continues to use outdated practice in relation to IV insulin (variable rate) practice with fluids. THEN the Trust will be in breach of national guidance and patients/staff are at potential risk of harm.

  Risk Scoring - Consequence: 4, Likelihood: 4, Current Risk Score = 16

- There is 1 risk showing on Radar as controlled (a reduction of 3 since the last report). This is where current risk scores for the risks are the same as their target risk scores. The controlled risk details are below:

  RSK-127 - 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

- There is 1 risk that has been identified as uncontrolled (a reduction of 2). This is therefore recorded as significant risk with no controls in place to reduce the risk. This risk will be reviewed with the relevant risk owner to identify whether there are controls in place and if not, discuss what controls need to be developed. The uncontrolled risk is listed below:

  RSK-247 - IF the wait times for ventilated babies and children requiring transfer to a tertiary centre continue to increase due to increasing pressures across the system. THEN the children's physiotherapy and on call team will be asked to assess and treat ventilated children. The physiotherapists do not currently have the training and competencies to complete this.

3. UPDATES

The Trust Secretary and the Risk Manager have continued the monthly meetings with the Divisional Triumvirates to review the divisional risk registers. The purpose of these meetings is to ensure risks are kept up to date, that they are appropriately scored, that the controls are being progressed, and that the risks reflect the current risk profile of each Division. The Risk Manager continues to review CSU/Divisional risk meeting papers, attend adhoc CSU/Divisional meetings, and meet with Risk Owners and Departmental Managers to help support them with the monitoring, review, and management of their risks, and to help develop oversight of risk across the Trust.

In early February 2022, Internal Audit highlighted that 44% of risks (at all levels) were overdue their review date. This was, in part, due to the transfer of risks from Datix to Radar. However, since these risk meetings commenced later in February 2022, that figure has been reduced to 13%, from 20% in the last report. There are currently 32 risks, out of a total of 239, that are overdue (13%) which demonstrates the positive impact these meetings are having.

To increase staff awareness of the risks associated with their areas, the Risk Manager has developed a weekly 'Risk Guardian' email to inform them of any risks that had been raised within a week. The 'Risk Guardian' also provides key information and/or learning in relation to risk.

A monthly report to staff on risks that are overdue their review dates and/or where there are gaps/incorrect formatting was also introduced in March 2022. The Risk Manager will contact Risk Owners where there appears to be a training need or to chase ongoing or significant breaches.

4. NEXT STEPS

As the steps being taken to improve the review of risks are being embedded, the Trust Secretary and Risk Manager are now working on improving risk communication in the Trust. The plan is to develop and embed an improved risk communications framework to significant enhance risk awareness among the Trust staff. Additionally, steps will be taken improving how risk is reported throughout the organisation, and to the Board.

Once the above processes are in place and have been embedded, the Risk Manager will develop an ongoing Risk Management training programme for staff. This will include looking at what information staff need to know at their induction, through to how regularly staff need to update and refresh their Risk Management knowledge and skills.

5. RECOMMENDATION

The Group is asked to review and discuss this paper.

6. APPENDICES

Appendix 1 - Significant Risk Register as at 28th April 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

Report Date: **28-Apr-2022**

Status Legend:
NotApplicable
Compliant
Planned
Pending
Overdue

Risk Score Legend:	
	Un scored
1 - 3	Very Low
4 - 6	Low
8 - 12	Moderate
15 - 25	High

Reference	Created on	Owner	Description	Impact of risk	Scope	Region	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	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. 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 6. harm to the patients 7. adverse impact on mental health of Pharmacy staff All resulting in adverse patient outcomes. Lack of financial control on medicines expenditure Breach of CQC regulations	Organisation		04-Apr-2022	14-Jul-2022	Planned	20	20	6	Actively recruiting staff	Business Case for additional staff(05-Apr-2022),Temporary role realignment towards patient facing roles(05-Apr-2022),Use of Agency Staff(05-Apr-2022)	Low	Treat	Business Case has been submitted, due for review Q1 2022/23
RSK-088	15-Oct-2021	Zuzanna Gawlowski	IF there is 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. THEN we will be unable to meet patient needs or network requirements (without the increase in cot numbers and corresponding cot spacing). We will also be unable to meet PHE recommendations for social distancing	LEADING TO potential 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	Region	Paediatric Services	28-Mar-2022	28-Apr-2022	Pending	25	20	9	New Women's & Children's hospital build	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),Business Case for Refurnishing Milk Kitchen and Sluice(15-Oct-2021),2. Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID(15-Oct-2021),3. Added to capital plan(15-Oct-2021)	Low	Treat	Risk assessment to be carried out again by LV. Risk reviewed 19/01/22 by CGL/ ZG/CS/JP/LV-risk grading to remain at present Update required regarding newbuild. Further clarification required regarding risk being reduced.
RSK-125	04-Nov-2021	Adam Biggs	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		01-Mar-2022	07-Feb-2022	Overdue	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)	Low	Treat	Trust follows national guidance on all responding mechanisms covering COVID-19 alongside its Category one responsibilities
RSK-126	04-Nov-2021	Zuzanna Gawlowski	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		07-Mar-2022	18-Jan-2022	Overdue	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)	Low	Treat	Risk transferred from Datix to Radar
RSK-131	04-Nov-2021	Paula Robinson	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 inability to manage patients privacy and dignity, an increased risk of infection due to overcrowding of facilities, and there will be a lack of capacity for appropriate management of CT and MRI within KPI and DM01 timescales	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	18-Apr-2022	20-Jun-2023	Planned	20	20	16	Business Case to be developed for Radiographers,Review of Radiologists - demand and capacity,New CT Machine to be implemented,Recruitment of staff	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)	Medium	Treat	Risk reviewed by Triumvirate. Risk linked to RSK-112. Risks merged. Additional controls added.

Reference	Created on	Owner	Description	Impact of risk	Scope	Region	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-158	12-Nov-2021	Adam Baddeley	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 Staff morale will reduce as they will not be providing the appropriate level of assessment and treatment to their patients Length of stay may increase as patients will not be seen in line with care plans due to prioritising discharges High volume of patients not being seen daily, only new assessments, discharges and acute chests being reviewed.	Organisation		18-Apr-2022	30-May-2022	Planned	16	20	12	Closure or Reduction in Escalation Beds	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 Physiotherapy to determine cover for the base wards. To work closely with community services to raise awareness and to increase discharge opportunities i.e. in reaching Therapies working with Long stay Tuesday initiative Therapies supporting new discharge pathway/process in the Trust Over recruitment of PT and OT band 5's Increase in therapy assistant staff base. Locum cover for vacant posts.(12-Nov-2021)	Low	Treat	Risk reviewed with Divisional Triumvirate. Control added
RSK-001	06-Sep-2021	Tina Worth	IF all known incidents, accidents and near misses are not reported on the Trust's incident reporting system (Radar); 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		28-Mar-2022	29-Jun-2022	Planned	20	16	12	Staff competence and confidence with Radar reporting, with improved reporting rate, reduction in inaccurate reports on system and/or failure of incidents being reported	Incident Reporting Policy(06-Sep-2021),Incident Reporting Mandatory/Induction Training(06-Sep-2021),Incident Reporting Training Guide and adhoc training as required. Radar to provide on site & bespoke training IT drop in hub to be set up 2 days a week for staff drop ins(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	Radar has been in sue now since November 2021. Increase in reporting rate starting to be seen however not to previous levels and still some staff uncertainty re system so risk grading unchanged
RSK-016	22-Sep-2021	Simon Nicholson	IF there is a lack of flow in the organisation THEN there may be an unsafe environment for patients	LEADING TO a potentially impact on bed space capacity, ambulance queues, missed Emergency Access Targets and overcrowding into ED/radiology corridors creating Health & Safety hazard and continued pressure, leading to poor patient care/treatment and delays in discharge/transfer and the potential for an increase of incidents being reported regarding assessment/care/treatment, and or significant number of patients with a high acuity/ dependency being cared for in areas that are not suitable for safe care	Region	Emergency Department	23-Feb-2022	12-Apr-2022	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 ongoing. Active management of Nursing/Consultant and Registrar gaps in rota daily to ensure filled.,RAT-ing process and medical specialty referrals having a RAG system developed to prioritise sickest patients to be assessed.,Walking majors and resus reconfigured. Expanded Cubicle space in Majors - extra 10 spaces, increased capacity using Acorn Suite.,Internal escalation policy in place. CSU lead developing trust escalation criteria to alert trust leads to problems sooner - diverting patients to; Ambulatory care,Since Covid pandemic, phasing plan in place with red and green zones within ED.,Escalation plan for ED to mitigate patient pressures		Low	Tolerate	Risk reviewed by C Rockliffe and CGL-Advised flow remains the same. Further update required from ADO.Review 1-2 months
RSK-036	28-Sep-2021	Helen Chadwick	If there is no capacity in the Pharmacy Team THEN there is a risk that Pharmacy and Medicines Policies and Procedures may not be reviewed and updated in a timely manner, nor new policies developed	Leading to: Potential for Policies & Procedures to be out of date Potential for staff to follow out of date Policies & Procedures Failure to meet CQC requirements Lack of guidance for staff Potential harm to patients	Organisation		04-Apr-2022	18-Aug-2022	Planned	16	16	6	Recruitment of staff	Use of remote bank staff to update policies(28-Sep-2021),Business Case for additional Pharmacy staff(19-Apr-2022)	Low	Treat	Control of risk is dependent on recruiting staff. See risk RSK-035

Reference	Created on	Owner	Description	Impact of risk	Scope	Region	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-064	07-Oct-2021	Julian Robins	IF the Eye Injection Clinic Capacity continues to grow and the Ophthalmology team are not be able to meet capacity demands THEN there will be an an increasing number of patients outstanding for eye injections (this is people plotted and increases every week as people are plotted from past injections).	LEADING TO a delay to sight saving treatment – time critical treatment.	Region	Head & Neck	26-Apr-2022	12-May-2022	Planned	20	16	4	Planning for second injection room - lack of space and need to need funding to convert room (21-Apr-2022),Increase Use of non medical, allied health professional injectors (21-Apr-2022),Weekend WLI clinics planned to catch up as temporary measure,Training up of Optometrists to do injections,Recruitment to SAS and fellowship roles,Team to consider an increase in nursing staff to run eye injection clinics,Nurse in training due to start in September & 2 nurses on ophthalmology course	Introduction of further Injection Clinics all day Friday (staff permitting)(21-Apr-2022),One stop clinics were introduced - increase 2 sessions to 4 - consultant led(21-Apr-2022)	Low	Treat	Risk reviewed at Ophthalmology CIG Meeting in March 2022. We are currently not meeting our targets for intravitreal injections and the time spans are increasing. Therefore Current Risk Score needs to be increased to 16.
RSK-079	14-Oct-2021	Celia Hyem-Smith	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 THEN the Physiotherapy waiting lists may reach unacceptable levels	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. Increased staff stress and sickness, staff being unable to treat as many patients as pre Covid-19, staff having to use clinical time for admin duties	Region	Therapies	15-Mar-2022	01-May-2022	Pending	20	16	12	Approval given for locum support until the end of November 2021 (02-Feb-2022),All referrals triaged on receipt and rated as urgent, routine and non-urgent. Maintain contact with long waiters to determine if they still need our service. Packs and leaflets sent out, as appropriate (02-Feb-2022),Set slots kept for very urgent cases but does not meet needs.,12-month fixed term contract approved for 1.00 WTE, Band 6 member of staff (06-Apr-2022),Request made to use the therapy treatment room on ward 14 for outpatient services. This area could remove 4 staff from the existing space and free up three clinic rooms and the need to access the gym,Plans to re-instate small group sessions allowing approx. 40 patients to be seen per week	Virtual clinic appointments have been introduced as part of the treatment pathway(14-Oct-2021),Additional areas suitable for telephone and video clinics have been identified and additional resources supplied(14-Oct-2021),Reconfiguration of department to support virtual working, enable social distancing and allowing appropriate staff to work from home(14-Oct-2021),An additional room has been refurbished for MSK. Refurbishment of two orthotics rooms has provided workspace for the WMH team.(14-Oct-2021),Separate risk assessment completed relating to under resourcing within the admin team(14-Oct-2021)	Low	Treat	Risk added to Risk Register following approval at Therapies governance meeting
RSK-080	15-Oct-2021	Andrew James	IF the pathway unit is not in place THEN moderate to severe head injury patients will not be appropriately cared for and will not be treated in accordance with NICE guidance (CG176: Head injury: assessment and early management, updated September 2019) These patients may frequently fall under the remit of the T&O Team or be nursed on a surgical ward when they should be under a neurological team.	LEADING TO Potential reduction in patient safety - T&O surgeons and nursing teams may be unaware of how to care for patients with moderate to severe head injuries especially patient who are anticoagulated. Clinicians may have to wait for an opinion from the Tertiary Centre staff training, competency and experience Serious incidents Reduced patient experience	Region	Musculos keletal	26-Apr-2022	30-May-2022	Planned	12	16	8	Implementation of Pathway Unit	- On going discussions with Senior Medical Team - CSU Lead to escalate via trauma network - Alert process is in place for escalation within T&O & externally. - Resources available at tertiary site for advice/support(15-Oct-2021),1, 2 c& 3. mitigating controls - Policy for management of head injuries has been developed - Awaiting appointment of head injury liaison Nurse - Long term plan for observation block to be built.(15-Oct-2021),GAPS: - Trust is not in line with other trauma units - Regional trauma centre advises head injury should not be managed by trauma and orthopaedics and after 24 hours the patient should be referred to neurosurgery. - Potential delay in opinion from Tertiary Centre(15-Oct-2021)	Low	Treat	Risk reviewed by Surgery Triumvirate - No change to risk until the Pathway Unit is in place
RSK-093	22-Oct-2021	Elizabeth Pryke	IF there is insufficient staffing within the dietetics department in paediatrics THEN they will be unable to assess and advise new patients and review existing patients in a timely manner.	LEADING TO an impact on patients nutritional status and longer term dietary management on what is a very vulnerable group of patients. The majority of our caseload is infants or tube fed infants and children where there nutrition and growth is a priority	Organisation		18-Apr-2022	30-Apr-2022	Pending	16	16	12	2 new starters to join the team in the next few weeks will start to increase paediatric dietetic provision - to review waiting list once new starters in post	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 basic grade dietitian is also being sourced from the locum agency, with the expectation that senior dietetic staff can cover the complex paediatric cases.(22-Oct-2021)	Low	Treat	Risk reviewed at Risk & Compliance Board. Escalation onto the Corporate Risk Register approved.
RSK-115	29-Oct-2021	Mark Brown	IF annual and quarterly test reports for Autoclaves and Washer Disinfectors used for critical processes are not being received in a timely manner from the Estates department and there is no Authorised Person (D) to maintain the day to day operational aspects of the role THEN the Trust will be unable to prove control, monitoring and validation of the sterilisation process as a control measure. Both units are reviewed only 1 day per month - a bulk of this time is spent checking records and the other aspects of the role do not get the sufficient time required to review and follow up.	LEADING TO possible loss of ISO 13485 accreditation due to non-compliance to national standards. Inconsistent checks or lack of scheduled tests for the steam plant also increase the risk.	Organisation		16-Mar-2022	02-May-2022	Pending	20	16	6	A meeting took place in January with estates managers, where HSDU were seeking assurance that the service would be covered. Estates have agreed to look for a plan to mitigate the risk and to keep HSDU fully informed. HSDU have informed the AE(D), so he is now aware that the site will not have any day to day operational AP(D) cover. (21-Feb-2022)	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	No AP(D) in post. no day to day operational cover. Once monthly report checks carried out by AE(D). Paperwork checks no operational checks.

Reference	Created on	Owner	Description	Impact of risk	Scope	Region	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-127	04-Nov-2021	Karan Hotchkin	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		26-Apr-2022	12-May-2022	Planned	20	16	16		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),Discussions on going with BLMK partners to understand CDEL flexability across the system.(21-Mar-2022)	Medium	Treat	Risk transferred from Datix to Radar
RSK-134	04-Nov-2021	Karan Hotchkin	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 and 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		26-Apr-2022	12-May-2022	Planned	20	16	8	The current funding has now been clarified and work is on going with BLMK system partners to finalise the funding allocations for 22/23	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	Tolerate	Risk transferred from Datix
RSK-135	04-Nov-2021	Jill Beech	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 and being unsupported by the supplier	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	20-Apr-2022	30-May-2022	Planned	16	16	4	Low Level Design to be 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-2021),Project Manager role identified to lead project for MKUH(04-Nov-2021),High Level Design Completed(01-Dec-2021)	Low	Treat	Risk reviewed at Pathology CIG on 12th April 2022. Proposed approximate 6-month delay with the LIMS go-live date from Clinisys due to microbiology workstream. S4 are consulting on the impact of this and a decision is due this week.
RSK-305	06-Dec-2021	Karan Hotchkin	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	LEADING To financial loss and reputational damage	Organisation		26-Apr-2022	12-May-2022	Planned	16	16	9		The trust has a process to target investment of available capital finance to manage risk and safety across the hospital(06-Dec-2021)	Medium	Treat	Risk was approved by Finance and Investment committee on 30/12/2021
RSK-335	25-Apr-2022	Melanie Kennedy	IF Medicine continues to use outdated practice in relation to IV insulin (variable rate) practice with fluids THEN the Trust will be in breach of national guidance and patients/staff are at potential risk of harm	LEADING TO	Region	Internal Medicine	25-Apr-2022	30-May-2022	Planned	16	16	8	Process developed by MKUH which maintains good practice in relation to IV insulin (variable rate) practice with IV fluids		Low	Treat	Risk approved to be added to the Risk Register at Internal Medicine CIG.
RSK-015	21-Sep-2021	Laura Sutton	IF there are ligature point areas in Ward 1 in various areas of the department THEN patients may use ligature points to self-harm	LEADING TO physical injury/cuts/overdose/ill health/death to patients, and psychological impact, stress, anxiety, breakdown to staff/visitors; Absence from work; Reduced staffing through absence; Ongoing mental health impact	Organisation		23-Feb-2022	09-Mar-2022	Overdue	15	15	10		See attached Risk Assessment.(21-Sep-2021)	Low	Treat	Reviewed by Laura Sutton/ Marion Fowler and Pauline Sharma. To discuss at SPEG tomorrow as grading last month was incorrect. To remain at 15 and not lowered as no change.
RSK-025	22-Sep-2021	Elizabeth Winter	IF there are vacancies of Band 5 and senior nursing skill mix 247 THEN wards could be experiencing some issues with nurse staffing levels and skill mix	LEADING TO a potential 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. Incidents may not be properly identified and raised.	Region	Internal Medicine	02-Apr-2022	30-Jun-2022	Planned	15	15	4	On-going recruitment drive (03-Apr-2022)		Low	Treat	Reviewed in SPEG increased level of risk.
RSK-055	01-Oct-2021	Robyn Norris	IF Theatres are unable to cover the increased demand for theatre staff in both elective and emergency/trauma theatre sessions, and are not able to manage staffing shortages across the theatre department THEN the team will be unable to meet the changes and developments in the service. Examples of the increased staffing demand below: Robotic lists x 5 days a week, COVID-19 secure pathway, increased elective activity & trauma activity & staffing the theatre procedure room.	LEADING TO less support for junior staff currently in post. The lack of experienced staff may also create issues around staff skill mix. Patient operations may be cancelled due to a lack of staff. This creates increased stress level with the clinical teams.	Region	Anaesthetics & Theatres	26-Apr-2022	30-May-2022	Planned	12	15	6	Approval of Business Case for 10x additional members of staff,10x additional members of staff to be recruited	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. Even with the additional support from bank and agency staff we still struggle to provide staff for all sessions, this has recently led to cancelling lists. These risks are exacerbated when staff are off sick or absent for training / annual leave.(01-Oct-2021),GAPS: There are significant gaps in the theatre rota - 19 WTE posts are required to meet latest review of theatre staffing requirements.(01-Oct-2021),Recruited to 8x WTE(27-Apr-2022),Recruited 5x International Nurses(27-Apr-2022)	Medium	Treat	Risk reviewed by Surgery Triumvirate - Controls updated

Reference	Created on	Owner	Description	Impact of risk	Scope	Region	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-082	15-Oct-2021	Ben Nichols	IF the trauma activity beyond existing capacity (5 cases per day on trauma list) continues to increase alongside the implemented green pathway for orthopaedic elective care patients THEN 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 trauma needs.	LEADING TO insufficient trauma capacity, the department may not be able to operate on all trauma patients within the required timelines leading to poor outcomes. The Trust may be required to close to trauma or cancel all elective lists for the day in theatres 11 and theatres 12 in order to facilitate trauma patients who are not covid swabbed, isolated for 72 hours or given social distancing advice. This will lead to longer elective wait times and possible 52 week breaches. Alternatively, the Trust may be required to close to trauma due to insufficient capacity.	Region	Musculos keletal	26-Apr-2022	30-May-2022	Planned	12	15	6	Approval of Business Case for 10x additional members of staff,10x additional members of staff to be recruited	Divisional Director for Operations to work with T&O and Theatre teams to implement all day weekend emergency theatre lists.(15-Oct-2021),Utilisation of theatre pm 1 for procedures that do not include metal work twice a week if staffing is available.(15-Oct-2021),Cancellation of elective activity if required.(15-Oct-2021),GAPS: There are occasional surges in trauma cases especially at the weekend which impacts on trauma/ elective lists on Mondays.(15-Oct-2021)	Low	Treat	Risk reviewed by Surgery Triumvirate - controls updated
RSK-101	25-Oct-2021	Melissa Davis	IF the maternity service at MKUK do not have their own dedicated set of theatres. THEN Elective Caesarean work is completed the Theatre 1 during a booked morning session, Theatre 3 is set for obstetric emergencies. All Phase 1 theatres in the afternoon are used for emergency lists for the whole trust. This leaves maternity vulnerable to not having a guaranteed emergency theatre available 24hrs a day. There is only 1 theatre team on site overnight for all emergency surgery in the trust, should they be dealing with an emergency outside of obstetrics, obstetrics would have to call on call theatre team in from home increasing the risk for mother and baby	LEADING TO increased risk of poor outcome for mothers and babies if theatre delay; Psychological trauma for staff dealing with potentially avoidable poor outcome; Financial implication to the trust	Region	Women's Health	24-Mar-2022	06-Jun-2022	Planned	15	15	6	Hospital new build to include Maternity theatres,Escalation policy available for staff to use in situations where a 2nd theatre is needed by can not be opened		Low	Treat	This risk remains the same.
RSK-142	04-Nov-2021	Elizabeth Pryke	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 meet their demands and needs (rather than the community contract). This means that these high risk groups of Children and Young People are not accessing the necessary specialist nutritional support at the appropriate time in their development THEN staff may be unable to cover a service that has not been serviced correctly, and the paediatric team cannot provide a full dietetic service to children and young people in the Milton Keynes area	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 patients nutritional status and longer term dietary management on what is a very vulnerable group of patients. The majority of our caseload is infants or tube fed infants and children where there nutrition and growth is a priority.	Organisation		18-Apr-2022	30-May-2022	Planned	15	15	3		Existing staff are working some additional hours but this remains insufficient to meet the needs of the service(04-Nov-2021)	Low	Treat	Risk reviewed at Risk & Compliance Board. Escalation onto the Corporate Risk Register approved.
RSK-143	04-Nov-2021	Amanda Brice	IF workload continued to increase in Pathology, requiring additional specimen storage, equipment, and staff THEN there is a risk that the available space within Cellular Pathology will not be enough to meet the demands of the service as workload continues to expand	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. Specimen reception area encroaches on cut-up area; an inability to safely operate and / or validate equipment; and insufficient space for record storage	Region	Diagnosti c & Screening	24-Apr-2022	30-May-2022	Planned	15	15	6	Additional ventilation installed in the tissue processing room, to mitigate the risk of exposure to formalin fumes in this area	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 regarding building work and expansion(04-Nov-2021),Business case required for Laboratory furnishings and layout(04-Nov-2021),Sink to be fitted and put into use in new space(01-Dec-2021)	Low	Treat	Risk update received from Amanda Brice 22/04/2022
RSK-159	12-Nov-2021	Adam Baddeley	If patients referred to Occupational Therapy and Physiotherapy inpatients covering medical wards are not being seen in timely manner THEN there will be a delay in these patients being treated	LEADING TO Deconditioning of vulnerable/complex patients requiring a short period of therapy; Increased length of stay; Potential readmission	Organisation		18-Apr-2022	30-May-2022	Planned	20	15	8	Review of Governance Structure,Review Model of Care,Review Equity Tool - Safe Staffing,Review Workforce Model and Structure,Recruitment and Retention of staff,Education and Training of staff	Daily prioritisation of patients cross covering and review of skill mix locum cover x1 OT and x1 PT in place Ward book for escalation wards setup and band 7 reviews the caseload on the ward daily Monday- Friday and requests the most urgent are reviewed. Recruitment process ongoing but vacancies have reduced slightly. Over recruitment of band 5 OT and PT roles. Non-recurrent funding application for increase in therapy assistants over winter months.(12-Nov-2021)	Low	Treat	Risk reviewed with Divisional Triumvirate. Controls updated

Reference	Created on	Owner	Description	Impact of risk	Scope	Region	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-199	16-Nov-2021	Melissa Davis	IF the Cardiotocography (CTG) documentation tool within eCare is not based on a human factors principles and the parameters within the CTG documentation tool on eCare do not match the parameters within the local clinical guidance THEN the mechanism for completion of the CTG assessment on eCare will not support the review of the whole clinical picture as second reviewer does not need to be in the room for the review and can activate this mechanism from a different computer.	LEADING TO 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	11-Apr-2022	30-May-2022	Planned	20	15	6	Implementation of physiological fetal surveillance	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 prioritisation of face-to-face reviews within the acute setting. Identification and action in place to remove the commencement of oxytocin prior to a face-to-face obstetric review.(16-Nov-2021),Review of CTG training in place as online module does not offer the optimal learning or MDT development. Project plan in place for transition to physiological CTG monitoring. Monthly reporting of training compliance through divisional governance processes.(16-Nov-2021)	Low	Treat	Sticker in use. 2nd audit underway. To reassess next month with updated audit.
RSK-247	26-Nov-2021	Jamie Stamp	IF the wait times for ventilated babies and children requiring transfer to a tertiary centre continue to increase due to increasing pressures across the system. THEN the children's physiotherapy and on call team will be asked to assess and treat ventilated children. The physiotherapists do not currently have the training and competencies to complete this.	LEADING TO 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-Mar-2022	29-Apr-2022	Pending	15	15	6			Low	Treat	Risk reviewed by Triumvirate. Joint Therapies and Paediatrics
RSK-310	22-Dec-2021	Melissa Davis	IF all maternity related incidents are not reported on the Trust incident reporting system THEN maternity's ability to demonstrate effective governance processes and procedures, both within internal trust mechanisms and to the external stakeholders will be negatively affected	LEADING TO a potential reduction in the ability to learn from incidents and improve patient care/safety, an increase in incidents occurring, and complaints and claims being received	Region	Women's Health	11-Apr-2022	30-May-2022	Planned	15	15	6	Review trust level training for radar	Reminders are send to staff of incidents that are identified as part of review(12-Apr-2022)	High	Treat	No change to risk
RSK-324	09-Feb-2022	Helder Prata	IF there are significant nursing vacancies within the Paediatric Unit, including Maternity Leave and Long-Term Sickness - we are currently 38% of permanent staff roles unfilled- this is being partially mitigated with use of regular Agency and Bank staff THEN there will not be sufficient/safe numbers of nursing staff to cover shifts.	LEADING TO an increased risk for children's safety due to the absence of permanent skilled staff; an increased use of agency; an increasing number of shifts that do not comply with national recommended safe staffing levels	Region	Paediatric Services	25-Apr-2022	30-May-2022	Planned	15	15	9	We are using regular Paediatric Agency and Bank staff to fill gaps wherever possible, we are planning a minimum of 50% of permanent staff on each shift. We are constantly advertising and interviewing for replacement staff- we are steadily recruiting. We are effectively managing Long term sickness in accordance with Trust guidance and with the input of HR,Establish Review to be completed		Low	Treat	Risk reviewed by W&C Triumvirate - Risk Owner amended and new outstanding control added.
RSK-331	06-Apr-2022	Celia Hyem-Smith	If current demands on the therapies admin service continues without the capacity to meet the volume of work Then clinicians diary slots will be left unfilled and patients won't be contacted in a timely manner.	Leading to increased waiting lists and poor patient outcomes. Lack of capacity to book appointments leaving diary slots unfilled; patients not achieving expected outcomes especially if treatment is not provided within post surgical timescales; negative impact and possible litigation against the Trust	Region	Therapies	06-Apr-2022	05-Jun-2022	Planned	15	15	9	Approval for two bank staff until 1.7.22		Medium	Treat	

Meeting Title	**Trust Board of Directors**	**Date: May 2022**
Report Title	**Board Assurance Framework**	**Agenda Item: 19**
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. a. The Board to note that Risk 13 would be retired after the May 2022 Trust Board meeting. b. The Board to also note two new entries: (i) Risk 17 which is related the Trust's Head and Neck (H&N) Cancer pathway; (ii) Risk 22 which is related to the Trust's Percutaneous Coronary Intervention pathway			
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	Finance and Investment Committee May 2022
Next Steps	Trust Executive Committee May 2022
Appendices/Attachments	Board Assurance Framework

The Board Assurance Framework – Summary of Activity in April 2022

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.

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

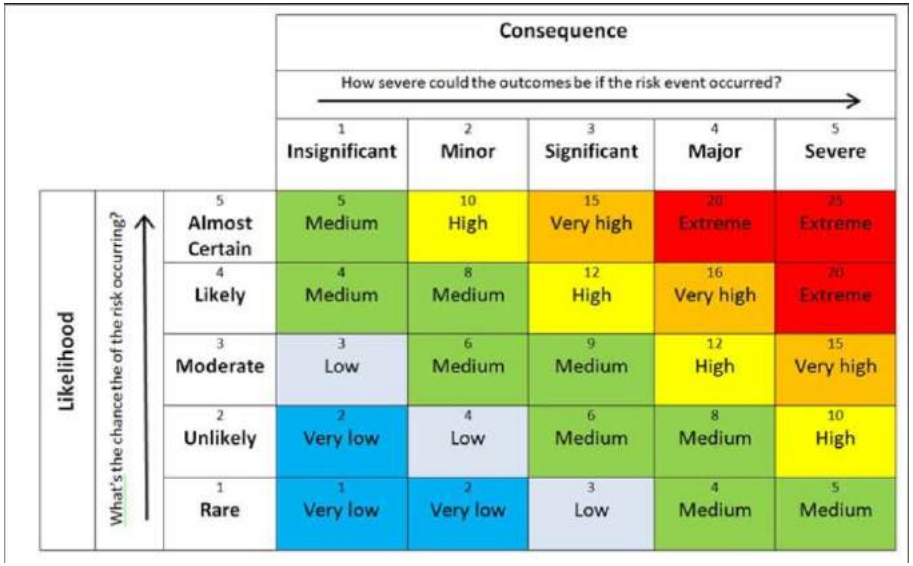
1. Keeping you safe in our hospital
2. Improving your experience of care
3. Ensuring you get the most effective treatment
4. Giving you access to timely care
5. Working with partners in MK to improve everyone's health and care
6. Increasing access to clinical research and trials
7. Spending money well 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:

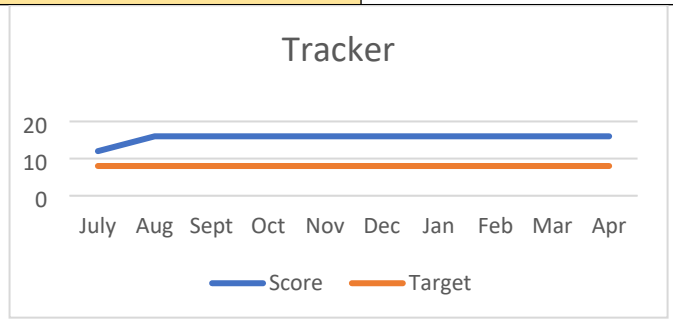
Green	**Positive assurance**: The Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat/ opportunity. There are no gaps in assurance or controls and the current exposure risk rating is at the target level; or gaps 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	28/04/22	**Risk Rating**	16	8			

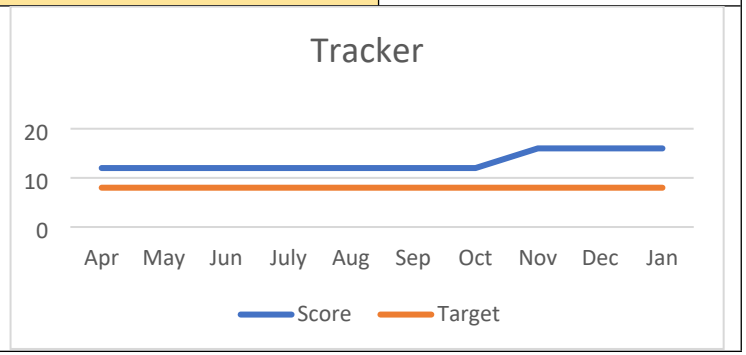
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Significant increase in activity and number of patients through the ED Significantly higher acuity of patients through the ED	Clinically and operationally agreed escalation plan Adherence to national 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 other areas to	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 the Winter Plan.	

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.	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.			

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	17/01/22	**Risk Rating**	16	8		



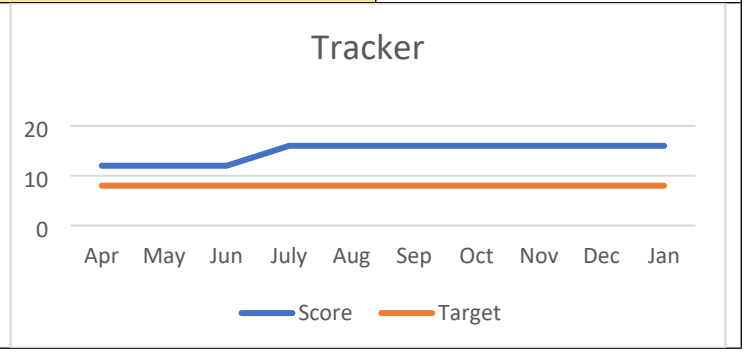
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Not appropriately reporting, investigating or learning from incidents. A lack of systematic sharing of learning from incidents.	Improvement in incident reporting rates SIRG reviews all evidence and action 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	17/01/22	**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 Regional and national data and forecasting	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			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

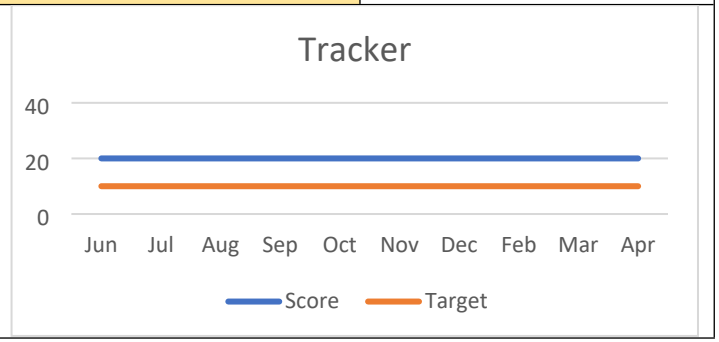
Strategic Risk	If the Trust does not carefully manage its significant digital change programme, then the delivery of clinical services may be impaired						**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	At target level – no tracker	
Executive Lead	Deputy Chief Executive	**Consequence**	4	4	**Risk Appetite**	Avoid		
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat		
Date of Review	20/04/22	**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	28/04/22	**Risk Rating**	20	10			

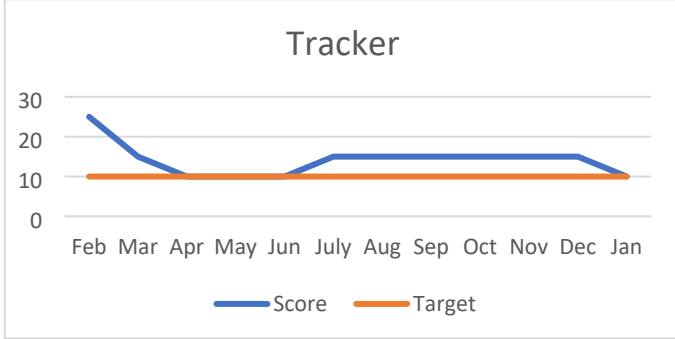
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Cessation of all routine elective care, including cancer screening and other pathways, during the peaks of the Covid-19 pandemic	Compliance with national guidance Granular understanding of demand and 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**	2	2	**Risk Treatment Strategy**	Treat
Date of Review	17/01/22	**Risk Rating**	10	10		



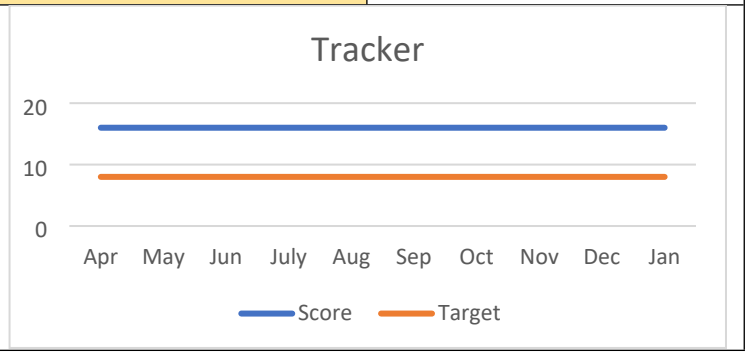
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Demand for ITU and inpatient beds exceeds capacity, including escalation capacity within the hospital and regionally. Risks have increased (since	Increased capacity across the hospital Increased capacity 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 COVID-19 patients	None currently	None currently	

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			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	17/01/22	**Risk Rating**	16	8		



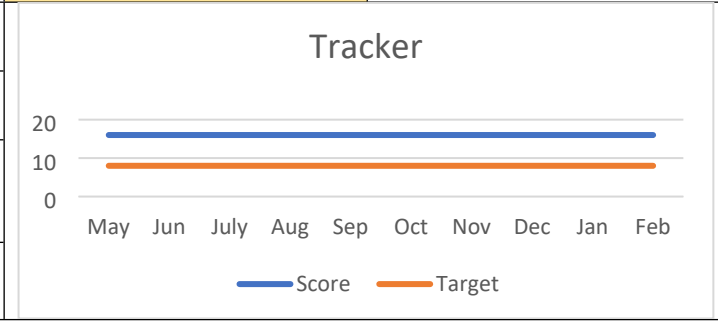
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Break down in the established relationship (subcontract) between Oxford University Hospitals and the private Genesis Care facility (Linford Wood, Milton Keynes)	Contingency for the provision of treatment 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	04/02/22	**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.	

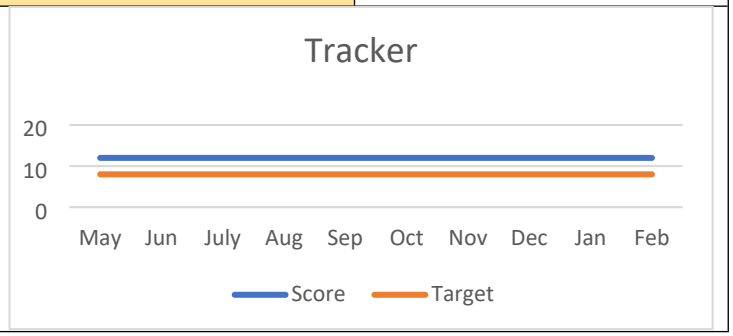
Adult Inpatient Survey Urgent and Emergency Care Survey Maternity Survey Cancer Patient Experience Survey	• Patent Experience Strategy • Learning Disabilities Strategy • Dementia Strategy • Nutrition steering group • Catering steering group • Domestic planning group • Discharge steering group • Induction 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	04/02/22	**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: • Patent Experience Strategy	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. Divisions to audit	**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.	

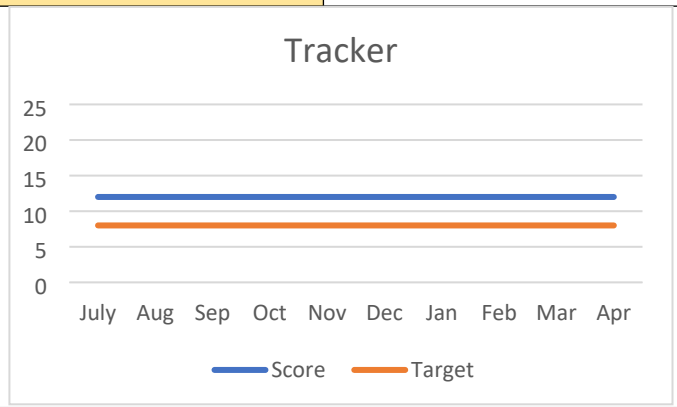
	• Learning Disabilities Strategy • Dementia Strategy • Nutrition steering group • Catering steering group • Domestic planning group • Discharge steering group • Induction training Customer service training – NHS Elect program Leadership training includes how to receive feedback from patients. Appreciative inquire approach to support complaints handling and response letters. Monthly divisional meetings with Head of Patient and Family Experience to review themes, complaints,	Audit of identified learning in divisions to ensure learning embedded.	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		

	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	31/03/22	**Risk Rating**	12	8		

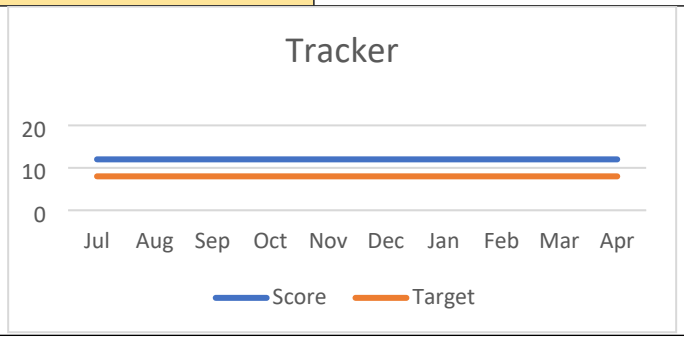


Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
1. Lack of understanding/ awareness of audit requirements by clinical audit leads 2. Resources not adequate to support data collection/	1. Designated audit leads in CSUs/ divisions 2. Clinical governance 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.

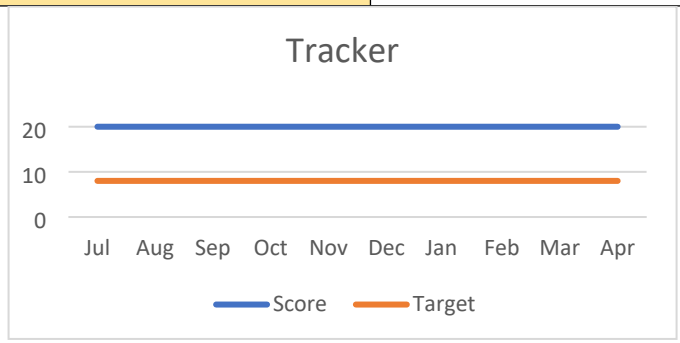
Strategic Objective 3: Improving Clinical Effectiveness

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	28/04/22	**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	Trust Executive Committee	**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	28/04/22	**Risk Rating**	20	10			

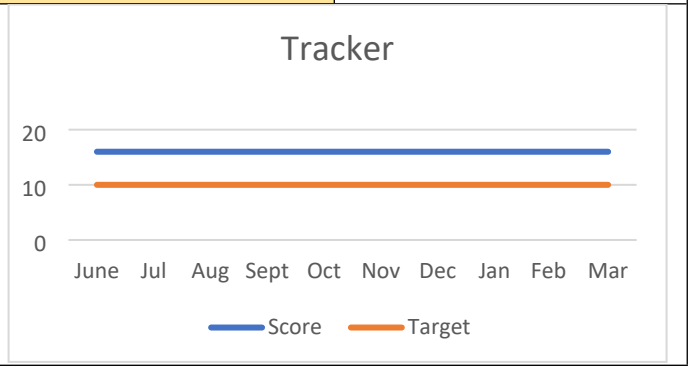
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Elective activity is suspended (locally or by national directive) to enable the Trust to cope with emergency demand or further Covid-19 surges, resulting in increasing waits for patients	Winter escalation 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	07/03/22	**Risk Rating**	16	10		

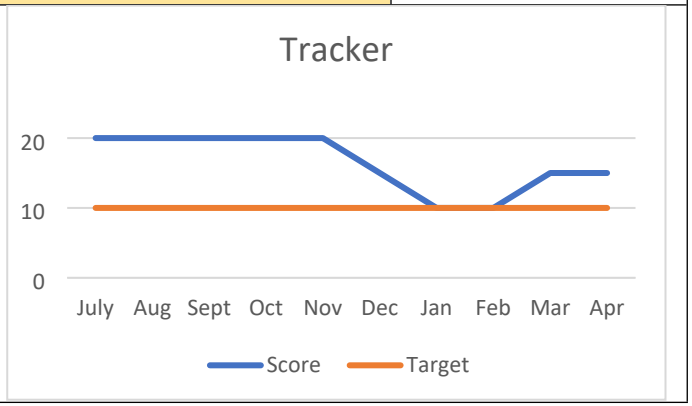


Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Following the FY21 year end audit the Trust had to adjust misstated capital expenditure of £4.5m relating to a capital bond. As a consequence, the Trust has brought forward capital	The Trust is introducing 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 could 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 could 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	20/04/22	**Risk Rating**	15	10			

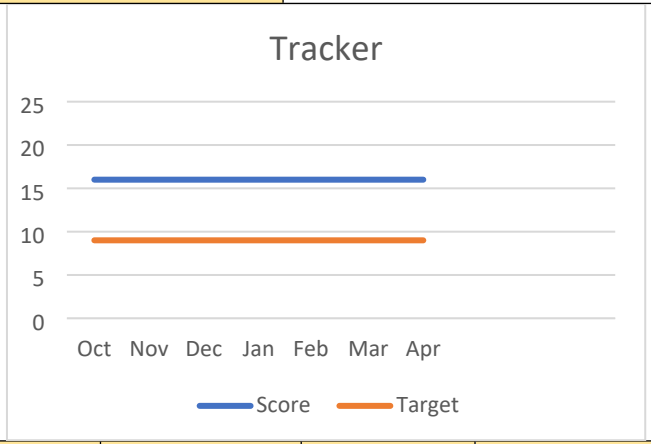
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Hardware failure due aged equipment Increasing Cyber-attacks across the world.	2 dedicated cyber security posts Good network protection from cyber security breaches such as Advanced Threat Protection (ATP) – A part of the national programmes	None identified	Continued review	External review and reporting Internal audit reports on cyber security taken with the management actions	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	26/04/22	**Risk Rating**	16	9		



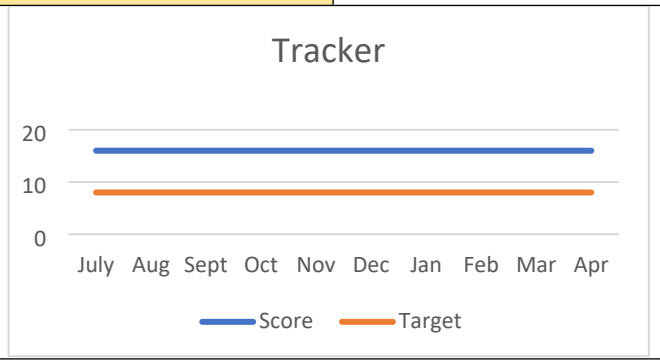
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
The current NHS capital regime does not provide adequate certainty over the availability of strategic capital finance. Consequently, it is difficult to progress development plans	The Trust has a process 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	26/04/22	**Risk Rating**	16	8		



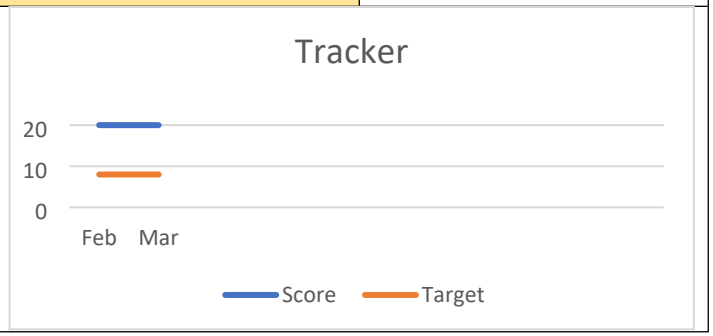
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Increase in operational expenditure in order to manage COVID-19 Reductions in non-NHS income streams as a direct result of COVID-19.	1. Cost and volume contracts replaced with block contracts (set nationally) for clinical income; 2. Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until September 2021);	Fragmented financial regime during 2021/22, no details known for 2022/23 and beyond. Significant changes expected as NHS transitions from rounding regime heavily influenced by the	Continued review of national funding intentions to maximise time to plan organisation response. Preparation of plans at earliest opportunity	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.	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.	pandemic. Trust has minimal ability to influence.	once 2022/23 national guidance is published.				

RISK 17: If the pathway for patients requiring Head and Neck (H&N) cancer services is not improved, users of MKUH services will continue to face disjointed care, unacceptably long delays for treatment and the risk of poor clinical outcomes.

Strategic Objective 2: Improving Patient Safety

Strategic Risk	If the pathway for patients requiring Head and Neck (H&N) cancer services is not improved, users of MKUH services will continue to face disjointed care, unacceptably long delays for treatment and the risk of poor clinical outcomes.				**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**	Low
Date of Assessment	31/03/22	**Likelihood**	5	2	**Risk Treatment Strategy**	Treat
Date of Review	31/03/22	**Risk Rating**	20	8		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
MKUH does not provide H&N cancer services but acts as a spoke unit to the hub at Northampton. Northampton faces: (1) increased	MKUH clinicians have escalated concerns (both generic and patient specific) to the management team at Northampton. MKUH clinicians are advocating 'mutual aid' from other cancer centres (Oxford,	No reliable medium to long term solutions is yet in place and a quality summit is pending.	Discussions with OUH, specialist commissioners and Northampton suggest that a medium-term solution may be a H&N link	Incident reporting. Ongoing discussions with commissioners, Northampton and Oxford.	Many elements outside Trust's direct control	Continued work with partners	

demand related to the pandemic; (2) staffing challenges in the service and (3) reduced capacity as a consequence of having reduced the scope of work permissible at MKUH as the spoke site.	Luton) where appropriate. The issue has been raised formally at Executive level, and with EoE specialist cancer commissioners.		up with OUH, with a permissive approach to the work that can be done (under appropriate network governance) at the spoke site.				

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

Strategic Objective 10: Innovating and Investing in the future of the Trust

Strategic Risk	Insufficient space in the Neonatal Unit to accommodate babies requiring special clinical 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	At target level – no tracker	
Executive Lead	Deputy Chief Executive	**Consequence**	4	4	**Risk Appetite**	Cautious		
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat		
Date of Review	20/04/22	**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 risk that if the	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	

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	At target level – no tracker
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Cautious	
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat	
Date of Review	15/03/22	**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 Benefits packages elsewhere	Variety of organisational change/staff engagement activities, e.g. • Event in the Tent, • Schwartz Rounds and coaching collaboratives.	None Currently	Continued review	External review and reporting Vacancy and Retention Rates	None Currently	None Currently	

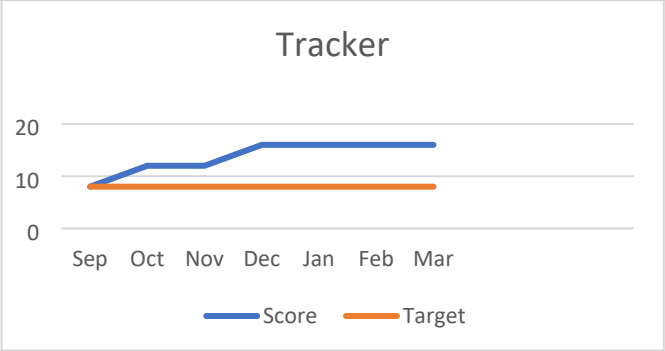
Culture within isolated departments	• Recruitment and retention premia policy • We Care programme • Onboarding and exit strategies/reporting • Annual Staff Survey • Learning and development programmes • Health and wellbeing initiatives, including P2P and Care First • Staff recognition - staff awards, 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.						

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	15/03/22	**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	None Currently	Continued review	External review and reporting Vacancy Rates	None Currently	None Currently	

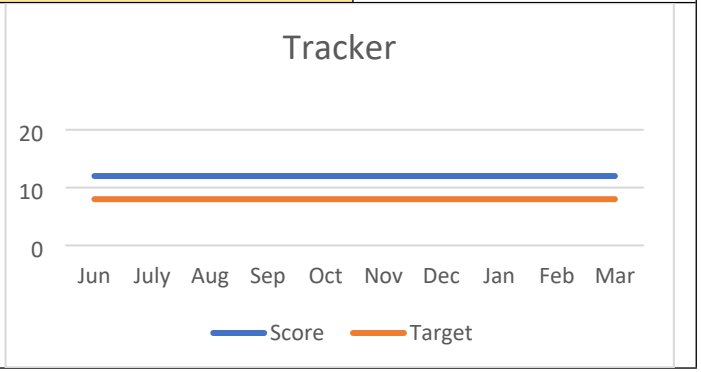
urology and trauma and orthopaedics Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply)	experience opportunities. • Exploration and use of new roles to help bridge particular gaps. • Use of recruitment and retention premia as necessary • Use of the Trac recruitment tool 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	15/03/22	**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 Brexit may reduce overseas supply	• Monitoring of uptake of placements & training programmes. • Targeted overseas recruitment activity. • Apprenticeships and work	None Currently	Continued review	External review and reporting Vacancy Rates	None Currently	None Currently	

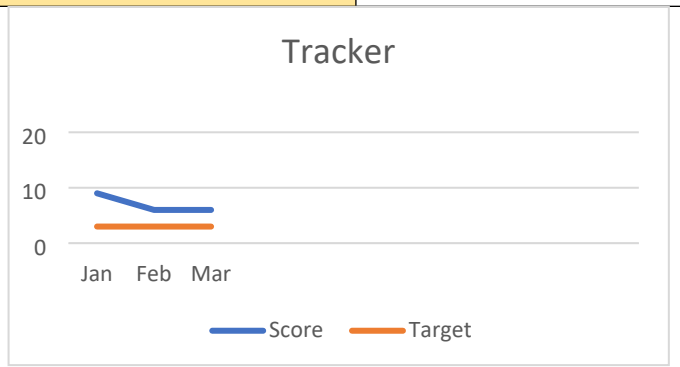
Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply) Large percentage of workforce predicted to retire over the next decade Large growth prediction for MK - outstripping supply Buoyant private sector market creating competition for entry level roles New roles upskilling existing	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.						

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 22: If the pathway for patients requiring percutaneous coronary intervention (PCI) is not improved, users of MKUH services will continue to face unacceptably long delays when admitted with non-ST elevation MI (heart attack) or ACS (acute coronary syndrome).

Strategic Objective 2: Improving Patient Experience

Strategic Risk	If the pathway for patients requiring percutaneous coronary intervention (PCI) is not improved, users of MKUH services will continue to face unacceptably long delays when admitted with non-ST elevation MI (heart attack) or ACS (acute coronary syndrome).				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient Harm
Executive Lead	Medical Director	**Consequence**	3	3	**Risk Appetite**	Cautious
Date of Assessment	07/03/22	**Likelihood**	3	1	**Risk Treatment Strategy**	Treat
Date of Review	07/03/22	**Risk Rating**	9	3		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
MKUH does not provide PCI services which is unusual given the size of the hospital. Patients requiring PCI are transferred to OUH or Bedford.	MKUH is working with Oxford University Hospitals to develop an 'OUH @ MKUH' satellite laboratory in Milton Keynes. This will allow patients to access very high	The British Cardiovascular Intervention Society (BCIS) assurance process is in train – the result of a BCIS visit in January 2022 is	Continued engagement in review process. Clear plan for commencement of service following 'go' decision (recognising	Regular OUH / MKUH collaborative project group. Developing Thames Valley Provider Alliance.	Some elements outside Trust's direct control	Continued work with partners	

Benchmark length of stay for the admitted group is 2-3 days, whereas the experience for MK residents (super-spell) is 5-6 days.	quality services in Milton Keynes (Oxford's cardiology research profile is world-leading attracting and retaining the best clinicians).	not yet known. Commissioners are provisionally supportive of the development (2019) but are now undertaking a review.	recruitment and training needs).				

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	At target level – no tracker	
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Avoid		
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat		
Date of Review	15/03/22	**Risk Rating**	8	8				

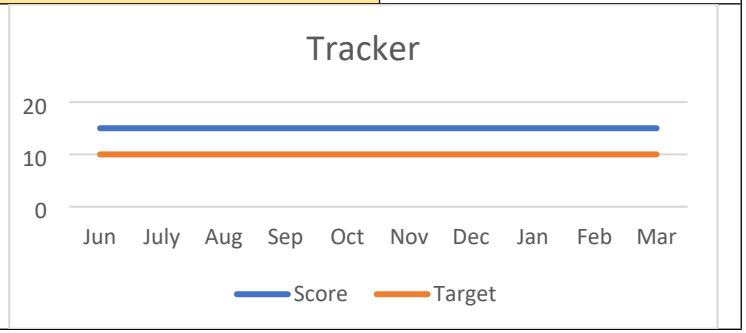
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Ability to maintain a safe working environment during the Covid-19 pandemic due to a lack of equipment, including PPE, or inadequate staffing numbers	• Incident command structure in place • Oversight 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	

	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	15/03/22	**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 from January to March.						

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board of Directors**	**Date: May 2022**
Report Title	**Proposed amendments to the Foundation Trust Constitution**	**Agenda Item: 20**
Lead Director	**Name: Kate Jarman**	**Title: Director of Corporate Affairs**
Report Author	**Name: Kwame Mensa-Bonsu**	**Title: Trust Secretary**

Key Highlights/ Summary	1. The amendments are being proposed after a routine review of the Milton Keynes University Hospital NHS Foundation Trust's Constitution by a sub-group of the Council of Governors include: a. The tenures of Governors, both elected and appointed, which will bring the Constitution broadly in alignment with current practice in the NHS. b. The Composition of the Council of Governors in relation to Partnership Governors. c. The qualification for appointment to the role of Non-Executive Director be formally extended to include candidates from the Trust's Patient Constituency. 2. The sub-group also proposes that the Council actively enforce paragraph 9.2 (and its sub clauses) of Annex 5 which stipulates the consequences if a Governor fails to attend three (3) consecutive Council meetings and any mitigating actions thereof. 3. There are other corrections to note: a. That 'NHS Improvement' had replaced 'Monitor'. b. That Integrated Case Systems (ICSs) are replacing Clinical Commissioning Group (CCGs). The Constitution is key to enabling the Trust to comply with its obligations as a Foundation Trust and to maintaining good corporate governance. It helps to define the respective remits of the Board of Directors and the Council of Governors, and the relationship between them. It is therefore important that this document remains relevant and fit for purpose and reflects current best practice.

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	Extraordinary Council of Governors Meeting – March 2022

Next Steps	Trust Board of Directors May 2022
Appendices/Attachments	Revised Trust Constitution

1. Purpose of the Report

To present proposed amendments to the Constitution for approval by the Council of Governors in accordance with paragraph 44.1. The review was in line with a best practice requirement to regularly review the Constitution to ensure that it remained fit for the purposes of a growing and evolving organisation.

2. Proposed amendments

A. Council of Governors - Tenure (page 8):

i. Paragraph 14.4 (page 8) – It is recommended that this: *'An elected Governor shall not hold office for more than six consecutive years, and shall not be eligible for re-election if his re-election would result in him holding office for more than six consecutive years',* **be amended to**: *An elected Governor shall not hold office for more than nine consecutive years and shall not be eligible for re-election if their re-election would result in their holding office for more than nine consecutive years.*

ii. New Paragraph 14.5 (page 8) – It is recommended that this line be inserted: *A Governor having held office for nine consecutive years, shall after a three-year gap, be eligible for re-election to only a single three-year term of office as Governor.*

These changes are consistent with the relevant provisions of Schedule 7 to the NHS Act 2006.

B. Composition of Council of Governors (Partnership Governors)

i. Annex 3 Paragraph 4.3 (page 25) – To remove the Community Action: MK from the list of partnership organisations who may appoint Governors to the Council. Due to operational requirements, Community Action: MK is no longer able to fulfil the requirement of being a member of the Council of Governors.

C. Tenure of Appointed Governors (page 63)

i. Annex 5 - Paragraph 6.3 (page 63) – It is recommended that this: *(An appointed Governor) may not hold office for longer than six consecutive years, and shall not be eligible for re-appointment if his re-appointment would result in him holding office for more than six consecutive years,* **be amended to**: *(An appointed Governor) may not hold office for longer than nine consecutive years and shall not be eligible for re-appointment if their re-appointment would result in them holding office for more than nine consecutive years.*

ii. Annex 5 - New Paragraph 6.4 (page 63) – It is recommended that this line be inserted: *(An appointed Governor) having held office for nine consecutive years, shall after a 3-year gap, be eligible for re-appointment to only a single three-year term of office as Governor.*

D. Board of Directors– qualification for appointment as a non-executive director (page 12)

i. It is recommended that the qualification for a person to be appointed as a Non-Executive Director be formally extended to include candidates from the Trust's Patient Constituency.

Paragraph 25.1 (page 12) – The recommendation is that this: *A person may be appointed as a non-executive director only if they are a member of the Public Constituency*, **be amended to**: *A person may be appointed as a non-executive director only if they are a member of the Public Constituency and/ or the Patient Constituency.*

E. Interpretations and definitions (page 4)

i. It is recommended that the following sentence in reference to Monitor: *Monitor is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act, currently working under a joint operating framework with the NHS Trust Development Authority under the operational name of NHS Improvement*, **be revised to**: *The body corporate known as Monitor, as provided by Section 61 of the 2012 Act, has been replaced since 01 April 2016 by* ***NHS Improvement ('NHSI' from hereon)***.

All references to Monitor reflect that it had been replaced by NHSI.

F. All references to Clinical Commissioning Group have been revised to include the line: *or the Integrated Care System when it is established*.

3. Request For Active Enforcement

i. The sub-group requests that the Council approve the active enforcement of Annex 5 Paragraph 9 to 9.2.2 which reads:

Paragraph 9 – A person holding office as a Governor shall immediately cease to do so if:

Paragraph 9.2 – they fail to attend three consecutive meetings of the Council of Governors, unless the other Governors are satisfied that:

Paragraph 9.2.1 – the absences were due to reasonable causes; and

Paragraph 9.2.2 – they will be able to start attending meetings of the Council of Governors again within such a period as the other Governors consider reasonable.

4. Recommendation

It is recommended that these changes to the Constitution are now ratified by the Council of Governors to enable onward referral to the Board for final approval and for the relevant changes to be incorporated into the Constitutional document.

The Council is also asked to approve the active enforcement of Annex 5 Paragraph 9 to 9.2.2.

Milton Keynes University Hospital NHS Foundation Trust

CONSTITUTION OF

MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

Approved by Board of Directors on the

Constitution of Milton Keynes University Hospital

NHS Foundation Trust

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Interpretation and definitions

Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012. Words importing the masculine gender only shall include the feminine gender, while words importing the singular shall import the plural and vice-versa.

the 2006 Act is the National Health Service Act 2006.

the 2012 Act is the Health and Social Care Act 2012.

Annual Members Meeting is defined in paragraph 13 of the constitution

constitution means this constitution and all annexes to it.

The body corporate known as **Monitor**, as provided by Section 61 of the 2012 Act, has been replaced since 01 April 2016 by **NHS Improvement ('NHSI' from hereon)**.

The **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act

2. Name

The name of the foundation trust is Milton Keynes University Hospital NHS Foundation Trust. ("the Foundation Trust").

3. Principal purpose

3.1 The principal purpose of the Foundation Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Foundation Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Foundation Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 working with partners in the promotion and protection of public health

3.4 The Foundation Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

4. Powers

4.1 The powers of the Foundation Trust are set out in the 2006 Act, subject to any restrictions in the terms of Authorisation.

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

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

5. Membership and constituencies

The Foundation Trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1 a public constituency

5.2 the patient constituency; and

5.3 a staff constituency

Further provisions as to members' meetings are set out in Annex 8.

6. Application for membership

An individual who is eligible to become a member of the Foundation Trust may do so on application to the Foundation Trust.

7. Public Constituency and Patient Constituency

7.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Foundation Trust.

7.2 Those individuals who live in an area specified in an area for any public constituency are referred to collectively as the Public Constituency.

7.3 The minimum number of members in each area for the Public Constituency is specified in Annex 1.

7.4 An individual who is a patient of the hospital may become or continue as a member of the Foundation Trust.

8. Staff Constituency

8.1 An individual who is employed by the Foundation Trust under a contract of employment with the Foundation Trust may become or continue as a member of the Foundation Trust provided:

8.1.1 they are employed by the Foundation Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 they have been continuously employed by the Foundation Trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the Foundation Trust, otherwise than under a contract of employment with the Foundation Trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

8.3 Those individuals who are eligible for membership of the Foundation Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into four descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

8.6 The Secretary shall make a final decision about the class of which an individual is eligible to be a member.

9. Automatic membership by default – staff

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency, and

9.1.2 invited by the Foundation Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

Shall become a member of the Foundation Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless he informs the Foundation Trust that he does not wish to do so. For the avoidance of doubt this does not include any individual who assists or provides services to the Foundation Trust on a voluntary basis, who shall (if eligible to become a member of the Staff Constituency) be admitted on application.

10. Restriction on membership

10.1 An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class of Milton Keynes University Hospital NHS Foundation Trust.

10.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency of Milton Keynes University Hospital NHS Foundation Trust.

10.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Foundation Trust are set out in Annex 9.

11. Annual Members' Meeting

11.1 The Foundation Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

11.2 Further provisions about the Annual Members' Meeting are set out in Annex 10 – Annual Members' Meeting.

12. Council of Governors – composition

12.1 The Foundation Trust is to have a Council of Governors, which shall comprise both elected and appointed Governors.

12.2 The composition of the Council of Governors is specified in Annex 3.

12.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

13. Council of Governors – election of Governors

13.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Rules for Elections, as may be varied from time to time. The Board of Directors will decide which of the two voting methods set out in the Model Rules for Elections is to be used.

No proceedings of the Council of Governors shall be invalidated by any vacancy in its membership or any defect in the appointment or election of any Governor'.

13.2 The Model Rules for Elections, as may be varied from time to time, form part of this constitution and are attached at Annex 4. Elections for Elected members of the Council of Governors will be held at a time most suitable in the financial year.

13.3 A variation of the Model Rules by the Department of Health shall not constitute a variation of the terms of this constitution. For the avoidance of doubt, the Foundation Trust cannot amend the Model Rules

13.4 An election, if contested, shall be by secret ballot.

14. Council of Governors - tenure

14.1 All Governors will hold office for a period of three years commencing immediately after the election result is announced or appointment was made.

14.2 An elected Governor shall cease to hold office if he ceases to be a member of the constituency or class by which they were elected.

14.3 An elected Governor shall be eligible for re-election at the end of their term.

14.4 An elected Governor shall not hold office for more than nine consecutive years and shall not be eligible for re-election if their re-election would result in their holding office for more than nine consecutive years.

14.5 A Governor having held office for nine consecutive years, shall after a three-year gap, be eligible for re-election to only a single three-year term of office as Governor.

14.6 For the purposes of these provisions concerning terms of office for elected Governors, “year” means a period of twelve months commencing immediately after the election result is announced.

14.7 Further provisions as to tenure for appointed Governors are set out at Annex 5.

15. Council of Governors – disqualification and removal

15.1 The following may not become or continue as a member of the Council of Governors:

15.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

15.1.2 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

15.1.3 a person who has made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it;

15.1.4 a person who within the preceding five years has been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.

15.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 5.

16. Council of Governors – duties of Governors

16.1 The general duties of the Council of Governors are –

16.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and

16.1.2 to represent the interests of the members of the trust as a whole and the interests of the public.

16.2 The Foundation Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as governors.

17. Council of Governors – meetings of Governors

17.1 The Chairman of the Foundation Trust (i.e. the Chairman of the Board of Directors, appointed in accordance with the provisions of paragraph 20.1 or paragraph 21.1 below) or, in their absence the Deputy Chairman (appointed in accordance with the provisions of paragraph 22 below) or, in their absence, one of the non-executive directors, shall preside at meetings of the Council of Governors. If the person presiding at any such meeting has a conflict of interest in relation to the business being discussed, the Vice Chairman of the Council of Governors (appointed in accordance with the provisions of paragraph 6 of Annex 5) will chair that part of the meeting.

17.2 Meetings of the Council of Governors shall be open to members of the public unless the Council of Governors decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds. Members of the public may be excluded from a meeting if they are interfering with or preventing the proper conduct of the meeting or for other special reasons.

18. Council of Governors – standing orders

The standing orders for the practice and procedure of the Council of Governors, as may be varied from time to time by the Council of Governors, are attached at Annex 6.

19. Council of Governors – referral to the Panel

19.1 In this paragraph, the Panel means a panel of persons appointed by NHSI to which a governor of an NHS foundation trust may refer a question as to whether the Foundation Trust has failed or is failing—

19.1.1 to act in accordance with its constitution, or

19.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006.

19.2 A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

20. Council of Governors - conflicts of interest of Governors

20.1 Members of the Council of Governors shall disclose to the Council of Governors any material interests (as defined below) held by a Governor, their spouse or partner, which shall be recorded in the register of interests of Governors.

20.2 Subject to the exceptions below a material interest is:

20.2.1.1 any directorship of a company;

20.2.1.2 any interest or position in any firm, company, business or organisation (including any charitable or voluntary organisation) which has or is likely to have a trading or commercial relationship with the Foundation Trust;

20.2.1.3 any interest in an organisation providing health and social care services to the National Health Service;

20.2.1.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

20.2.1.5 any connection with any organisation, entity or company considering entering into a financial arrangement with the Foundation Trust including but not limited to lenders or banks.

20.3 The exceptions which shall not be treated as interests or material interests for the purposes of these provisions are as follows:

20.3.1.1 shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;

20.3.1.2 an employment contract with the Foundation Trust held by a Staff Governor;

20.3.1.3 an employment contract with a Clinical Commissioning Group (or the Integrated Care System when it is established) held by a Clinical Commissioning Group (or the Integrated Care System when it is established) Governor;

20.3.1.4 an employment contract with a local authority held by a Local Authority Governor;

20.3.1.5 an employment contract with or other position of authority within a partnership organisation held by a Partnership Governor.

20.4 Any Governor who has an interest in a matter to be considered by the Council of Governors (whether because the matter involves a firm, company, business or organisation in which the Governor or their spouse or partner has a material interest or otherwise) shall declare such interest to the Council of Governors and:

20.4.1 shall withdraw from the meeting and play no part in the relevant discussion or decision; and

20.4.2 shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

20.5 Details of any such interest shall be recorded in the register of interests of Governors.

20.6 Any Governor who fails to disclose any interest or material interest required to be disclosed under these provisions must permanently vacate their office if required to do so by a majority of the remaining Governors.

21 Council of Governors – travel expenses

The Foundation Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Foundation Trust.

22 Council of Governors – further provisions

Further provisions with respect to the Council of Governors are set out in Annex 5.

23 Board of Directors – composition

23.1 The Foundation Trust is to have a Board of Directors, which shall comprise both executive and non-executive directors.

23.2 The Board of Directors is to comprise:

23.2.1 a non-executive Chairman

23.2.2 not less than five but not more than seven other non-executive directors; and

23.2.3 not less than five but not more than seven executive directors.

23.3 One of the executive directors shall be the Chief Executive.

23.4 The Chief Executive shall be the Accounting Officer.

23.5 One of the executive directors shall be the finance director.

23.6 One of the executive directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

23.7 One of the executive directors is to be a registered nurse or a registered midwife.

24 Board of Directors – general duty

The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the trust so as to maximise the benefits for the members of the Foundation Trust as a whole and for the public.

25 Board of Directors– qualifications for appointment as a non-executive director

A person may be appointed as a non-executive director only if –

25.1 they are a member of the Public Constituency and/ or the Patient Constituency, and

25.2 they are not disqualified by virtue of paragraph 31 below or Annex 7.

26 Board of Directors – appointment and removal of chairman and other non-executive directors

26.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the chairman of the Foundation Trust and the other non-executive directors.

26.2 The Council of Governors at a general meeting of the Council of Governors shall appoint as a non-executive director of the Foundation Trust a nominee from the University of Buckingham and, in reaching that decision, shall have regard to the recommendation of the Non-Executive Appointments Committee set up under Annex 7.

26.3 Removal of the chairman or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

26.4 Further provisions as to the appointment and removal of the chairman and other non-executive directors are set out at Annex 7.

27 Board of Directors – appointment of deputy chairman

The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non-executive directors as a deputy chairman. If the Chairman is

unable to discharge their office as Chairman of the Foundation Trust the Deputy Chairman of the Board of Directors shall be acting Chairman of the Foundation Trust.

28 Board of Directors - appointment and removal of the Chief Executive and other executive directors

28.1 The non-executive directors shall appoint or remove the Chief Executive.

28.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

Appointment of Executive Directors

28.3 A committee consisting of the Chairman, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

Deputy Chief Executive appointment

28.4 The Board of Directors shall nominate one of the executive directors to be the Deputy Chief Executive.

29 Board of Directors – disqualification

The following may not become or continue as a member of the Board of Directors:

29.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

29.2 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986).

29.3 a person who has made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it.

29.4 a person who within the preceding five years has been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.

29.5 a person who does not satisfy all of the requirements of Regulation 5(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014/2936 (as amended or updated from time to time).

Further provisions as to the circumstances in which an individual may not become or continue as a member of the Board of Directors are set out at Annex 6.

30 Board of Directors – meetings

30.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

30.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

31 Board of Directors – standing orders

The standing orders for the practice and procedure of the Board of Directors, as may be varied from time to time by the Board of Directors, are attached at Annex 7.

32 Board of Directors - conflicts of interest of directors

32.1 The duties that a director of the Trust has by virtue of being a director include in particular –

32.1.1 A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

32.1.2 A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

32.2 The duty referred to in sub-paragraph 32.1.1 is not infringed if –

32.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or

32.2.2 the matter has been authorised in accordance with the constitution.

32.3 The duty referred to in sub-paragraph 32.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.4 In sub-paragraph 32.1.2, “third party” means a person other than –

32.4.1 the Trust; or

32.4.2 a person acting on its behalf.

32.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

32.6 If a declaration under this paragraph proves to be, or becomes inaccurate or, incomplete, a further declaration must be made.

32.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

32.8 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

32.9 A director need not declare an interest –

32.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

32.9.2 if, or to the extent that, the directors are already aware of it;

32.9.3 if, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered –

32.9.3.1 by a meeting of the Board of Directors; or

32.9.3.2 by a committee of the directors appointed for the purpose under the constitution.

32.10 A matter shall be authorised for the purposes of paragraph 34.2.2 if:

32.10.1 the Board of Directors by majority disapplies the provision of the constitution which would otherwise prevent a director from being counted as participating in the decision-making process;

32.10.2 the director's interest cannot reasonably be regarded as likely to give rise to a conflict of interest; or

32.10.3 the director's conflict of interest arises from a permitted cause (as determined by the Board of Directors from time to time).

32.11 Any Director who has an interest in a matter to be considered by the Board of Directors (whether because the matter involves a firm, company, business or organisation in which the Director or their spouse, partner or close family member has a material interest or otherwise) shall declare such interest to the Board of Directors and:

32.11.1 shall withdraw from the meeting and play no part in the relevant discussion or decision; and

32.11.2 shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

32.12 Details of any such interest shall be recorded in the register of interests of the Board of Directors.

33 Board of Directors – remuneration and terms of office

33.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other non-executive directors.

33.2 The Foundation Trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

34 Registers

The Foundation Trust shall have:

34.1 a register of members showing, in respect of each member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

34.2 a register of members of the Council of Governors;

34.3 a register of interests of Governors;

34.4 a register of directors; and

34.5 a register of interests of the directors.

35 Admission to and removal from the registers

35.1 The Secretary shall remove from the register of members the name of any member who ceases to be entitled to be a member under the provisions of this constitution.

35.2 The Secretary is to send to NHSI a list of persons who were first elected or appointed as Governors and Directors.

36 Registers – inspection and copies

36.1 The Foundation Trust shall make the registers specified in paragraph 34 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

36.2 The Foundation Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Foundation Trust, if the member so requests.

36.3 So far as the registers are required to be made available:

36.3.1 they are to be available for inspection free of charge at all reasonable times; and

36.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

36.4 If the person requesting a copy or extract is not a member of the Foundation Trust, the Foundation Trust may impose a reasonable charge for doing so.

37 Documents available for public inspection

37.1 The Foundation Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

37.1.1 a copy of the current constitution;

37.1.2 a copy of the current authorisation;

37.1.3 a copy of the latest annual accounts and of any report of the external auditor on them;

37.1.4 a copy of the latest annual report;

37.1.5 a copy of the latest information as to its forward planning;

37.1.6 a copy of any notice given under section 25 of the 2006 Act;

37.1.7 a copy of the Foundation Trust's membership strategy.

37.1.8 a copy of the Foundation Trust's policy for the composition of the Council of Governors and of the non-executive directors.

37.2 The Foundation Trust shall also make the following documents relating to a special administrator of the Trust available for inspection by members of the public free of charge at all reasonable times:

37.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) of 65LA (trusts to be dissolved) of the 2006 Act;

37.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act;

37.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act;

37.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act

37.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act;

37.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (NHSI's decision), 65KB (Secretary of State's response to NHSI's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;

37.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

37.2.8 a copy of any final report published under section 65I (administrator's final report);

37.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act; and

37.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

37.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy or extract.

37.4 If the person requesting a copy or extract is not a member of the Foundation Trust, the Foundation Trust may impose a reasonable charge for doing so.

38 External Auditor

38.1 The Foundation Trust shall have an external auditor.

38.2 The Council of Governors shall appoint or remove the external auditor at a general meeting of the Council of Governors.

38.3 The external auditor is to carry out their duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by NHSI on standards, procedures and techniques to be adopted.

39 Audit Committee

The Foundation Trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

40 Annual Accounts

40.1 The Foundation Trust must keep proper accounts and proper records in relation to the accounts

40.2 NHSI may with the approval of the Secretary of State give directions to the Foundation Trust as to the content and form of its accounts

40.3 The accounts are to be audited by the Foundation Trust's external auditor.

40.4 The Foundation Trust shall prepare in respect of each Financial Year annual accounts in such form as NHSI may with the approval of the Secretary of State direct.

40.5 The functions of the Foundation Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

41 Annual Report and Forward Plans and non-NHS work

41.1 The Foundation Trust shall prepare an Annual Report and send it to NHSI. Further provisions as to Annual Reports are set out at Annex 10.

41.2 The Foundation Trust shall give information as to its forward planning in respect of each Financial Year to NHSI.

41.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

41.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

41.5 Each forward plan must include information about-

41.5.1 the activities other than the provision of goods and services for the purposes of the Health service in England that the Foundation Trust proposes to carry on, and

41.5.2 the income it expects to receive from doing so.

41.6 Where a forward plan contains a proposal that the Foundation Trust carry on an activity of a kind mentioned in sub paragraph 41.5.1 the Council of Governors must-

41.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Foundation Trust of its principal purpose or the performance of its other functions, and

41.6.2 where the Foundation Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of health service in England it may implement the proposal only if more than half of the members of the Council of governors of the Foundation Trust voting approve its implementation.

42 Presentation of the annual accounts and reports to the governors and members

42.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

42.1.1 the annual accounts

42.1.2 any report of the external auditor on them

42.1.3 the annual report

42.2 The documents shall also be presented to the Members of the Foundation Trust at the Annual Members meeting by at least one member of the Board of Directors in attendance.

42.3 The Foundation Trust may combine a meeting of the Council of Governors convened for the purposes of sub paragraph 44.1 with the Annual Members Meeting.

43 Instruments

43.1 The Foundation Trust shall have a seal.

43.2 The seal shall not be affixed except under the authority of the Board of Directors.

44 Amendment of the constitution

44.1 The Foundation Trust may make amendments of its constitution only if –

44.1.1 More than half of the members of the Council of Governors of the Foundation Trust voting approve the amendments, and

44.1.2 More than half of the members of the Board of Directors of the Foundation Trust voting approve the amendments.

44.2 Amendments made under paragraph 44.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act.

44.3 Where an amendment is made to the constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Foundation Trust) –

44.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

44.3.2 The Foundation Trust must give the members an opportunity to vote on whether they approve the amendment.

44.4 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the trust must take such steps as are necessary as a result.

44.5 Amendments by the Foundation Trust of its constitution are to be notified to NHSI. For the avoidance of doubt, NHSI's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.49

45 Mergers etc. and significant transactions

45.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of all the members of the Council of Governors.

45.2 The constitution does not contain any descriptions of the term ‘significant transaction’ for the purposes of section 51A of the 2006 Act (Significant Transactions).

46 Indemnity

46.1 Members of the Board of Directors and Council of Governors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust.

46.2 The Trust may purchase and maintain for members of the Board of Directors and Council of Governors insurance in respect of directors’ and officers’ liability, including, without limitation, liability arising by reason of the Trust acting as a corporate trustee of an NHS charity.

ANNEX 1 – THE PUBLIC CONSTITUENCY

(Paragraphs 7.1 and 7.3)

The areas of the Public Constituency are:

Bletchley & Fenny Stratford, Denbigh, Eaton Manor, Whaddon

Emerson Valley, Furzton, Loughton Park

Linford South, Bradwell, Campbell Park

Hanslope Park, Olney, Sherington, Newport Pagnall North, Newport Pagnall South, Linford North

Walton Park, Danesborough, Middleton, Woughton

Stantonbury, Stony Stratford and Wolverton

Outer catchment area: The parishes within the areas of Buckingham, Winslow, Leighton Buzzard, Linslade, Woburn Sands, Hanslope, Old Stratford, Beachampton, The Horwoods, The Brickhills, Woburn

Extended area: The remainder of the county area of Northamptonshire (not already covered in the outer catchment area), the remainder of the county area of Buckinghamshire (not already covered in the outer catchment area), the remainder of the county area of Bedfordshire (not already covered in the outer catchment area), the unitary council area of Luton and the district council areas of Cherwell, Oxford City and South Oxfordshire

The minimum number of members of each of the areas of the Public Constituency is to be three

ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraphs 8.4 and 8.5)

The classes of the Staff Constituency are:

2.1 registered medical practitioners and registered dentists

2.2 registered nurses and registered midwives

2.3 allied healthcare professionals

2.4 all other staff

The minimum number of members of each class of the Staff Constituency is to be four.

ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraphs 12.2 and 12.3)

1 The aggregate number of Public Governors is to be more than half of the total number of members of the Council of Governors.

2 The Council of Governors, subject to the 2006 Act, shall seek to ensure that through the composition of the Council of Governors:

2.1 the interests of the community served by the Foundation Trust are appropriately represented;

2.2 the level of representation of the Public Constituency, the classes of the Staff Constituency and the appointing organisations strikes an appropriate balance having regard to their legitimate interest in the Foundation Trust's affairs;

and to this end, the Council of Governors:

2.3 shall at all times maintain a policy for the composition of the Council of Governors which takes account of the membership strategy, and

2.4 shall from time to time and not less than every three years review the policy for the composition of the Council of Governors, and

2.5 appropriate shall propose amendments to this constitution.

3 The Council of Governors of the Foundation Trust is to comprise:

3.1 15 Public Governors from the following areas of the Public Constituency:

3.1.1 Bletchley & Fenny Stratford, Denbigh, Eaton Manor, Whaddon – two Public Governors

3.1.2 Emerson Valley, Furzton, Loughton Park – two Public Governors

3.1.3 Linfield South, Bradwell, Campbell Park – two Public Governors

3.1.4 Hanslope Park, Olney, Sherington, Newport Pagnall North, Newport Pagnall South, Linford North – two Public Governors

3.1.5 Walton Park, Danesborough, Middleton, Woughton – two Public Governors

3.1.6 Stantonbury, Stony Stratford and Wolverton – two Public Governors

3.1.7 Outer catchment area: Buckingham, Winslow, Leighton Buzzard, Linslade, Woburn Sands, Hanslope, Old Stratford, Beachampton, The Horwoods, The Brickhills, Woburn – two Public Governors

3.1.8 Extended area: The remainder of the county area of Northamptonshire (not already covered in the outer catchment area), the remainder of the county area of Buckinghamshire (not already covered in the outer catchment area), the remainder of the county area of Bedfordshire (not already covered in the outer catchment area), the unitary council area of Luton and the district council areas of Cherwell, Oxford City and South Oxfordshire – one Public Governor

3.2 seven Staff Governors from the following classes;

3.2.1 registered medical practitioners and registered dentists – one Staff Governor

3.2.2 registered nurses and registered midwives – two Staff Governors

3.2.3 allied healthcare professionals – one Staff Governor

3.2.4 all other staff, including registered volunteers – three Staff Governors

3.3 one Governor to be appointed by Milton Keynes Clinical Commissioning Group (or the Integrated Care System when it is established and if they wish to continue with this practice);

3.4 one Local Authority Governor to be appointed by Milton Keynes Council;

3.5 three Partnership Governors to be appointed by partnership organisations;

3.6 One representative from Milton Keynes Youth Council. (non voting)

3.7 One representative of the University of Buckingham Medical School.

4 The partnership organisations that may appoint a Partnership Governor (one each) are:

4.1 Healthwatch Milton Keynes

4.2 Milton Keynes Business Leaders;

4.3 any appropriate community organisation

ANNEX 4 –THE MODEL RULES FOR ELECTIONS

(Paragraph 13.2)
The Model Election Rules

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PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"2006 Act" means the National Health Service Act 2006;

"corporation" means the public benefit corporation subject to this constitution;

"Council of Governors" means the council of governors of the corporation;

"declaration of identity" has the meaning set out in rule 21.1;

"election" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the Council of Governors;

"e-voting" means voting using either the internet, telephone or text message;

"e-voting information" has the meaning set out in rule 24.2;

"ID declaration form" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"internet voting system" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"lead governor" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (As updated in July 2014) or any later version of such code.

"list of eligible voters" means the list referred to in rule 22.1, containing the information in rule 22.2;

"method of polling" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"Monitor" means the corporate body known as Monitor as provided by section 61 of the 2012 Act (Monitor has been replaced by NHSI since 01 April 2016);

"numerical voting code" has the meaning set out in rule 64.2(b)

"polling website" has the meaning set out in rule 26.1;

"postal voting information" has the meaning set out in rule 24.1;

"telephone short code" means a short telephone number used for the purposes of submitting a vote by text message;

"telephone voting facility" has the meaning set out in rule 26.2;

"telephone voting record" has the meaning set out in rule 26.5 (d);

"text message voting facility" has the meaning set out in rule 26.3;

"text voting record" has the meaning set out in rule 26.6 (d);

"the telephone voting system" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"the text message voting system" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"voter ID number" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"voting information" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday; or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as they consider necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of their functions under these rules; and

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of their functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held;

(b) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency;

(c) the details of any nomination committee that has been established by the corporation;

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer;

(f) the date and time by which any notice of withdrawal must be received by the returning officer;

(g) the contact details of the returning officer; and

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form; and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name;

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication); and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation; and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that they are not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and

(b) for a member of the Public Constituency, of the particulars of their qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate;

(b) their declaration of interests as required under rule 11, is true and correct; and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand;

(b) decides that the nomination form is invalid;

(c) receives satisfactory proof that the candidate has died; or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election;

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11;

(d) that the paper does not include a declaration of eligibility as required by rule 12; or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after they have received it and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate

standing; and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the Council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the Council of Governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be Council of Governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules; and

(b) the returning officer is to order a new election to fill any vacancy which

remains unfilled, on a day appointed by them in consultation with the corporation.

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts their vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts their vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts their vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts their ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation;

(b) the constituency, or class within a constituency, for which the election is being held;

(c) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency;

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available;

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll; and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (Public Constituencies)

21.1 The corporation shall require each voter who participates in an election for a Public Constituency to make a declaration confirming:

(a) that the voter is the person:
  (i) to whom the ballot paper was addressed; and/or

  (ii) to whom the voter ID number contained within the e-voting information was allocated;

(b) that they have not marked or returned any other voting information in the election; and

(c) the particulars of their qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return their declaration of identity with their ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which their voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation;

(b) the constituency, or class within a constituency, for which the election is being held;

(c) the number of members of the Council of Governors to be elected from that constituency, or class with that constituency;

(d) the names, contact addresses, and other particulars of the candidates

standing for election, with the details and order being the same as in the statement of nominated candidates;

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post;

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3;

(g) the address for return of the ballot papers;

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located;

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located;

(k) the date and time of the close of the poll;

(l) the address and final dates for applications for replacement voting information; and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope;

(b) the ID declaration form (if required);

(c) information about each candidate standing for election, pursuant to rule 64 of these rules; and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast their vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if

required);

(b) the voter's voter ID number;

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate; and

(d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it; and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer:

(a) the completed ID declaration form if required; and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election, then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election, then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election, then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter their voter ID number; and

(ii) where the election is for a Public Constituency, make a declaration of identity;

in order to be able to cast their vote;

(b) specify:

(i) the name of the corporation;

(ii) the constituency, or class within a constituency, for which the election is being held;

(iii) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency;

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll; and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than they are entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter their voter ID number in order to be able to cast their vote; and

(ii) where the election is for a Public Constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation;

(ii) the constituency, or class within a constituency, for which the election is being held;

(iii) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency;

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll; and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than they are entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide their voter ID number; and

(ii) where the election is for a Public Constituency, make a declaration of identity;

in order to be able to cast their vote;

(b) prevent a voter from voting for more candidates than they are entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as they consider necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with their ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if they can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless they:

(a) are satisfied as to the voter's identity; and

(b) have ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter; and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it); and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with their text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if they can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless they are satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter; and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it); and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received their voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless they:

(a) are satisfied as to the voter's identity;

(b) have no reason to doubt that the voter did not receive the original voting information; and

(c) have ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter;

(b) the details of the unique identifier of the replacement ballot paper, if applicable; and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, they are also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter;

(b) the unique identifier of any replacement ballot paper issued under this rule; and

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (Public Constituencies)

32.1 In respect of an election for a public constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast their vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter their voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast their vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom they wish to cast their vote.

33.5 The voter will not be able to access the internet voting system for an election once their vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast their vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter their voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast their vote by keying in the numerical voting code of the candidate or candidates, for whom they wish to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once their vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast their vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain their voter ID number and the numerical voting code for the candidate or candidates, for whom they wish to

vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope; or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted; or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, they are to:

(a) put the ID declaration form if required in a separate packet; and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, they are to:

(a) mark the ballot paper “disqualified”;

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper;

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, they are to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, they areto:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified";

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (Public Constituency)

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified".

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper; and

(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election they shall:

(a) only accept as duly returned the first vote received that was cast using the

relevant voter ID number; and

(b) mark as “disqualified” all other votes that were cast using the relevant voter ID number.

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper “disqualified”;

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper;

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”;

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet; and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it;

(b) the ID declaration forms, if required;

(c) the list of spoilt ballot papers and the list of spoilt text message votes;

(d) the list of lost ballot documents;

(e) the list of eligible voters; and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

41. Not used

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the Board of Directors and the Council of Governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election; and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(a)(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

44. Rejected ballot papers and rejected text voting records

44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced;

(b) on which votes are given for more candidates than the voter is entitled to vote;

(c) on which anything is written or marked by which the voter can be identified except the unique identifier; or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules 44.2 and 44.3, be rejected and not counted.

44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place;

(b) otherwise than by means of a clear mark;

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that they can be identified by it.

44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted; and

(b) in the case of a ballot paper on which any vote is counted under rules 44.2 and 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot

paper;

(b) voting for more candidates than the voter is entitled to;

(c) writing or mark by which voter could be identified; and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote;

(b) on which anything is written or marked by which the voter can be identified except the voter ID number; or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules 44.7 and 44.8, be rejected and not counted.

44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

44.8 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark;

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that they can be identified by it.

44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted; and

(b) in the case of a text voting record on which any vote is counted under rules 44.7 and 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to;

(b) writing or mark by which voter could be identified; and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

45. Not used

46. Not used

47. Not used

48. Not used

49. Not used

50. Not used

51. Equality of votes

51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

52. Declaration of result for contested elections

52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the Council of Governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who they have declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust; or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom they have declared

elected.

52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not); and

(b) the number of rejected ballot papers under each of the headings in rule 44.5;

(c) the number of rejected text voting records under each of the headings in rule 44.10,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected;

(b) give notice of the name of each candidate who they havedeclared elected to the chairman of the corporation; and

(c) give public notice of the name of each candidate who they havedeclared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records;

(b) the ballot papers and text voting records endorsed with “rejected in part”;

(c) the rejected ballot papers and text voting records; and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule

26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it;

(b) the list of spoilt ballot papers and the list of spoilt text message votes;

(c) the list of lost ballot documents; and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents;

(b) the date of the publication of notice of the election;

(c) the name of the corporation to which the election relates; and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll; or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent; or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the Board of Directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing:

(i) any rejected ballot papers, including ballot papers rejected in part;

(ii) any rejected text voting records, including text voting records rejected in part;

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records; or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the Board of Directors of the corporation.

58.2 A person may apply to the Board of Directors of the corporation to inspect any of the documents listed in rule 58.1, and the Board of Directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The Board of Directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to:

(a) persons;

(b) time;

(c) place and mode of inspection; and/or

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the Board of Directors of the corporation must:

(a) in giving its consent; and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established:

(i) that their vote was given; and

(ii) that NHSI has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

59. Countermand or abandonment of poll on death of candidate

59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class; and

(b) order a new election, on a date to be appointed by them in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

59.2 Where a new election is ordered under rule 59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

59.3 Where a poll is abandoned under rule 59.1(a), rules 59.4 to 59.7 are to apply.

59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received;

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records, and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

59.6 The returning officer is to endorse on each packet a description of:

(a) its contents;

(b) the date of the publication of notice of the election;

(c) the name of the corporation to which the election relates; and

(d) the constituency, or class within a constituency, to which the election relates.

59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules 59.4 to 59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to NHSI under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses;

(b) travelling expenses, and expenses incurred while living away from home; and

(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise; or

(b) give a candidate or their family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates; and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair;

(b) equivalent in size and content for all candidates;

(c) compiled and distributed in consultation with all of the candidates standing for election; and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words;

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"); and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of their own services voluntarily, on their own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to NHSI for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to NHSI by:

(a) a person who voted at the election or who claimed to have had the right to vote; or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity; and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. NHSI will refer the application to the independent election arbitration panel appointed by NHSI.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 NHSI shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. Secrecy

67.1 The following persons:

(a) the returning officer; and

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted;

(ii) the unique identifier on any ballot paper;

(iii) the voter ID number allocated to any voter; and

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to

a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as they think fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom they have voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation;

(b) an employee of the corporation;

(c) a director of the corporation; or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24; or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as they consider appropriate.

ANNEX 5 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

(Paragraphs 14.7,15, 18 and 22)

Elected Governors

1. A member of the Public Constituency may not vote at an election for a Public Governor unless within twenty-one days before they vote they have made a declaration in the form specified by the Secretary that they are qualified to vote as a member of the relevant area of the Public Constituency. It is an offence to knowingly or recklessly make such a declaration which is false in a material particular.

Appointed Governors

2. The Secretary, having consulted Milton Keynes Clinical Commissioning Group (CCG) (or the Integrated Care System when it is established) is to adopt a process for agreeing the appointment of the CCG Governor with that CCG (or the Integrated Care System when it is established).

3. The Secretary, having consulted Milton Keynes Borough Council, is to adopt a process for agreeing the appointment of the Local Authority Governor with that local authority.

4. The Partnership Governors are to be appointed by the partnership organisations, in accordance with a process agreed with the Secretary.

Appointment of Vice Chairman of the Council of Governors

5. The Council of Governors shall appoint the Lead Governor to be Vice Chairman of the Council of Governors.

Tenure for appointed Governors

6. An appointed Governor:

6.1 shall hold office for a period of three years commencing immediately after their appointment is made;

6.2 shall be eligible for re-appointment at the end of their term;

6.3 may not hold office for longer than nine consecutive years and shall not be eligible for re-appointment if their re-appointment would result in them holding office for more than nine consecutive years.

6.4 having held office for nine consecutive years, shall after a 3-year gap, be eligible for re-appointment to only a single three-year term of office as Governor.

7. An appointed Governor shall cease to hold office if the appointing organisation which appointed them terminates the appointment.

Further provisions as to eligibility to be a Governor

8. A person may not become a Governor of the Foundation Trust, and if already holding such office will immediately cease to do so, if:

8.1 they are a Director of the Foundation Trust;

8.2 they have been previously removed as a Governor pursuant to paragraph 10 of this Annex 5;

8.3 being a member of the Public Constituency, they refuse to sign a declaration in the form specified by the Secretary of particulars of their qualification to vote as a member of the Foundation Trust, and that they are not prevented from being a member of the Council of Governors;

8.4 they are subject to a sex offender order.

9. A person holding office as a Governor shall immediately cease to do so if:

9.1 they resign by notice in writing to the Secretary;

9.2 they fail to attend three consecutive meetings of the Council of Governors, unless the other Governors are satisfied that:

9.2.1 the absences were due to reasonable causes; and

9.2.2 they will be able to start attending meetings of the Council of Governors again within such a period as the other Governors consider reasonable;

9.3 they have refused without reasonable cause to undertake any training which the Council of Governors requires all Governors to undertake;

9.4 they have failed to sign and deliver to the Secretary a statement in the form required by the Secretary confirming acceptance of the code of conduct for Governors;

9.5 they are removed from the Council of Governors under the following provisions.

10. A Governor may be removed from the Council of Governors by a resolution approved by not less than three-quarters of the remaining Governors present and voting on the grounds that:

10.1 they have committed a serious breach of the code of conduct; or

10.2 they have acted in a manner detrimental to the interests of the Foundation Trust; and

10.3 the Council of Governors consider that it is not in the best interests of the Foundation Trust for them to continue as a Governor.

Vacancies amongst Governors

11. Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.

12. Where the vacancy arises amongst the appointed Governors, the Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office.

13. Where the vacancy arises amongst the elected Governors, the Council of Governors shall be at liberty either:

13.1 to call an election within three months to fill the seat for the remainder of that term of office; or

13.2 if the unexpired period of the term of office is less than six months, to leave the seat vacant until the next elections are held; or

13.3 to invite the next highest polling candidate for that seat at the most recent election, where that candidate is available and willing to take office, to fill the seat until the next annual election, at which time the seat will fall vacant and subject to election for any unexpired period of the term of office.

Further provisions as to meetings of Council of Governors

14. The Council of Governors is to meet at least three times in each financial year. Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least fourteen days written notice of the date and place of every meeting of the Council of Governors together with an agenda and any supporting papers to all Governors. Notice will be published on the Foundation Trust's website and other media as considered appropriate.

15. Meetings of the Council of Governors may be called by the Secretary, or by the Chairman, or by ten Governors (including at least two elected Governors and two appointed Governors) who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Governors as soon as possible after receipt of such a request. The Secretary shall call a meeting on at least fourteen but not more than twenty-eight days' notice to discuss the specified business. If the Secretary fails to call such a meeting then the Chairman or ten Governors, whichever is the case, shall call such a meeting. The meeting will be limited to the specified business only.

16. Ten Governors including not less than four Public Governors, not less than one Staff Governor and not less than one appointed Governor shall form a quorum.

17. The Council of Governors may invite the Chief Executive or any other member or members of the Board of Directors, or a representative of the external auditor or other advisors to attend a meeting of the Council of Governors.

18. The Council of Governors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

19. Subject to the following provisions of this paragraph, questions arising at a meeting of the Council of Governors shall be decided by a majority of votes.

19.1 In case of an equality of votes the person presiding at or chairing the meeting shall have a second and casting vote.

19.2 No resolution of the Council of Governors shall be passed if it is opposed by all of the Public Governors present.

20. The Council of Governors may not delegate any of its powers to a committee or sub-committee, but it may appoint committees consisting of its members, Directors, and other persons to assist the Council of Governors in carrying out its functions. The Council of Governors may, through the Secretary, request that advisors assist them or any committee they appoint in carrying out its duties.

21. All decisions taken in good faith at a meeting of the Council of Governors or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Governors attending the meeting.

Declaration

22. An elected Governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the form specified by the Secretary of the particulars of their qualification to vote as a member of the Foundation Trust and that they are not prevented from being a member of the Council of Governors. An elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors, and every agenda for meetings of the Council of Governors will draw this to the attention of elected Governors.

ANNEX 6 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(Paragraph 18)

RULES OF PROCEDURE

FOR

MEETINGS OF THE COUNCIL OF GOVERNORS

OF

MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

1 INTERPRETATION

In these Rules:

(a) unless the context otherwise requires, the following expressions have the following meanings:

"**the Board"**	means the board of directors of the Foundation Trust from time to time;
"**the Constitution"**	means the constitution of the Foundation Trust as amended from time to time;
"**the Council"**	means the Council of Governors of the Foundation Trust from time to time;
"**the Foundation Trust"**	means Milton Keynes University Hospital NHS Foundation Trust;
"**Meeting"**	means a duly convened meeting of the Council;
"**Question on Notice"**	means a question from a Governor or Governors (notice of which has been given pursuant to Rule 7) about a matter over which the Council has powers or duties or which affects the services provided by the Foundation Trust;

(b) other terms defined in the Constitution shall have the same meaning in these Rules.

2 APPROVAL OF THE RULES

These Rules of Procedure shall be agreed and adopted by majority vote at the first meeting of the Council. Any subsequent amendments to these Rules of Procedure may only be made pursuant to Rule 19.

3 MEETINGS

Meetings of the Council shall be held at regular intervals and at least three times per year, at such times and places as the Chairman may determine from time to time. The Secretary will publish the dates, times and locations of meetings of the Council for the year six months in advance. Other, or emergency, meetings of the Council may be called in accordance with the Constitution.

4 AGENDAS AND PAPERS

An agenda, copies of any Questions on Notice and/or motions on notice to be considered at the relevant Meeting and any supporting papers shall be sent to each Governor so as to arrive with each Governor no later than seven days in advance of each Meeting. Minutes of the previous Meeting will be circulated with these papers for approval and this will be a specific agenda item.

5 REPORTS FROM THE EXECUTIVE DIRECTORS

At any meeting a Governor may ask any question through the Chairman without notice on any report by an executive director, or other officer of the Foundation Trust, after that report has been received by or while such report is under consideration by the Council at the Meeting. Unless the Chairman decides otherwise no statements will be made other than those which are strictly necessary to define any question posed and in any event no statements will be allowed to last longer than three minutes each. A Governor who has put such a question may also put one supplementary question if the supplementary question arises directly out of the reply given to the initial question. The Chairman may, in its absolute discretion, reject any question from any Governor if in the opinion of the Chairman the question is substantially the same and relates to the same subject matter as a question which has already been put to that Meeting or a previous Meeting. At the absolute discretion of the Chairman, questions may, at any Meeting which is held in public, be asked of the executive directors present by members of the Foundation Trust or any other members of the public present at the Meeting.

6 QUESTIONS ON NOTICE AT MEETINGS

Subject to the provisions of Rule 7, a Governor may ask a Question on Notice of:

(a) the Chairman;

(b) another Governor;

(c) an executive director of the Foundation Trust;

(d) the chair of any sub-committee or working group of the Council.

7 NOTICE OF QUESTIONS

Notice of a Question on Notice must be given in writing to the Secretary at least 14 days prior to the relevant Meeting. For the purposes of this Rule 7, receipt of any such Questions on Notice via electronic means is acceptable.

8 RESPONSE TO A QUESTION ON NOTICE

An answer to a Question on Notice may take the form of:

(a) a direct oral answer at the relevant Meeting (which may, where the desired information is in a publication of the Foundation Trust or other published work, take the form of a reference to that publication);

(b) where the reply cannot conveniently be given orally at the relevant Meeting, a written answer which will be circulated as soon as reasonably practicable to the questioner and to the other Governors with the agenda for the next Meeting; or

(c) a brief oral answer at the relevant Meeting supplemented by a written answer circulated as soon as reasonably practicable to the questioner and to the other Governors with the agenda for the next Meeting.

9 SUPPLEMENTARY QUESTIONS IN RESPECT OF A QUESTION ON NOTICE

Supplementary questions for the purpose of clarification of a reply to a Question on Notice may be asked at the absolute discretion of the Chairman.

10 MOTIONS ON NOTICE

(a) Notice

Subject to Rule 11, a motion may only be submitted by Governors and must be received by the Secretary in writing at least 14 days prior to the Meeting at which it is proposed to be considered, together with any relevant supporting papers. Except for motions which can be moved without notice under Rule 11, the notice of every motion must be signed or transmitted by at least two Governors. For the purposes of this Rule 10, receipt of any such motions via electronic means is acceptable. All motions received by the Secretary will be acknowledged by the Secretary in writing to the Governors who have signed or transmitted the same.

(b) Scope

Motions may only be about matters for which the Council has a responsibility or which affect the services provided by the Foundation Trust.

11 MOTIONS WITHOUT NOTICE

The following motions may be moved at any Meeting without notice:

(a) in relation to the accuracy of the minutes of the previous Meeting;

(b) to change the order of business in the agenda for the Meeting;

(c) to refer a matter discussed at a Meeting to an appropriate body or individual;

(d) to appoint a working group arising from an item on the agenda for the Meeting;

(e) to receive reports or adopt recommendations made by the Board;

(f) to withdraw a motion;

(g) to amend a motion;

(h) to proceed to the next business on the agenda;

(i) that the question be now put;

(j) to adjourn a debate;

(k) to adjourn a Meeting;

(l) to suspend a particular Rule contained within these Rules (provided that any Rule may only be suspended if at least one half of the aggregate number of Governors are present at the Meeting in question and provided also that the Rule in question may only be suspended for the duration of the Meeting in question);

(m) to exclude the public and press from the Meeting in question (the motion shall be "To exclude the press and public from the remainder of the Meeting, owing to the confidential nature of the business to be transacted.");

(n) to not hear further from a Governor, or to exclude them from the Meeting in question (if a Governor persistently disregards the ruling of the Chairman or behaves improperly or offensively or deliberately obstructs business, the Chairman, in its absolute discretion, may move that the Governor in question be not heard further at the Meeting in question. If seconded, the motion will be voted on without discussion. If the Governor continues to behave improperly after such a motion is carried, the Chairman may move that either the Governor leaves the meeting room or that the Meeting in question is adjourned for a specified period. If seconded, the motion will be voted on without discussion);

(o) to give the consent of the Council to any matter where its consent is required pursuant to the Constitution.

12 URGENT MOTIONS OR QUESTIONS

Urgent motions or questions may only be submitted by a Governor and must be received by the Secretary in writing before the commencement of the Meeting in question. The Chairman shall decide whether the motion or question in question should be tabled.

13 VOTING

(a) Every question at a Meeting shall be determined by a majority of the votes of the Chairman of the Meeting and Governors present and voting on the question and, in the

case of the number of votes for and against a motion being equal, the Chairman of the Meeting shall have a second or casting vote.

(b) All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.

(c) If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

(d) If a Governor so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

(e) In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

14 ANY OTHER BUSINESS

There will not be an agenda item entitled “Any Other Business”. Instead, there will an item for “Motions or Questions on Notice” (which are subject to the other provisions of these Rules). There will be another item for “Urgent Motions or Questions” (which are subject to Rule 12).

15 SPEAKING RULES

This Rule applies to all forms of speech/debate by Governors or members of the Foundation Trust and the public in relation to the motion or question under discussion at a Meeting.

(a) Content and Length of Speeches

Any approval to speak must be given by the Chairman. Governors will be heard first, and after their debate is complete the Chairman will, if the meeting is in public, ask for any questions or comments from members of the Foundation Trust and the public in that order. Speeches must be directed to the matter, motion or question under discussion or to a point of order. Unless in the opinion of the Chairman it would not be desirable or appropriate to time limit speeches on any topic to be discussed having regard to its nature complexity or importance, no proposal, speech, nor any reply, may exceed three minutes. In the interests of time the Chairman may, in its absolute discretion, limit the number replies questions or speeches which are heard at any one Meeting.

(b) When a person may speak again

A person who has already spoken on a matter at a Meeting may not speak again at that Meeting in respect of the same matter, except:

(i) in exercise of a right of reply;

(ii) on a point of order.

(c) Identification

All speakers must state their name and role before starting to speak to ensure the accuracy of the minutes.

16 ATTENDANCE

Governors who are unable to attend a Meeting shall notify the Secretary in writing in advance of the Meeting in question so that their apologies may be submitted.

17 QUORUM

The quorum for a Meeting will be as set out in the Constitution.

18 CHAIR

The Council will be chaired in accordance with the Constitution. If the Council is dealing with the matter of succession of the Chairman, then the Vice Chairman of the Council will preside. If the Vice Chairman is not present, the meeting will be chaired, for that part of the meeting only, by a Public Governor selected from among those present.

19 AMENDMENTS TO RULES OF PROCEDURE

These Rules of Procedure may only be amended at a Meeting. A motion to change the Rules of Procedure must be signed by a majority of the Governors and submitted to the Secretary in writing at least 21 days before the Meeting at which the motion is intended to be proposed.

20 DISPUTE BETWEEN THE COUNCIL AND THE BOARD

In situations where any conflict arises between the Board and the Council, the Chairman may initiate an independent review to investigate and make recommendations in respect of how the conflict may be settled. Normally this will be achieved by inviting the chair of another foundation trust to conduct the review, and the choice of individual will be agreed by both the Council and the Board.

21 TERMS OF REFERENCE AND CODE OF CONDUCT FOR GOVERNORS

Governors shall at all times comply with the Council of Governors' Terms of Reference and the Code of Conduct for Governors.

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(Paragraph 26)

STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

CONTENTS

INTRODUCTION

Statutory Framework

Milton Keynes University Hospital NHS Foundation Trust (the Trust) is a public benefit corporation authorised by the Independent Regulator of NHS Foundation Trusts which was established under the Health and Social Care (Community Health Standards) Act 2003.

The Trust's principal place of business is:

Milton Keynes University Hospital
Standing Way
Eaglestone
Milton Keynes
MK6 5LD

NHS Foundation Trusts are governed by statute, mainly the National Health Service Act 2003, by their constitutions and by the terms of their authorisation issued by Monitor (collectively 'the Regulatory Framework'). Monitor has since 01 April 2016 been replaced by NHSI

The functions of the Trust are conferred by the Regulatory Framework.

As a body corporate the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

The Constitution requires the Board of Directors to adopt Standing Orders (SOs) for the regulation of its practice and procedure.

Delegation of Powers

Under the SOs relating to the Arrangements for the Exercise of Functions by Delegation (SO 4) the Board exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of SO 5, in each case subject to such restrictions and conditions as the Board thinks fit or as the Independent Regulator may direct. Delegated Powers are covered in a separate document (Reservation of Powers to the Board and Delegation of Powers). That document has effect as if incorporated into the Standing Orders.

1. INTERPRETATION

1.1 Save as permitted by law, and subject to the Constitution, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of SOs (on which they should be advised by the Chief Executive or Trust Secretary).

1.2 Any expression to which a meaning is given in the NHS Act 2006 or in the Regulations or Orders made under the Act shall have the same meaning in this interpretation and in addition:

"ACCOUNTING OFFICER" shall be the Officer responsible and accountable for funds entrusted to the Trust. They shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

"TRUST" means the Milton Keynes University Hospital NHS Foundation Trust.

"BOARD" shall mean the Chairman, non-executive Directors, and the executive Directors of the Trust as a collective body.

"BUDGET" shall mean a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

"CHAIRMAN" is the person appointed by the Council of Governors to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chairman of the Trust" shall be deemed to include the Deputy Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable.

"CHIEF EXECUTIVE" shall mean the chief executive officer of the Trust.

"COMMITTEE" shall mean a sub-committee appointed by the Board.

"COMMITTEE MEMBERS" shall be persons formally appointed by the Board to sit on or to chair specific committees.

"DEPUTY CHAIRMAN" means the non-executive Director appointed by the Council of Governors to take on the Chairman's duties if the Chairman is unable to discharge his office as Chairman , for any reason.

"DIRECTOR" shall mean a person appointed as a Director of the Trust in accordance with the Constitution and includes the Chairman.

"DIRECTOR OF FINANCE " shall mean the chief finance officer of the Trust.

"THEY" or "THEM" (instead of "HE/SHE & HIS/HERS") OR (instead of "HIM/HER") shall refer to the appropriate postholder and are to be read as the gender of that post which may change.

"FUNDS HELD ON TRUST" shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept. Such funds may or may not be charitable.

"COUNCIL OF GOVERNORS" means the Council of Governors of the Trust as constituted by the Constitution.

"NHSI" means the Independent Regulator of NHS Foundation Trusts.

"MOTION" means a formal proposition to be discussed and voted on during the course of a meeting.

"NOMINATED OFFICER" means an officer charged with the responsibility for discharging specific tasks within Standing Orders (SOs) and Standing Financial Instructions (SFIs).

"NON-EXECUTIVE DIRECTOR" means a Director, including the Chairman, who does not hold an executive office of the Trust.

"SECRETARY" means a person appointed by the Trust to act independently of the Board, to provide advice to the Board on corporate governance issues and monitor the Trust's compliance with the law, these SO's , and the Regulatory Framework.

"SFIs" means Standing Financial Instructions.

"SOs" means Standing Orders.

2. THE TRUST

2.1 All business shall be conducted in the name of the Trust.

2.2 All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

2.3 The Board has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in "Reservation of Powers to the Board" and have effect as if incorporated into the Standing Orders.

2.4 **Composition of the Trust Board** - In accordance with the Constitution the composition of the Board shall be:

The Chairman of the Trust

not less than five but not more than seven non- executive Directors

not less than five but not more than seven executive Directors

including:

- the Chief Executive
- the Director of Finance
- a registered medical or dental practitioner
- a registered nurse or midwife

2.5 **Appointment of the Chairman and Directors**

2.5.1 **Appointment and removal of Non-Executive Directors.**

The Chairman and the other non-executive directors are appointed and removed by the Council of Governors in accordance with the procedure described in the Constitution.

2.5.1.1 **Non-Executive Appointments Committee**

The Trust shall appoint a Non-Executive Appointments Committee (a Committee of the Council of Governors) which will comprise of the Chairman of the Trust (or, when a Chairman is being appointed, the Deputy Chairman/ Senior Independent Director unless they are standing for appointment, in which case another non-executive director), three elected Governors and one Appointed Governor. The Committee will be chaired by a Governor. The Chairman of another Foundation Trust will be invited to act as an independent assessor to the Committee.

2.6 **Appointment and removal of Chief Executive**
In accordance with the Constitution the non-executive Directors of the Trust will appoint and remove the Chief Executive as a director of the Trust. The appointment of the Chief Executive is subject to the approval of a majority of the members of the Council of Governors present and voting at a meeting of the Council of Governors.

2.7 **Appointment and removal of Executive Directors**
In accordance with the Constitution the Board shall appoint an Executive Remuneration and Nominations Committee (a Committee of the Board of Directors) consisting of the Chairman, the Chief Executive, and the other non-executive Directors to appoint or remove the executive Directors other than the Chief Executive. The Committee will be chaired by the Chairman of the Trust.

2.8 **Terms of Office of the Chairman and Non-Executive Directors** – The Chairman and the non-executive Directors, including the non-executive Director nominated by the University of Buckingham, are to be appointed for a period of office in accordance with the terms and conditions of office decided by the Council of Governors at a general meeting and, in reaching that decision, the Council of Governors shall have regard to the recommendation of the Non-Executive Appointments Committee.

2.9 **Terms of Office of Executive Directors** - The Executive Remuneration and Nominations Committee consisting of non-executive Directors shall decide the terms and conditions of office including remuneration and allowances of executive Directors.

2.10 **Appointment of Deputy Chairman** - For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chairman, the Council of Governors will appoint a non-executive Director to be Deputy Chairman for such a period, not exceeding

the remainder of their term as non-executive Director of the Trust, as they may specify on appointing them.

2.11 Any non-executive Director so elected may at any time resign from the office of Deputy Chairman by giving notice in writing to the Chairman and the Council of Governors, who may thereupon appoint another non-executive Director as Deputy Chairman in accordance with paragraph 2.10.

2.12 **Powers of Deputy Chairman** - Where the Chairman of the Trust has died or has otherwise ceased to hold office or where they have been unable to perform their duties as Chairman owing to illness, absence from England and Wales or any other cause, the Deputy Chairman of the Board of Directors shall be acting chairman of the Trust and references to the Chairman in these SOs shall, so long as there is no Chairman able to perform their duties, be taken to include references to the Deputy Chairman.

3. MEETINGS OF THE BOARD

3.1 **Calling Meetings** - Ordinary meetings of the Board shall be held at such times and places as the Board may determine.

3.2 The Secretary may call a meeting of the Board at any time. The Chairman or four Directors may request the Secretary to call a meeting giving written notice of the business to be carried out. The Secretary shall send a written notice to all Directors as soon as possible after the receipt of such a request. The Secretary shall call a meeting on at least 14 but not more than 28 days' notice to discuss the specified business. If the Secretary fails to call such a meeting then the Chairman or four Directors, whichever is the case, shall call such a meeting.

3.3 **Notice of Meetings** – Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give to all Directors at least 14 days, but not more than 28 days, written notice of the date and place of every meeting of the Board of Directors.

3.4 Before each meeting of the Board, a notice of the meeting, specifying the business proposed to be transacted at it, shall be delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to them at least five clear days before the meeting.

3.5 Lack of service of the notice on any director shall not affect the validity of a meeting.

3.6 Failure to serve such a notice on more than two Directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

3.7 In the case of a meeting called by four Directors or the Chairman in default of the Secretary, the notice shall be signed either by those Directors or the Chairman and no business shall be transacted at the meeting other than that specified in the notice.

3.8 **Setting the Agenda** - The Board may determine that certain matters shall appear on every agenda for a meeting of the Board and shall be addressed prior to any other business being conducted.

3.9 A Director desiring a matter to be included on an agenda shall make their request in writing to the Chairman at least 10 days before the meeting, subject to SO 3.3. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairman.

3.10 **Chairman of Meeting** - At any meeting of the Board, the Chairman, if present, shall preside. If the Chairman is absent from the meeting the Deputy Chairman, if present, shall preside. If the Chairman and Deputy Chairman are absent such non-executive Director as the Directors present shall choose shall preside.

3.11 If the Chairman is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy Chairman, if present, shall preside. If the Chairman and Deputy Chairman are absent, or are disqualified from participating, such non-executive Director as the Directors present shall choose shall preside.

3.12 **Notices of Motion** - A Director of the Trust desiring to move or amend a motion shall send a written notice thereof at least 10 days before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to SO 3.7.

3.13 **Withdrawal of Motion or Amendments** - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

3.14 **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the Director who gives it and also the signature of 4 other Directors. When any such motion has been disposed of by the Board, it shall not be competent for any Director other than the Chairman to propose a motion to the same effect within 6 months, however the Chairman may do so if they consider it appropriate.

3.15 **Motions** - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

3.16 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

• An amendment to the motion.

• The adjournment of the discussion or the meeting.

• That the meeting proceed to the next business. (*)

• The appointment of an ad hoc sub-committee to deal with a specific item of business.

• That the motion be now put. (*)

* In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Director who has not previously taken part in the debate and who is eligible to vote. No amendment to the motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

3.17 **Chairman's Ruling** - Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

3.18 **Voting** - Every question at a meeting shall be determined by a majority of the votes of the Directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

3.19 All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

3.20 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

3.21 If a Director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

3.22 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.23 Any director or member of a committee of the Directors may participate in a meeting of the Board of Directors or such committee by means of a conference telephone or similar communications equipment whereby all persons participating in the meeting can hear each other and participation in the meeting in this manner shall be deemed to constitute presence in person at such meeting.

3.24 An acting Director who has been appointed formally by the Executive Remuneration and Nominations Committee as an additional Director, in accordance with the Constitution, to carry out a vacant Director's duties during a period of temporary incapacity shall be entitled to exercise the voting rights of the executive Director. An officer attending the Board to represent an executive Director during a period of incapacity or temporary absence without being formally appointed to the Board may not exercise the voting rights of the executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

3.25 **Minutes** - The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

3.26 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.27 Minutes shall be circulated in accordance with the Directors' wishes.

3.28 **Suspension of Standing Orders** - Except where this would contravene any statutory provision or any direction made by NHSI, any one or more of the SOs may be suspended at any meeting, provided that at least two-thirds of the Board are present, including one executive Director and one non-executive Director, and that a majority of those present vote in favour of suspension.

3.29 A decision to suspend SOs shall be recorded in the minutes of the meeting.

3.30 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Directors.

3.31 No formal business may be transacted while SOs are suspended.

3.32 **Variation and Amendment of Standing Orders** - These SOs shall be amended only if:

• a notice of motion under Standing Order 3.12 has been given; and

• no fewer than half the total of the Trust's non-executive Directors vote in favour of amendment; and

• at least two-thirds of the Directors are present ; and

• the variation proposed does not contravene a statutory provision or direction made by NHSI.

3.33 **Record of Attendance** - The names of the Directors present at the meeting shall be recorded in the minutes.

3.34 **Quorum** - No business shall be transacted at a meeting of the Board unless at least six Directors including not less than three executives (one of whom must be either the Chief Executive or the Deputy Chief Executive) and not less than three non-executive Directors (one of whom must be the Chairman or Deputy Chairman of the Board of Directors) are present.

3.35 **Associate Directors** – Unless the Chairman decides otherwise, for proper grounds, Associate Directors shall be entitled to receive notice of, and to attend and speak at meetings of the Board but shall not be entitled to vote or count in the quorum, at such meetings.

3.36 Procedure for asking questions at Board of Director meetings

Questions may be submitted in writing on any matter within the powers and the duties of the Trust. The Chair reserves the right to refuse any written question that:
• Is not within the powers and duties of the Trust to answer;
• Is defamatory or offensive, or related to individual members of staff;
• Would require the disclosure of confidential or exempt information;
• Is substantially the same as a question that has previously been answered. In addition, the Chair may decide not to deal with complex or lengthy subjects in the public setting of the question session and may choose to respond with written answers only. The Chair has discretion on whether a question can be submitted for answer.

3.36.1 Process for submitting questions

Questions will be answered if submitted in writing to the Trust Secretary by 10am at least 4 working days before the date of the Board meeting. Questions must show the name and address of the person submitting the question, and if on behalf of an organisation, its address must also be stated. No more than two questions may be submitted by any person at any meeting, to allow the Trust to deal with a fair cross-section of questions. The Trust will provide a written response in time for the meeting, which will normally be read out by the Chair.

3.36.2 Procedure at the Board meeting in public

The Chair will first close the Board meeting and then announce the start of the question session, usually lasting up to 15 minutes. If the person who has submitted the question is present, they will be invited to read out their question, with the Chair then reading out the written response. If the questioner is not present the Chair may choose to read out the question before giving the answer. Discussion will not normally follow at the question session except that the Chair may allow one additional oral question to be put after an answer. If the response to this oral question is not easily available, then a further written answer may be provided at the Chair's discretion.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Subject to SO 2.3 and such directions as may be given by NHSI, the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 5.1 or 5.2 below, in each case subject to such restrictions and conditions as the Board thinks fit.

4.2 **Emergency Powers** - The powers which the Board has retained to itself within these SOs (SO 2.3) may in emergency be exercised by the Chief Executive and the Chairman after having consulted at least two non-executive Directors. The exercise of such powers by the Chief Executive and the Chairman shall be reported to the next formal meeting of the Board for ratification.

4.3 **Delegation to Committees** – The Board shall agree from time to time to the delegation of executive powers to be exercised by committees which it has formally constituted. The composition and terms of reference of these committees, and their specific executive powers shall be approved by the Board.

4.4 **Delegation to Officers** - Those functions of the Trust which have not been retained as reserved by the Board or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain an accountability to the Board.

4.5 The Chief Executive shall prepare a Scheme of Delegation identifying their proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board as indicated above.

4.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance or any other executive Director to provide information and advise the Board in accordance with any statutory requirements or NHSI.

4.7 The arrangements made by the Board as set out in the "Reservation of Powers to the Board and Delegation of Powers" shall have effect as if incorporated in these Standing Orders.

5. COMMITTEES

5.1 **Appointment of committees** - Subject to SO 2.7 and such directions as may be given by NHSI, the Board may and, if directed by NHSI, shall appoint committees of the Board, consisting wholly or partly of Directors of the Trust.

5.2 A committee appointed under SO 5.1 may, subject to such directions as may be given by NHSI or the Board, appoint sub-committees of the committee consisting wholly or partly of members of the committee or wholly of persons who are not members of the committee (whether or not they are Directors of the Trust).

5.3 The SOs of the Board, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committees of the Board.

5.4 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board.

5.6 The Board shall approve the appointments to each of the committees which it has formally constituted.

5.7 Where the Trust is required to appoint persons to a committee and/or to undertake statutory functions as required by NHSI and where such appointments are to operate

independently of the Board such appointment shall be made in accordance with applicable statute and regulations and with the guidance issued by NHSI.

5.8 The committees established by the Board are:

- Remuneration
- Audit
- Quality and Clinical Risk
- Finance and Investment
- Workforce and Development Assurance
- Charitable Funds

5.9 **Confidentiality** - A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board or shall otherwise have concluded on that matter.

5.10 A Director of the Trust or a member of a committee or a sub-committee shall not disclose any matter reported to the Board or otherwise dealt with by the committee or sub-committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee or sub-committee shall resolve that it is confidential.

6. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

6.1 **Custody of Seal** - The Common Seal of the Trust shall be kept by the Secretary in a secure place.

6.2 **Sealing of Documents** - The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board.

6.3 **Register of Sealing** - An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Trust Board at the next meeting. (The report shall contain details of the seal number, the description of the document and date of sealing).

7. SIGNATURE OF DOCUMENTS

7.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

7.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or a committee or sub-committee to which the Board has delegated appropriate authority.

8. MISCELLANEOUS

8.1 **Standing Orders to be given to Directors** - It is the duty of the Chief Executive to ensure that existing Directors and all new appointees are notified of and understand their responsibilities within SOs and SFIs. Updated copies shall be issued to all Directors. New Directors shall be informed in writing and shall receive copies where appropriate of SOs and SFIs.

8.2 **Documents having the standing of Standing Orders** - Standing Financial Instructions and Reservation of Powers to the Board and Delegation of Powers shall have the effect as if incorporated into SOs.

8.3 **Review of Standing Orders** - SOs shall be reviewed annually by the Board. The requirement for review extends to all documents having the effect as if incorporated in SOs.

ANNEX 8 – ADDITIONAL PROVISIONS – MEMBERS AND ANNUAL MEMBERS MEETING

(Paragraphs 4 and 8.3)

1. DISQUALIFICATION FROM MEMBERSHIP

1.1 An individual may not become a member of the Foundation Trust if:

1.1.1 they are under 14 years of age; or

1.1.2 within the last five years they have been involved as a perpetrator in a serious incident of violence, whether at any of the Foundation Trust's hospitals or facilities or against any of the Foundation Trust's employees or other persons who exercise functions for the purposes of the Foundation Trust, or against any registered volunteer, or elsewhere or against any other person.

2. TERMINATION OF MEMBERSHIP

2.1 A member shall cease to be a member if:

2.1.1 they resign by notice to the Trust Secretary;

2.1.2 they die;

2.1.3 they are expelled from membership under this constitution;

2.1.4 they cease to be entitled under this constitution to be a member of the Public Constituency or of any of the classes of the Staff Constituency;

2.1.5 it appears to the Trust Secretary that they no longer wish to be a member of the Foundation Trust, and after enquiries made in accordance with a process approved by the Council of Governors, they fail to demonstrate that they wish to continue to be a member of the Foundation Trust.

2.2 A member may be expelled by a resolution approved by not less than two-thirds of the Governors present and voting at a General Meeting. The following procedure is to be adopted.

2.2.1 Any member may complain to the Trust Secretary that another member has acted in a way detrimental to the interests of the Foundation Trust.

2.2.2 If a complaint is made, the Council of Governors may itself consider the complaint having taken such steps as it considers appropriate to ensure that each member's point of view is heard and may either:

2.2.2.1 dismiss the complaint and take no further action; or

2.2.2.2 for a period not exceeding twelve months suspend the rights of the member complained of to attend members meetings and vote under this constitution;

2.2.2.3 arrange for a resolution to expel the member complained of to be considered at the next General Meeting of the Council of Governors.

2.2.3 If a resolution to expel a member is to be considered at a General Meeting of the Council of Governors, details of the complaint must be sent to the member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

2.2.4 At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.

2.2.5 If the member complained of fails to attend the meeting without due cause the meeting may proceed in their absence.

2.3 A person expelled from membership will cease to be a member upon the declaration by the Chairman of the meeting that the resolution to expel them is carried.

2.4 No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of two-thirds of the Council of Governors present and voting at a General Meeting.

3. MEMBERS MEETINGS

3.1 The Foundation Trust is to hold a members meeting (called the annual members meeting) within six months of the end of each financial year.

3.2 All members meetings other than annual meetings are called special members meetings.

3.3 Both Annual Members' Meetings and any Special Members' Meetings shall be open to all members of the trust, members of the Council of Governors and members of the Board of Directors, together with representatives of the trust's external auditors, and to members of the public. The Council of Governors may invite representatives of the media and any experts or advisors whose attendance they consider to be in the best interests of the Foundation Trust to attend a members meeting.

3.4 All members meetings are to be convened by the Secretary by order of the Council of Governors.

3.5 The Council of Governors may decide where a members meeting is to be held and may also for the benefit of members:

3.5.1 arrange for the annual members meeting to be held in different venues each year:

3.5.2 make provisions for a members meeting to be held at different venues simultaneously or at different times. In making such provision the Council of Governors shall also fix an appropriate quorum for each venue, provided that

the aggregate of the quorum requirements shall not be less than the quorum set out below.

3.6 At the annual members meeting:

3.6.1 the Board of Directors shall present to the members:

3.6.1.1 the annual report;

3.6.1.2 the annual accounts;

3.6.1.3 any report of the auditor;

3.6.1.4 forward planning information for the next Financial Year

3.6.2 the Council of Governors shall present to the members a report on:

3.6.2.1 steps taken to secure that (taken as a whole) the actual membership of the Public Constituency and of the classes of the Staff Constituency is representative of those eligible for such membership;

3.6.2.2 the progress of the membership strategy; and

3.6.2.3 any proposed changes to the policy for the composition of the Council of Governors and of the non-executive Directors

3.6.3 the results of the election and appointment of Governors and the appointment of non-executive Directors will be announced.

3.7 Notice of a members meeting is to be given:

3.7.1 by notice to all members;

3.7.2 by notice prominently displayed at the head office and at all of the Foundation Trust's places of business; and

3.7.3 by notice on the Foundation Trust's website at least 14 clear days before the date of the meeting. The notice must:

be given to the Council of Governors and the Board of Directors, and to the auditor;

3.7.4 state whether the meeting is an annual or special members meeting;

3.7.5 give the time, date and place of the meeting; and

3.7.6 indicate the business to be dealt with at the meeting.

3.8 The quorum for a members' meeting shall be [8 (eight)] members present and entitled to vote. If a quorum is not present within thirty minutes from the time appointed for the meeting, the meeting shall stand adjourned for a minimum of seven days until such time as the Board of Directors determine. If a quorum is not present within half an

hour of the time fixed for the start of the adjourned meeting, the number of members present during the meeting is to be a quorum.

3.9 The Foundation Trust may make arrangements for members to vote by post, or by using electronic communications.

3.10 It is the responsibility of the Council of Governors, the Chairman of the meeting and the Secretary to ensure that at any members meeting:

3.10.1 the issues to be decided are clearly explained;

3.10.2 sufficient information is provided to members to enable rational discussion to take place.

3.11 The Chairman of the Foundation Trust, or in their absence the Deputy Chairman of the Board of Directors, shall act as chairman at all members meetings of the Foundation Trust. If neither the Chairman nor the Deputy Chairman of the Board of Directors is present, the members of the Council of Governors present shall elect one of their number to be Chairman and if there is only one Governor present and willing to act they shall be Chairman.

3.12 A resolution put to the vote at a members meeting shall be decided upon by a poll.

3.13 Every member present and every member who has voted by post or using electronic communications is to have one vote. In the case of an equality of votes the Chairman of the meeting is to have a second and casting vote.

3.14 The result of any vote will be declared by the Chairman and entered in the minute book. The minute book will be conclusive evidence of the result of the vote.

ANNEX 9 – FURTHER PROVISIONS

1. COMMITMENTS

1.1 The Foundation Trust shall exercise its functions effectively, efficiently and economically.

Representative membership

1.2 The Foundation Trust shall at all times strive to ensure that taken as a whole its actual membership is representative of those eligible for membership. To this end:

1.2.1 the Foundation Trust shall at all times have in place and pursue a membership strategy which shall be approved by the Council of Governors, and shall be reviewed by them from time to time, and at least every three years,

1.2.2 the Council of Governors shall present to each annual members meeting a report on:

1.2.2.1 steps taken to secure that (taken as a whole) the actual membership of the Public Constituency and of the classes of the Staff Constituency is representative of those eligible for such membership;

1.2.2.2 the progress of the membership strategy;

1.2.2.3 any changes to the membership strategy.

Co-operation with NHS bodies and local authorities

1.3 In exercising its functions the Foundation Trust shall co-operate with NHS bodies and local authorities.

Openness

1.4 In conducting its affairs, the Foundation Trust shall have regard to the need to provide information to members and conduct its affairs in an open and accessible way.

Prohibiting distribution

1.5 The profits or surpluses of the Foundation Trust are not to be distributed either directly or indirectly in any way at all among members of the Foundation Trust.

2. FRAMEWORK

2.1 The affairs of the Foundation Trust are to be conducted by the Board of Directors, the Council of Governors and the members in accordance with this constitution and the Foundation Trust's authorisation. The members, the Council of Governors and the Board of Directors are to have the roles and responsibilities set out in this constitution.

Members

2.2 Members may attend and participate at members meetings, vote in elections to, and stand for election to, the Council of Governors, and take such other part in the affairs of the Foundation Trust as is provided in this constitution.

Council of Governors

2.3 The roles and responsibilities of the Council of Governors, which are to be carried out in accordance with this constitution and the Foundation Trust's terms of Authorisation, are:

2.3.1 at a General Meeting:

2.3.1.1 to appoint or remove the Chairman and the other non-executive Directors;

2.3.1.2 to approve an appointment (by the non-executive Directors) of the Chief Executive;

2.3.1.3 to decide the remuneration and allowances, and the other terms and conditions of office, of the non-executive Directors;

2.3.1.4 to appoint or remove the Foundation Trust's external auditor;

2.3.1.5 to be presented with the annual accounts, any report of the external auditor on them and the annual report;

2.3.2 to provide their views to the Board of Directors when the Board of Directors is preparing the document containing information about the Foundation Trust's forward planning;

2.3.3 to respond as appropriate when consulted by the Board of Directors in accordance with this constitution;

2.3.4 to undertake such functions as the Board of Directors shall from time to time request;

2.3.5 to prepare and from time to time review the Foundation Trust's membership strategy and its policy for the composition of the Council of Governors and of the non-executive Directors and when appropriate to make recommendations for the revision of this constitution.

Board of Directors

2.4 The business of the Foundation Trust is to be managed by the Board of Directors, who shall exercise all the powers of the Foundation Trust, subject to any contrary provisions of the 2006 Act as given effect by this constitution.

3. TRUST SECRETARY

3.1 The Foundation Trust shall have a Secretary who may be an employee. The Trust Secretary may not be a Governor, or the Chief Executive or the Finance Director. The Secretary's functions shall include:

3.1.1 acting as Secretary to the Council of Governors and the Board of Directors, and any committees;

3.1.2 summoning and attending all members meetings, meetings of the Council of Governors and the Board of Directors, and keeping the minutes of those meetings;

3.1.3 keeping the register of members and other registers and books required by this constitution to be kept;

3.1.4 having charge of the Foundation Trust's seal;

3.1.5 publishing to members in an appropriate form information which they should have about the Foundation Trust's affairs;

3.1.6 preparing and sending to NHSI and any other statutory body all returns which are required to be made.

3.2 Minutes of every members' meeting, of every meeting of the Council of Governors and of every meeting of the Board of Directors are to be kept. Minutes of meetings will be read at the next meeting and signed by the Chairman of that meeting. The signed minutes will be conclusive evidence of the events of the meeting.

3.3 The Secretary is to be appointed and removed by the Board of Directors.

3.4 The Board of Directors of Milton Keynes University Hospital NHS Foundation Trust shall appoint the first Secretary of the Foundation Trust.

4. FURTHER PROVISIONS AS TO ACCOUNTS

4.1 The following documents will be made available to the Controller and Auditor General for examination at their request:

4.1.1 the accounts;

4.1.2 any records relating to them; and

4.1.3 any report of the external auditor on them.

4.2 In preparing its annual accounts, the Accounting Officer shall cause the Foundation Trust to comply with any directions given by NHSI with the approval of the Treasury as to:

4.2.1 the methods and principles according to which the accounts are to be prepared;

4.2.2 the information to be given in the accounts;

and shall be responsible for the functions of the Foundation Trust as set out in paragraph 25 of Schedule 7 to the 2006 Act.

4.3 The Accounting Officer shall cause the Foundation Trust to:

4.3.1 lay a copy of the annual accounts, and any report of the external auditor on them, before Parliament; and

4.3.2 once it has done so, send copies of those documents to NHSI.

5. FURTHER PROVISIONS AS TO ANNUAL REPORTS

5.1 The annual reports are to give:

5.1.1 information on any steps taken by the Foundation Trust to secure that (taken as a whole) the actual membership of the Public Constituency and of the classes of the Staff Constituency is representative of those eligible for such membership; and

5.1.2 any other information NHSI requires.

5.2 The Foundation Trust is to comply with any decision NHSI makes as to:

5.2.1 the form of the reports;

5.2.2 when the reports are to be sent to it;

5.2.3 the periods to which the reports are to relate.

6. INDEMNITY

Members of the Council of Governors and the Board of Directors and the Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Foundation Trust. The Foundation Trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of members of the Council of Governors and the Board of Directors and the Secretary.

7. DISPUTE RESOLUTION PROCEDURES

7.1 Every unresolved dispute which arises out of this constitution between the Foundation Trust and:

7.1.1 a member; or

7.1.2 any person aggrieved who has ceased to be a member within the six months prior to the date of the dispute; or

7.1.3 any person bringing a claim under this constitution; or

7.1.4 an office-holder of the Foundation Trust

is to be submitted to an arbitrator agreed by the parties or in the absence of agreement to be nominated by NHSI. The arbitrator's decision will be binding and conclusive on all parties.

7.2 Any person bringing a dispute must, if required to do so, deposit with the Foundation Trust a reasonable sum (not exceeding £250) to be determined by the Council of Governors and approved by the Secretary. The arbitrator will decide how the costs of the arbitration will be paid and what should be done with the deposit.

8. DISSOLUTION

The Foundation Trust may not be dissolved except by order of the Secretary of State for Health, in accordance with the 2003 Act.

9. HEAD OFFICE

The Foundation Trust's head office is at Standing Way, Eaglestone, Milton Keynes MK6 5LD or such other place as the Board of Directors shall decide.

10. NOTICES

10.1 Any notice required by this constitution to be given shall be given in writing or shall be given using electronic communications to an address for the time being notified for that purpose. "Address" in relation to electronic communications includes any number or address used for the purposes of such communications.

10.2 Proof that an envelope containing a notice was properly addressed, prepaid and posted shall be conclusive evidence that the notice was given. A notice shall be treated as delivered 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent.

11. FURTHER PROVISIONS AS TO TRANSITION

11.1 The Board of Directors of Milton Keynes University Hospital NHS Foundation Trust shall prepare and approve the first membership strategy and the first policy for the composition of the Council of Governors and of the non-executive Directors.

11.2 These will be reviewed by the Council of Governors following the election and appointment of the initial Governors.

11.3 For the purposes of the period before Milton Keynes General NHS Trust becomes the Foundation Trust:

11.3.1 elections shall be carried out in accordance with the Model Rules for Elections set out at Annex 4, using the single transferable vote method of voting;

11.3.2 the Chief Executive of Milton Keynes University Hospital NHS Foundation Trust will approve

11.3.2.1 a membership application form;

11.3.2.2 a form of declaration required by section 60 (1) of the 2006 Act;

11.3.2.3 a form of declaration required by section 60 (1) of the 2006 Act;

11.3.2.4 a form of declaration required by section 60 (3) of the 2003 Act;

11.3.2.5 a form confirming acceptance of a code of conduct for Governors;

11.3.3 the Chief Executive of Milton Keynes University Hospital NHS Foundation Trust will consult and agree arrangements with the appointing organisations for the appointment of appointed Governors;

11.3.4 the Chief Executive of Milton Keynes University Hospital NHS Foundation Trust shall make a final decision about the class of the Staff Constituency of which an individual is eligible to be a member.

ANNEX 10 – ANNUAL MEMBERS' MEETING

1. MEMBERS' MEETINGS

1.1. The trust shall hold a members' meeting for all members (called the "Annual Members' Meeting") within six months of the end of each financial year of the trust.

1.2. Any members' meeting other than the Annual Members' Meeting shall be called a "Special Members' Meeting".

1.3. Both Annual Members' Meetings and any Special Members' Meetings shall be open to all members of the trust, members of the Council of Governors and members of the Board of Directors, together with representatives of the trust's external auditors, and to members of the public. The trust may invite representatives of the media and any experts or advisors whose attendance they consider to be in the best interests of the trust to attend any such meeting.

1.4. The Board of Directors may convene an Annual Members' Meeting or a Special Members' Meeting when it thinks fit. The Council of Governors may request the Board of Directors to convene a members' meeting.

1.5. The Board of Directors (or at least one member thereof) shall present to the members at the Annual Members' Meeting:

1.5.1. the annual accounts;

1.5.2. any report of the external auditor on them;

1.5.3. the annual report;

1.5.4. a report on steps taken to secure that (taken as a whole) the actual membership or the trust is representative of those eligible for such membership;

1.5.5. the progress of the membership plan

1.5.6. the results of any election and appointments to the Council Governors, and any other reports or documentation it considers necessary or otherwise required by NHSI or the 2006 Act.]

1.6. The trust shall give notice of all members' meetings:

1.6.1. by notice in writing to all members;

1.6.2. by notice prominently displayed at the trust's headquarters and at all of the trust's hospitals;

1.6.3. by notice on the trust's website; and

1.6.4. to the Council of Governors, the Board of Directors, and to the trust's external auditors,

stating whether the meeting is an Annual Members' Meeting or a Special Members' Meeting including the time, date, place of the meeting, and the business to be dealt with at the meeting at least 14 working days before the date of the relevant members' meeting (or, in the case of an Annual Members' Meeting, at least 21 working days before the date of the relevant meeting).

1.7. An accidental omission to give notice of a members' meeting or to send, supply or make available any document or information relating to the meeting, or the non-receipt of any such notice, document or information by a person entitled to receive any such notice, document or information shall not invalidate the proceedings at that meeting.

1.8. The Chair or in their absence the Deputy Chair shall preside at all members' meetings of the trust. If neither the Chair nor the Deputy Chair is present, the governors present shall elect on of their number to act as Chair and if there is only one governor present and willing to act that person shall be Chair. If no governor is willing to act as Chair or if no governor is present within fifteen minutes after the time appointed for holding the meeting, the members present and entitled to vote shall choose one of their number to act as Chair.

1.9. The quorum for a members' meeting shall be [8 (eight)] members present and entitled to vote. If a quorum is not present within thirty minutes from the time appointed for the meeting, the meeting shall stand adjourned for a minimum of seven days until such time as the Board of Directors determine.

1.10. The Chair may, with the consent of a members' meeting at which a quorum is present (and shall, if so directed by the meeting), adjourn a members' meeting from time to time and from place to place or for an indefinite period.

1.11. A resolution put to the vote of a members' meeting shall be decided on a show of hands.

1.12. No business shall be transacted at an adjourned meeting other than business which might properly have been transacted at the meeting had the adjournment not taken place.

1.13. If the Board of Directors, in its absolute discretion, considers that it is impractical or unreasonable for any reason to hold a members' meeting at the time, date or place specified in the notice calling that meeting, it may move and/or postpone the general meeting to another time, date and/or place.

1.14. In the case of a members' meeting is adjourned or postponed for 14 days or more, at least seven working days' notice shall be given specifying the time and place of the adjourned members' meeting and the general nature of the business to be transacted. Otherwise, it shall not be necessary to give any such notice.

1.15. The Board of Directors may make any arrangement and impose any restriction it considers appropriate to ensure the security of a members' meeting.

1.16. Any approval to speak at a members' meeting must be given by the Chair. Speeches must be directed to the matter, motion or question under discussion or to a

point of order. Unless in the opinion of the Chair it would not be appropriate or desirable to time limit speeches on any topic to be discussed having regard to its nature, complexity or importance, no proposal, speech or any reply may exceed three minutes. In the interests of time, the Chair may, in their absolute discretion, limit the number of replies, questions or speeches which are head at any one members' meeting.

1.17. A person who has already spoken on a matter at a members' meeting may not speak again at that meeting in respect of the same matter except (i) in exercise of a right of reply, or (ii) on a point of order.

1.18. The Board of Directors shall cause minutes to be made and kept, in writing, of all proceedings at members' meetings.

Agenda item 21.1
Public Board 05.05.22

Meeting of the Finance and Investment Committee held on 01 March 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

a. The Committee **approved** the Witan Gate Lease Extension..

Summary of matters considered at the meeting:

- Regarding the Year End Forecast, the Committee noted the plan to deliver the out-turn in line with the planned deficit of £1.1m, the actions and assumptions therein, and the possibility that the year-end position may change due to factors outside the control of the Trust.

- Regarding discharge planning, the Committee reviewed the steps being taken to support system partners, such as Milton Keynes Council, to sustain effective patient discharge flows in 2022/23.

- The Committee reviewed a report which outlined the options with regard to the future of the CERNER EPR Contract and recommended a 3-year extension of the contract to the Trust Board of Directors.

- Regarding performance in month 10, the Committee noted the challenges that were presented by the COVID-19 Omicron wave in terms of patient backlogs, and an increasing number of both stranded and super stranded patients due to pressures in the care system. The Committee also noted the steps being taken to mitigate the risks associated with the challenges.

- The Committee received an update on progress against the capital projects programme for 2021-22.

- The Committee received an update on the progress made against the steps to terminate and transition the Dermatology Service provision from HCRG Care Group, formerly Virgin Care.

Milton Keynes University Hospital NHS Foundation Trust

Agenda item 21.2
Public Board 05.05.22

Meeting of the Finance and Investment Committee held on 05 April 2022

REPORT TO THE BOARD OF DIRECTORS

The Committee noted matters approved at an Extraordinary Committee meeting on 25 March 2022:

a. Ward 24 Lease Extension – The Committee approved the recommendation to extend the current rental period of Ward 24's Portakabin facility for two years and take the benefit of the reduction in the rental cost.

b. Cerner EPR Contract Extension – The Committee approved the three-year extension of the current contract to May 2028.

Summary of matters considered at the meeting:

- Regarding the M11 Performance Dashboard, the Committee reviewed the trajectories of all key performance indicators.
- Regarding the M11 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.
- The Committee noted the progress which had been made to award a three-year contract for the Trust's Dermatology Service to a new preferred provider.
- The Committee reviewed the outline of the draft 2022/23 Financial Plan, noted that the significant risks to achieving its targets and the steps being taken with the regional and national team to mitigate those risks.
- The Committee discussed the proposed capital allocations for 2022/23, 2023/24 and 2024/25, and noted that the Trust found the proposed allocations to be unacceptable.

Agenda Item 21.3
Public Board 05 May 2022

Meeting of the Audit Committee held on 21 March 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

a. The Committee approved the 2022/23 Counter Fraud Workplan.
b. The Committee approved the Annual Report, Annual Accounts and Quality Report Timetable.

Summary of matters considered at the meeting:

Trust Risk Register and Board Assurance Framework (BAF)
The Committee comprehensively reviewed the Trust Risk Register and the gaps thereof and noted the improvement actions being undertaken.

Revised Risk Management Framework
The Committee reviewed and noted the Trust's revised Risk Management Framework.

External Auditor's Update
The Audit Committee received the 2021/22 External Audit Plan

Internal Audit Report
The Committee noted that Internal Auditors had since December 2021 issued 4 draft internal audit reports in the following areas:

- Cyber Security
- Patient Experience
- Consultant Job Planning
- Risk Management
- Freedom to Speak Up

Local Counter Fraud Specialist (LCFS) Progress Report
The Committee reviewed the report and the noted the activities of the LCFS since December 2021.

Financial Controller's Report
The Committee was assured by the robust processes in place to recover debts from overseas patients.

2021 Declarations of Interest and Gifts and Hospitality Report
The Audit Committee received the 2021 report and noted the significant improvements achieved since 2020.

Milton Keynes University Hospital NHS Foundation Trust

Agenda item 21.4
Public Board 05.05.22

Workforce & Development Assurance Committee Meeting held on 21 April 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

a. N/A.

Summary of matters considered at the meeting:

HR Services and Systems (Q4) – The Committee received an update that the processes to enable staff to sell or bank their annual leave were working well, with managers taking steps to ensure that staff health and wellbeing was not being negatively impacted. The Committee noted that, to ensure staff do not lose out on their annual leave, the Trust had taken the decision to remove the limit on the number of days that may be carried over to the following year. This would allow staff to determine how best to manage any remaining leave they may have.

Resourcing (Q4) – The Committee noted that due to the national mandatory COVID-19 vaccine policy issued in December 2021, the time to hire had been significantly lengthened. The Committee was informed that candidates with unconditional offers of employment in January and February 2022 have been reissued with conditional offers subject to them providing proof of vaccination.

Employee Relations and Equality, Diversity and Inclusion (Q4) – The Committee noted that Equality, Diversity and Inclusion (EDI) Team had commenced planning for a neurodiversity awareness campaign, which would include a training programme for managers on how to identify and implement reasonable adjustments for people with conditions such as autism, ADHD and dyslexia.

Staff Health and Wellbeing Annual Report – The Committee was informed that:

a. A support group for long-Covid sufferers had been established, as part of steps to enhance health and wellbeing support for staff.
b. A Menopause Policy was progressing towards publication.

2021 NHS Staff Survey Results – The Committee received and reviewed the 2021 NHS Staff Survey Report

Freedom to Speak Up Annual Report 2021 – The Committee received and reviewed the Annual Report.

Milton Keynes University Hospital NHS Foundation Trust

Agenda item: 21.5
Public Board 05.05.2022

Meeting of the Trust Executive Committee held on 09 March 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

1. The following important policies:

a. Risk Management Framework
b. Conflicts of Interest, Hospitality, Gifts, Donations & Sponsorship Policy
c. Menopause Policy
d. Flexible Working Policy

Summary of matters considered at the meeting:

- The Committee was briefed on the lessons learnt from the implementation of the new Radar risk and incident management system in November 2021.
- Staff sickness absences continued to decline, the health and wellbeing support for the staff had been strengthened.
- The 'time to hire' had been lengthened because of new requirements associated with the national policy on COVID-19 vaccination.
- An increase in formal complaints in Q3 21/22, and the development of an action plan by Internal Audit to address gaps and inefficiencies. It was noted that communication and the introduction of COVID-19 restricted visiting practices were some of the causes of the patient complaints.

Divisional update:

- Women's and Children Division: Professor Jacqueline Dunkley-Bent the Chief Midwife for England visited the Trust on 03 March 2022 and attended the March 2022 Trust Board meeting.

Milton Keynes University Hospital NHS Foundation Trust

Agenda item: 21.6
Public Board 05.05.2022

Meeting of the Trust Executive Committee held on 13 April 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

1. The following revenue business cases for:

   a. The extension of the Crispin Orthotics Contract
   b. A Spinal Consultant
   c. A ward-based Clinical Pharmacy Service

Summary of matters considered at the meeting:

- Workforce Month 11 – The internationally recruited nurses were settling down well and contributing to the Trust.
- Patient and Family Experience Q3 Report – A patient experience platform had been implemented since December 2021 which enabled the Trust to view real-time data.

Divisional Update

a. Surgery Division – There was a shortage of available beds, high levels of staff sickness, increased activity and a backlog of patients in the Outpatient department.
b. Core Clinical – Increased activity and the capacity to deliver remained challenging with space constraints and staffing pressures from high levels of Covid related absences.

Milton Keynes University Hospital NHS Foundation Trust

Agenda item 21.7
Public Board 05.05. 2022

Meeting of the Quality & Clinical Risk Committee held on 21 March 2022

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 increased activity and the restrictions to the capacity to deliver by the estate and staffing pressures.

Quarterly Highlight Report – The Committee reviewed and discussed the following themes:

a. The increased activity in Maternity due to the actions plans associated with the national reviews from Ockendon and other initiatives already being implemented.
b. The significantly increase pressure on the Trust's Urgent and Emergency Care pathways which impacts on the hospital capacity to provide consistently high quality of care and the experience of patients and renders the system to be less resilient to the inevitable disruption of 'high impact events'.

2022/23 Quality Priorities – The Committee reviewed the 2022/21 Quality Priorities.

Maternity Experience Report – The Committee reviewed and discussed the report and noted the improvement actions being implemented.

Quarterly Trust-Wide Serious Incidents Report – The Committee reviewed and discussed the report, and noted the mitigations put in place to prevent further occurrences.

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Board of Directors**	**Date: 5 May 2022**
Report title:	**Use of Trust Seal**	**Agenda item: 22**
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 2022						

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:

a. 1 March 2022
Medical School Development:

I. Principal Designer's Collateral Warranty
II. Architect's Collateral Warranty
III. Civil/Structural Engineers' Collateral Warranty
IV. Geo-Technical and Geo-Environmental Consultant's Collateral Warranty
V. Employer's Agent's Collateral Warranty
VI. Building Services Engineers Warranty
VII. Planning Consultant's Collateral Warranty
VIII. Sub-contractor Warranty to Landlord between Queniborough Aluminium Services Ltd
IX. Contractor Warranty to Landlord between E W Beard Ltd
X. Subcontractor Warranty to Landlord between Kone Public Limited Company
XI. Subcontractor Warranty to Landlord between Mechanical Installation Heating Services (Glos) Limited
XII. Subcontractor Warranty to Landlord between Craft Interior Limited
XIII. Subcontractor Warranty to Landlord between C T Walters (Electrical) Limited
XIV. Subcontractor Warranty to Landlord between Ferco Seating Systems Limited
XV. Subcontractor Warranty to Landlord between Cahill Welding Services Limited
XVI. Subcontractor Warranty to Landlord between M3 Solutions Limited
XVII. Subcontractor Warranty to Landlord between WPL (UK) Limited
XVIII. Subcontractor Warranty to Landlord between Devcor Precast Limited

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
	Equality, Diversity and Inclusion Update
	Patient Experience Report

Additional Agenda Items

Month	Assurance Reports/Items
January	Objectives Update
	Antimicrobial Stewardship - Annual Report
March	
May	Freedom to Speak Up Guardian Annual Report
	Quality Priorities
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