Bundle Trust Board Meeting in Public 7 July 2022

1.1	10:00 - Agenda 1. Agenda Board Meeting in Public - 07.07.22 v 2.docx
1.2	10:05 - Apologies
2	10:05 - Declarations of Interest
3	10:05 - Previous Minutes of the Meeting 3. Minutes Trust Board Meeting in Public 05.05.22 draft v 2.docx
4	10:05 - Matters Arising 4. Board Action Log 07.07.22.pdf
5	10:05 - Chair's report 5. Chair's Report July 2022.docx
6	10:10 - Chief Executive's Report
7	10:20 - Patient Story
8	10:35 - Patient and Family Experience Report 8. Patient and Family Experience report Q4 2021 to 2022.docx
9	10:40 - Maternity Update *To Follow*
10	10:50 - Serious Incident Report 10. SI report for Trust Board July 2022.doc
11	10:55 - Focus on Falls (2021-22 Annual Report) 11. Falls Presentation.pptx
12	11:00 - Focus on Pressure Damage (2021-22 Annual Report) 12. Pressure Ulcer Presentation.pptx
13	11:05 - Safeguarding Annual Report 2021-22 13. SAFEGUARDING ANNUAL REPORT 2022 FINAL.docx
14	11:10 - Nursing Staffing Update 14. Nursing Workforce Overview June 2022 V3.docx
15	11:15 - Workforce Report 15. Workforce Report M2 202223.docx
15.1	11:20 - Break
16	11:30 - Performance Report 16.1 2022-23 Executive Summary M02 Coversheet.docx 16.2 2022-23 Executive Summary M02.docx 16.3 2022-23 Board Scorecard M02.pdf
17	11:35 - Finance Report 17. Finance report month 02 v3.docx
18	11:40 - Financial Plan - 2022/23 18. Financial Plan FY23 - front sheet.docx 18.1 Financial Plan FY23 for Board Approval.pptx
19	11:50 - Annual Claims Report 2021-22 19. Annual Claims Report 2021 - 2022_IR.doc
20	11:55 - Medical Revalidation Annual Report 2021-22 20. MKUH Board Report - Medical Revalidation 290622.pdf
21	12:00 - Significant Risk Register 21.1 Risk Report July 2022.docx 21.2 Significant Risk Register - as at 28th June 2022.pdf
22	12:05 - Board Assurance Framework

22. Board Assurance Framework July 2022.docx

23 12:10 - Summary Reports

23.1 FIC Summary Report 03 May 2022.docx

23.2 FIC Summary Report 07 June 2022.docx

23.3 FIC Summary Report 16 June 2022.docx

23.4 Audit Committee 18 May 2022.docx

23.5 Audit Committee 13 June 2022.docx

23.6 Trust Executive Committee 11 May 2022.docx

23.7 Trust Executive Committee 8 June 2022.docx

24 12:15 - Use of Trust Seal

24. Use of Trust Seal July 2022.docx

25 12:20 - Forward Agenda Planner

Trust Board Meeting In Public Forward Agenda Planner.docx

26 12:25 - Questions from Members of the Public

23.1 FND.docx

23.2 Parkinsons.docx

23.3 Appendix 1_letter.docx

23.4 Appendix 2_Poster.pdf

27 12:30 - Motion to Close the Meeting

28 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."

Agenda for the Board of Directors' Meeting in Public

Meeting to be held at 10:00 am on Thursday 07 July 2022
in the Conference Room at the Academic Centre and via MS Teams

Item No.	Timing	Title	Purpose	Lead	Paper
Introduction and Administration					
1	10:00	Apologies	Receive	Chair	Verbal
2		Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda	Information	Chair	Verbal
3		Minutes of the Trust Board meeting held in public on 05 May 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	Receive and Discuss	Chief Executive	Verbal
Patient Experience					
7	10:20	Patient Story	Receive and Discuss	Director of Patient Care and Chief Nurse	Presentation
8	10:35	Patient and Family Experience Report	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached
Patient Safety					
9	10:40	Maternity Update	Receive and Discuss	Director of Patient Care and Chief Nurse	Presentation
10	10:50	Serious Incident and Learning Report	Receive and Discuss	Director of Corporate Affairs/ Medical Director	Attached

Item No.	Timing	Title	Purpose	Lead	Paper
11	10:55	Focus on Falls (2021/22 Annual Report)	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached
12	11:00	Focus on Pressure Damage (2021/22 Annual Report)	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached
13	11:05	Safeguarding Annual Report	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached
Workforce					
14	11:10	Nursing Workforce Report	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached
15	11:15	Workforce Report Month 02	Receive and Discuss	Director of Workforce	Attached
11:20 – Break (10 mins)					
Performance and Finance					
16	11:30	Performance Report Month 02	Receive and Discuss	Chief Operations Officer	Attached
17	11:35	Finance Report Month 02	Receive and Discuss	Director of Finance	Attached
18	11:40	2022/23 Financial Plan	Approve	Director of Finance	Attached
Assurance and Statutory Items					
19	11:50	Annual Claims Report	For Noting	Medical Director/Director of Corporate Affairs	Attached
20	11:55	Medical Revalidation Annual Report 2021-22	For Noting	Medical Director	Attached
21	12:00	Significant Risk Register	Receive and Discuss	Director of Corporate Affairs	Attached
22	12:05	Board Assurance Framework	Receive and Discuss	Director of Corporate Affairs	Attached
23	12:10	(Summary Reports) Board Committees • Finance & Investment Committee 03/05/2022,	Assurance and Information	Chairs of Board Committees	Attached

Item No.	Timing	Title	Purpose	Lead	Paper
		07/06/2022 and 16/06/22 • Audit Committee 18/05/2022 and 13/06/2022 • Trust Executive Committee 11/05//2022 and 08/06/2022			
24		Use of Trust Seal	Noting	Director of Corporate Affairs	Attached
Administration and Closing					
25		Forward Agenda Planner	Information	Chair	Attached
26		Questions from Members of the Public • Functional Neurological Disorders • Parkinsons	Receive and Respond	Chair	 Attached Attached
27		Motion To Close The Meeting	Receive	Chair	Verbal
28	12.15	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, 08 September 2022					

BOARD OF DIRECTORS MEETING

Minutes of the Trust Board of Directors Meeting in Public held on Thursday, 5 May 2022 at 10.00 hours via Teams

Present:		
Alison Davis	Chair	(AD)
Professor Joe Harrison	Chief Executive	(JH)
Heidi Travis	Non-Executive Director	(HT)
Dr Luke James	Non-Executive Director	(LJ)
Haider Husain	Non-Executive Director	(HH)
Bev Messinger	Non-Executive Director	(BM)
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)
Liz Winter (Item 7)	Chief Nurse for Medicine	(LW)
Beverley Byrne (Item 7)	Lead Frailty Nurse	(BB)
Hannah Jones (Item 7)	Lead Frailty Occupational Therapist	(HJ)
Philip Ball (Item 13)	Freedom to Speak Up Guardian	(PB)
Kwame Mensa-Bonsu	Trust Secretary	(KMB)

1 Welcome and Apologies

1.1 AD welcomed all present to the meeting. There were apologies from:

Gary Marven, Non-Executive Director
Professor James Tooley, Non-Executive Director
Helen Smart, Non-Executive Director and
John Blakesley, Deputy Chief Executive

2 Declarations of interest

2.1 JH declared that he was the Chair of the University of Buckingham.

There were no other declarations of interest in relation to the agenda items.

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

3.1 The minutes of the Trust Board Seminar held on 3 March 2022 were reviewed and **approved** by the Board.

4 Matters Arising

4.1 Action 1
This action was completed. Closed

Action 3
KJ advised that auditing of the maternity action plans would be discussed with the internal auditor as part of the planning discussions. Closed.

There were no other matters arising.

5 Chair's Report

5.1 AD presented the Chair's Report and highlighted the following

1. The new Outpatient Pharmacy which was opened next to the hospital's main entrance in April 2022. AD noted that it was a modern and welcoming facility, the layout of which was designed by members of the Pharmacy team.
2. The Hospital Charity was organising a Gala Ball, which had a Midsummer Night theme to raise funds for the Trust's cancer patients. The Gala Ball would be held at the DoubleTree by Hilton in Bletchley, on Friday, 24 June 2022.

5.2 AD noted that Non-Executive Director Andrew Blakeman retired from the Board at the end of March 2022. AD, on behalf of the Board, thanked him for his service to the Trust.

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

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

6.1 JH highlighted 5 May was the International Day of the Midwife and that International Nurses Day would take place on 12 May.

6.2 He reported that a bed change-over programme was underway, led by TW who advised that the 500 beds across the hospital were being replaced by beds which were more manoeuvrable and better for patients from a tissue viability perspective. The change-over was being assisted by the Trust's reservist teams. TW confirmed that the old beds would support humanitarian aid efforts in Ukraine.

6.3 JH informed the Board that pressure on the hospital had increased significantly over the last few days with elective and emergency services heavily impacted.

6.4 JH and IR had attended a positive meeting with the Leader of Milton Keynes Council, CNWL and primary care discussing the four main areas of focus for MK place. These related to:

1. Discharge from hospital;
2. Child and adolescent mental health;
3. Patients with complex needs; and
4. Obesity

JH described the challenge facing Place in addressing these issues and explained that the Health and Wellbeing Board would be accountable for the four programmes, working with relevant third sector organisations and healthcare partners across Milton Keynes. JH reported growing concern over the lack of financial support from the Integrated Care System (ICS) for this and other agendas, and he highlighted the importance of ensuring that the ICS governance structure complemented those already in place across the system. As an example of how this challenge could be met, he advised that an open invitation had been extended to ICS colleagues to attend the Trust's Quality and Clinical Risk Committee to provide the required assurance. JH went on to advise that the process for nomination and selection to the Integrated Care Board (ICB) was awaited and that he had been put forward by MK Place to provide Milton Keynes perspective.

6.5.1 <u>Staff survey report</u>

DP reminded the Board that the survey had taken place in the autumn of 2021 with questions based around the NHS People Promise. There were 126 participating acute and community hospitals. The Trust's response rate was 42% and the median response rate had been 46%. Although the results appeared to have worsened year on year, compared to peers MKUH had performed very well against the backdrop of the pandemic, achieving the highest score in one area. DP explained that at the end of the process, the results from the two survey providers, Quality Health and Picker, would be combined

and evaluated. In the meantime, MKUH scored fourth for staff engagement, ninth for morale, and achieved the top score for motivation. This was testament to all the dedication from managers in supporting their staff. The Trust also scored well for people feeling they could report bullying and harassment where this was experienced. DP advised that there were three questions out of 111 where the Trust performed worse than peers, mirroring previous years' outcomes:

- Staff working additional paid hours
- Staff experiencing violence from patients / service users
- Staff experiencing discrimination

The score for working additional unpaid hours had reduced this year and DP explained that as the Trust operated an internal bank, it could be supposed that responders were electing to work additional shifts. Notwithstanding, the Trust was committed to filling all vacancies to enable staff to work only the hours they wanted to. Regarding the violence experienced by staff, DP reminded the Board that in previous years this had included violence from other staff and she confirmed that there were no reports of staff experiencing violence of this kind, this year. Different approaches were being used in efforts to reduce the incidence of violence from patients and service users. DP expected plans coming online over the next 18 months to have a significant impact on reducing discrimination within the Trust. AD advised that the Workforce & Development Assurance Committee had requested a further breakdown of the response rates to cover ethnicity and gender to provide greater assurance.

6.5.2 Results from two of the seven themes within the People Promise were significantly better, 73 scores were significantly better than the sector and only four scores were worse.

6.5.3 The return rate had dipped both this and last year, assumed to be as a result of Covid, but DP expected the rate to return to pre-pandemic levels. She highlighted the more equal split of corporate and clinical respondents compared to previous years but would be seeking a better return rate from health care and maternity care assistants.

6.5.4 In terms of next steps, DP advised that the heatmaps would be rolled out to individual areas and the 'Staff Survey Goes Large' approach would continue, giving staff the opportunity to share their views. The violence and aggression working group continued to progress their agenda. Values based recruitment and appraisals would be rolled out following Living Our Values workshops held last year. In response to a question from HH, DP advised that in the appraisal paperwork, where staff were asked to evidence how they met the Trust's values, they would also be asked to evidence how they met the Trust's expected behaviours.

Action: DP to share examples of comparisons with other organisations on their approach towards appraisals at the next Workforce & Development Assurance Committee

6.5.5 HH asked whether there was an opportunity to learn from the best performing trusts to address violence from patients and service users. KJ acknowledged that this was a problem across the NHS and the group had been working with national groups. A lot of situational awareness training had been undertaken but a better understanding of the drivers was required and greater knowledge over de-escalation of violence. JH invited LW to share a recent experience and she highlighted the impact of a violent patient on a ward not just on staff but also on other patients within the ward. She reiterated the point made by KJ over recognising the triggers and looking after people on an individual basis. JH said that this example demonstrated the further work required to enable staff to foresee potential outcomes. KJ added that the way in which the organisation used enforcement was also being considered to prevent staff from being assaulted at work. AD remarked that from her experience zero-tolerance of violence and aggression was effective. KJ advised that mental health colleagues had been, and continued to be, supportive in helping the organisation address this issue. She added that the number of people reporting incidents of racism was extremely small and that it was clear the organisation needed to consider alternative means of capturing incidents and to develop a means of responding to them in real time.

6.5.6 IR highlighted the influence of external factors in determining staff's lived experience and warned that the year ahead would be extremely difficult from a financial resource perspective which would inevitably impact on staff experience. He felt that the organisation should focus on those areas within the organisation's control. LJ added that the cost of living crisis was another external factor that could influence next year's survey results.

6.5.7 JH noted that the results from General Messenger's review of health and social care leaders were due later in the month and he suggested that the Trust's approach to engaging with the requirements should be shared at September's Board.

6.5.8 JH expressed his pride in the way in which the organisation reflected its values and expected staff behaviours relative to the rest of the NHS and he thanked teams for this.

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

7 Patient Story

7.1 NBM advised that the anticipated story in relation to the Chaplaincy had been replaced with one around frailty and she introduced BB and HJ. BB was the Lead Nurse for the Acute Assessment Frailty Team, a multi-disciplinary team introduced in 2014 that worked closely with community services and the only one of its kind in the Bedford, Luton and Milton Keynes ICS. HJ was the Clinical Lead Occupational Therapist for the Frailty Team and specifically, the Same Day Emergency Service, a service that had been trialled since November 2021.

7.2 BB and HJ presented the case of an 86 year old patient presenting with a clinical frailty score of 5 who had fallen in the bath. A full geriatric assessment took place providing a full overview of the patient. She was expected to be admitted for 24-48 hours with support from the frailty hub and Age UK amongst others. However, the following day she was found to be Covid positive and was therefore moved to a Covid ward instead of the assessment unit where she would have been looked after by the frailty team. She was assigned an enhanced observer due to her cognitive impairment. Community services were unable to support her package of care for up to 9 days and since most patients referred to the frailty team would be in their final year, Bev advised that it would not have been in her best interests to stay in hospital for that length of time because of the probable loss of independence and deconditioning that would occur. Having explained this to the family and following further assessments, the patient was discharged with the family's full support and with wrap around care. The team were then able to assess the patient in her own home and arrange further equipment as necessary. Length of stay was significantly reduced as a result.

7.3 BB highlighted some of the planned initiatives aimed at encouraging inpatients to mobilise to prevent deconditioning and she explained that the frailty assessment service covered all the adult wards but predominantly the Emergency Department and Wards 1-3. The service was staffed by 14 qualified and unqualified full and part-time individuals. She described the Masters module that had been developed for local staff through Northampton University, facilitated by the frailty team.

7.4 In response to a question from HT, BB advised that the team were currently challenged to meet all the demands on their time.

7.5 Regarding the patient referenced, BM asked what actions the team had taken to prevent falls occurring in the first instance. BB advised that the frailty hub linked in to all the relevant services such as the falls prevention team and the B-Well Therapy service and HJ highlighted the importance of building good relationships and maintaining good communication with each area despite the challenges involved given the number of counties covered.

7.6 AD thanked BB, HJ and LW for sharing their experiences.

The Board **noted** the Patient Story.

8 Ockenden Final Report Update

8.1 NBM reminded the Board that the second Ockenden Report was published in March but there was no timeframe for compliance as the East Kent report was still awaited. She highlighted the amber areas within the report presented in relation to the first Ockenden Report, one of which related to non-executive director oversight of maternity services specifically in terms of attendance at the Maternity Voices Partnership. The second and third amber areas related to out of date guidelines.

8.2 KJ highlighted the challenge of managing the governance of the maternity service given the huge amount of information requested.

8.3 IR felt it was optimistic to call the report the final Ockenden report in view of the further reports due out later in the year. Despite the number of red and amber recommendations, IR remained confident that solutions would be sought to meet these. However, he had been surprised by some of the recommendations and he advised that the Trust may decide not to comply with these.

8.4 JH challenged the board to find a means of balancing improvements to local health outcomes against the input requirements to comply with the many maternity reports. NBM advised that a lot of the information provided to Board was proscribed but that conversations around specific outcomes from the interventions took place with the Head of Midwifery. In the first instance, AD suggested that the Board define a set of principles. JH reflected that MKUH had built its reputation around health and wellbeing, tech and the green agenda without a central steer and he asked the Board to consider how to get ahead of the curve on the clinical outcomes piece. HH highlighted the importance of data in allowing the organisation to pursue a different agenda from that pursued nationally based on local outcomes. The Board agreed to return to this topic at a future Board Seminar. AD suggested revisiting the process for how the Board came to agree on pursuing its own agenda on tech, health and wellbeing etc. and using that as the blueprint for future discussions.

The Board **noted** the Ockenden Final Report Update.

9 Serious Incident and Learning Report

9.1 IR highlighted the serious incident themes around pressure damage, largely from Wards 1, 8 and 22. He explained that these were patients who came into the hospital and relatively early on in their journey were found to have tissue damage. Patients waiting for ambulances or on trolleys and deconditioning were all elements that increased the likelihood of pressure damage. The ongoing bed replacement was fundamental in addressing the issues. An audit of Waterlow scores (a tool for assessing the risk of pressure damage) had recently been undertaken and NBM explained that the Waterlow audit had demonstrated that the scores were accurate but issues were uncovered in respect of the sub-questions.

9.2 Regarding learning from incidents, IR referenced the ongoing appreciative inquiry sessions stating that from his point of view, one of the key elements of the initiative was about being open, honest and appreciative of patients' experiences of their care. KJ advised that the new head of quality improvement and a quality improvement manager would be taking up their posts at the end of the month. She added that the clear pathway described in the report was designed specifically for Milton Keynes and was based on a stories-based approach toward capturing what worked well, using positive experience to drive positive change.

9.3 LJ asked if there were any systemic issues with regard to the medication incidents and IR responded that pharmacy departments were under great pressure both locally and nationally due to a number of reasons, notably Covid and redeployment to support vaccine centres. To address the staff shortages within the department, a business case for £500k had recently been approved by the Trust Executive Committee. Noting that two of the incidents had taken place within Paediatrics IR advised that the department had recently gone live with eCARE (the hospital's electronic patient record system), which included an e-prescribing element that for children, was far more complex than for adults. Additionally,

IR advised that one of the lead nurses of long-standing in Paediatrics had recently retired. Furthermore, the new paperless processes had exposed some issues with junior doctor prescribing. HH advised of a tool, Safedose, that the organisation could consider to assist prescribers.

9.4 HH fed back from a meeting with HS and NBM regarding pressure ulcers where a lot assurance had been gained over processes and the main issue had been around escalation and de-escalation. NBM clarified that this related to ordering of appropriate beds. IR advised that a lot more work would be done to address the issues and he highlighted that around 18 months ago the parameters had changed where 'failure to assess within 6 hours' and 'deep tissue injuries' were both now categorised as serious incidents.

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

10 Patient and Family Experience Report Q3

10.1 NBM highlighted the following from the report.

1. The Comms team were supporting the work to obtain feedback from the public enabling people to share their views on how the hospital could improve.
2. The Patient Experience Matron had been focusing on appreciative inquiry supporting work in respect of time-critical medications and a communication and listening focus, particularly in relation to patients with learning disabilities and autism within emergency care pathways; the work was being led by the Deputy Chief Nurse.
3. Response rates for the Friends and Family Test continued to improve following the introduction of text messaging up from 3000 responses in Q2 to 16000 in Q3 with 93% of responses in the 'good' or 'very good' categories.
4. Collaboration with the Patient Experience Platform (PEP) was productive, resulting in very interesting data and a dashboard was being created which would be shared with the Board.
5. Discussions were ongoing with the Equality, Diversity and Inclusion leads regarding focused work with communities around ethnicity.
6. Volunteers were beginning to return to the organisation.
7. A new chaplain joined the Trust in November in partnership with Willen Hospital providing continuity and standardisation of service for end of life patients.

10.2 JH highlighted the PEP dashboard within the report which was assisting the organisation at divisional level to assess results much sooner than had previously been possible, helping the organisation in improving patient experience. HH advised that he had met with the Patient Experience Team and had been extremely impressed with the work they were doing and the step change following the introduction of both PEP and the MyCare app. LJ commented on the high rate of compliments for the Emergency Department.

Action: NBM to update that the 'You said, we did' page on the website which HH reported was significantly out of date

11 Nursing Staffing Update

11.1 NBM highlighted the following from the report.

- The international recruitment campaign was going really well particularly since the OSCE (NMC's test of competence) capacity had increased. NBM was keen to ensure that the more experienced overseas nurses were deployed to roles that reflected their experience and she advised that a programme of support was being launched.
- The Assistant Director of Infection Prevention and Control, Angie Legate, would be attending a garden party at Buckingham Palace.

- In addition to the leadership programme for managers, following feedback over lived experience, a bespoke module would be introduced for ward managers.
- A new adult safeguarding lead had recently joined the Trust from the psychiatric team from CNWL.

Action: NBM to add an explanation in the report for the difference between fill rates during the day and at night.

11.2 In response to a suggestion from AD, DP confirmed that succession and workforce planning was undertaken and monitored by the Workforce Department.

The Board **noted** the Nursing Staffing Update

12 Workforce Report Month 12

12.1 DP reported that turnover was increasing but that this had been expected since many people had decided to remain in their posts until the end of the pandemic. Exit and new starter interviews were being held.

AD asked about the timescales for people facing disciplinaries and DP advised that processes followed local policies but that there were some long-standing cases for reasons outside the Trust's control. She added that the informal route was now being used more often. NBM added that nurses would normally require Royal College representation but that there was currently only one representative at this organisation and she was pursuing this with the regional representative.

The Board **noted** the Workforce Report

13 Freedom to Speak Up Guardian (FTSU) Annual Report

13.1 AD introduced PB who referenced the presentation under Item 7 and reported that work was ongoing with the Frailty Team around recognition of the dying which was an area requiring greater focus following the results from the national audit for care of people at end of life.

13.2 Amongst the themes of the cases within the report, PB highlighted a staff member raising concern over the way in which their return to work had been handled by their line manager, and in particular, the line manager's attitude toward violence in the workplace. The issue was subsequently resolved and PB added that none of the cases in the report resulted in formal investigations and had been adequately dealt with at a lower level.

13.3 PB stated that a key area of focus was around encouraging doctors to speak up given that there had been no issues raised from this cohort within the last year. He advised that there were no FTSU Champions from within that cohort. AD noted the enthusiasm to encourage more people across the organisation to become FTSU Champions.

13.4 Regarding the many different ways that staff could raise issues and concerns, JH asked PB if there was a way to triangulate the information and PB advised that one option was to review whether people had raised concerns elsewhere before approaching FTSU and also to ask union representatives to identify themes.

13.5 Having been the previous FTSU Guardian, NBM asked PB if people were any less reluctant to reveal their names and PB advised that no-one had refused to reveal their identities to date but some had requested that their name was not used upon escalation and he sought agreeable solutions to this. AD suggested that the Trust's ambition should be for those raising concerns to have the confidence to do so in their own name.

13.6 DP recognised the excellent job PB had done in raising FTSU's profile across the organisation and she thanked him for all his hard work.

The Board **noted** the Freedom to Speak Up Guardian Annual Report.

14 Performance Report Month 12

14.1 EL reported that March had been a particularly difficult and challenging month and the organisation remained on a very high escalation level. She highlighted the following from the report.

1. Emergency Department performance dropped to 80.5% in month with a final year end position of 83.9%.
2. The South Central Ambulance Service continued to compliment the organisation for ambulance handover performance and further interventions to drive improvements were still being introduced.
3. Elective capacity in the last two weeks had improved with more bed capacity within the surgical footprint. The regional team had asked for all 104 week waiters to be cleared before the end of March and EL was pleased to report that MKUH had been successful in doing so and was also able to provide support within T&O to Bedford Hospitals in this regard.
4. The lack of capacity within cancer was causing delays but EL expected to see a significant improvement by mid-May.
5. Diagnostic performance, whilst poor, remained consistent at 65% where peers across the country were finding that their performance was deteriorating.
6. The change of providers in Dermatology had gone well and the backlog was being cleared.
7. The number of super stranded patients rose again for the third consecutive month as partner agencies struggled throughout the system.
8. From a patient experience perspective, it was noted that ward moves at night were increasing as a result of Covid and EL hoped that on the back of new guidance this metric would improve.

14.2 HH asked what had driven the breaches in Duty of Candour and KJ advised that this was due to delays in issuing letters but she was sure that all initial verbal contacts had been made appropriately.

14.3 LJ asked what the drivers were for ambulance handovers and EL explained that problems usually occurred where several ambulances arrived at the same time.

14.4 EL advised that some investment had been secured with an additional staff member available to keep abreast of the situation in the local vicinity with out of area and provider ambulances.

14.5 JH drew the Board's attention to the increasing waiting list. There had been around 13,000 patients on the combined elective and diagnostic waiting list and this had increased to around 27,000, causing many other different pressures within the system, for example, the complaints and PALS teams and JH anticipated this becoming an increasing problem.

The Board **noted** the Performance Report.

15 Finance Report Month 12

15.1 TW reported the financial position from April 2021-March 2022. A draft year position of a £722k deficit was reported against the plan of a deficit of £1.1m. In context, the organisation's turnover was around £300m. The cash position had decreased significantly from £79m in February to £58m. This had been expected and was due to the pay structure within the capital programme. A £31m spend on capital was reported in the draft annual accounts which was £2m more than the trust's capital spend limit and this pressure was being managed across the system. Subject to audit, there was a £7m underspend across the system and TW advised that there would be some reflection within the system to ensure resources were managed more effectively in future. There had been issues with the outsourced supplier, SBS, around timely payments to suppliers but TW explained there was clear understanding of the drivers for that which were being worked through with the supplier to ensure there were no further incidents. TW would be updating the Board on the draft plan for 2022-23 later in the day.

The Board **noted** the Finance Report

16 Research & Development Strategy Jan 2022-Dec 2025

16.1 IR explained that the strategy had been shared at various committees and was presented today for approval. He highlighted the Trust's ambition to make it a patient's right to be involved in a National Institute for Health and Care Research (NHIR) trial. He added that discretionary efforts were being used to design pathways for nurses and allied health professionals to progress their research careers.

16.2 HH asked how the Trust aimed to increase the number of commercial studies and IR responded that he expected this to be done in areas where the research function was more developed such as in Cardiology and Oncology.

16.3 HH requested further detail on the strategy for partnerships and IR explained that there were several informal partnerships with local universities which would be encouraged, but the vast majority of funding came from NHIR which did not place great value on partnerships.

16.4 With regard to a dedicated space for Research & Development, IR advise that there was a desire for a dedicated clinic room.

The Board **approved** the Research & Development Strategy

17 2022/2023 Quality Priorities

17.1 KJ reported that the Quality Priorities had been discussed at various committees and had been approved by the Council of Governors. They were:

1. A reduction in deep tissue injuries
2. Improvements in Outpatient efficiencies
3. A reduction of length of stay for older patients

17.2 AD advised that the Council of Governors had queried the work around diabetes which had been a quality priority for 2021-22 and had been assured that the work to improve outcomes in that area would continue.

The Board **noted** the Quality Priorities.

18 Significant Risk Register

18.1 KJ presented the register and JH highlighted that Risk 247 was showing as uncontrolled in relation to waiting times for babies requiring ventilation before transfer to a tertiary centre, adding that there were sufficiently trained and competent staff members, not necessarily physiotherapists, who would be capable of managing that situation.

Action: IR to provide detail on Risk 335 (outdated practice in relation to IV insulin)

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

19 Board Assurance Framework (BAF)

19.1 KJ presented the BAF and highlighted the following changes for noting:

1. Risk 13 would be retired after this meeting
2. Two new entries:
   a) Risk 17 relating to the Trust's Head and Neck (H&N) Cancer pathway; and
   b) Risk 22 which is related to the Trust's Percutaneous Coronary Intervention (PCI) pathway

19.2 HH highlighted that despite the focus on patient experience, the tracker for Risk 8 had not changed for the past 12 months and that this was the case for most of the risks. He asked what the process was for updating the risks. In addition, BM queried whether actions related to assurance as opposed to mitigating actions to reduce the risk. KJ responded that KMB met with executives individually each month to review the risks, including the scores. She further explained that there were actions against gaps in control and the overall rating related to how assured committees were over the management of the risk. KJ proposed holding a Board Seminar on risk.

Action: Sub-committee chairs to give greater scrutiny to the BAF at their respective meetings.

The Board **noted** the Board Assurance Framework

20 Amendments to the Foundation Trust Constitution

20.1 KJ advised that the Constitution had been reviewed by a sub-committee of the Council of Governors. The Council had approved the changes which would be formally approved at the Annual Members Meeting in September. JH reminded the Board that despite the focus on the integrated care system, the hospital was regulated as a sovereign organisation and it was important not to lose sight of this.

The Board **ratified** the amendments to the Foundation Trust Constitution

21.1 Summary Report for the Finance and Investment Committee Meeting – 01 March 2022

The Board **noted** the report.

21.2 Summary Report for the Finance and Investment Committee Meeting – 5 April 2022

The Board **noted** the report.

21.3 Summary Report for the Audit Committee Meeting – 21 March 2022

The Board **noted** the report.

21.4 Summary Report Workforce and Development Assurance Committee Meeting – 21 April 2022

21.4.1 The Board **noted** the report. AD said that she had been made aware that the sunflower lanyards, for people with hidden disabilities, were being issued for people without a hidden disability. JH explained that the disability network had specifically requested that there was no criteria requirement for people requesting a sunflower lanyard and therefore anyone could be issued with one.

21.5 Summary Report Trust Executive Committee Meeting – 09 March 2022

The Board **noted** the report.

21.6 Summary Report Trust Executive Committee Meeting – 13 April 2022

The Board **noted** the report.

21.7 Summary Report Quality and Clinical Risk Committee Meeting – 21 March 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 With regard to the Above Difference Seminar on 12 May, DP advised that the surveys required a total of three responders.

26 The meeting closed at 12:37

Updated : 21/06/22

NHS
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
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 February 2022	NBM	07-Jul-22	A survey report, which only provides a comparison to other Trusts who use Picker as their survey contractor, is likely to be available in September 2022. A report to the Board can be provided in October/November 2022. A CQC report which enables comparison with all Trusts is scheduled to be published in January/February 2023.	Completed
4	03-Mar-22	11.8	Maternity Self-Assessment	Board Seminar discussion - Review of patient risks (with a focus on maternity risks) to seek/provide Board assurance	KMB	06-Oct-22		Open
5	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.	AD / DP	07-Jul-22	A verbal update to be provided at the July 2022 Board meeting in private	Completed
6	05-May-22	6.5.4	Staff Survey	Comparisons with other organisations on their approach towards appraisals to be shared at the next Workforce & Development Assurance Committee	DP	03-Aug-22		Open
7	05-May-22	10.2	Patient and Family Experience Report Q3	The 'You said, we did,' page on the website to be refreshed	NBM	07-Jul-22	A meeting has been scheduled early in July 2022 between the Patient and Family Experience and Communications Teams to refresh. These meetings between the teams are regularly held to refresh the page.	Completed
8	05-May-22	11.1	Nursing Staffing Update	An explanation for the differences between day and night fill rates to be included in the report	NBM	07-Jul-22	Included in the Nursing Staffing report.	Completed
9	05-May-22	18.1	Significant Risk Register	Detail on Risk 335 (outdated practice in relation to IV insulin) to be provided	IR	07-Jul-22	The risk has been reviewed by the Medicine Divisional team. The risk has been reworded, updated and the overall score moderated and downgraded to ensure consistency across other Divisional / Trust risks. The intravenous fluid described has now been obtained, and modifications in eCare (ePMA prescribing) are awaited. The proposed change has been approved at Clincal Improvement Group and the relevant updated documentation is awaiting ratification by the Trust Documentation Committee, after which training will commence.	Completed
10	05-May-22	19.3	Board Assurance Framework	Greater scrutiny of the BAF to be given at sub-committee meetings	Sub-committee chairs	06-Oct-22		Open

Chair's Report **July 2022**

To provide details of activities, other than routine committee attendance, and items for information to the Trust Board:

1. A bit of very good news, the hospital Summer Gala Ball held on Friday 24th June was a huge success and raised £52,000 for the Cancer Centre! It was a great evening, extremely well organised and thoroughly entertaining.
   A big thank you to Vanessa Holmes, Associate Director Charity and Fundraising, for all her hard work and to the organising committee and our many generous sponsors—the support for MKUH from our community is amazing.
   (I also made my first purchase at an auction!)

2. More good news, the Staff Awards took place in person on the 10th June. Once again, the nominations revealed so much about the many members of staff who go the extra mile and are greatly appreciated by their colleagues. Congratulations to all nominees, the Highly Commended and the Award winners. It's a privilege to be part of an organisation with so many outstanding individuals and Teams.

3. In May, the Trust Board took part in a 'Leading Inclusively with Cultural Intelligence (CQ) Masterclass' training day from Above Difference, facilitated by Jennifer Izekor. It was an illuminating session and promoted a lot of discussion and reflection. Follow up work with Jennifer is planned later in the year, to build on and incorporate the learning in MKUH.

4. Consultant interviews since my last report have successfully resulted in appointments in paediatrics and haematology.

5. It has been an interesting two months visiting various services at MKUH;

   - The almost completed Maple Centre.
   - Cancer Centre
   - Neonatal services
   - Theatres
   - Emergency Department
   - Maternity services
   - Catering services
   - Therapy services (Allied Health Professionals

6. Integrated Care Boards (ICB) and Integrated Care Partnerships (ICP) became legal entities on the 1st July, which are the next phase of the Integrated Care System (ICS). The ICP, of which I am a member has met in shadow form prior to the establishment of these new governance arrangements.
   For further information and updates, the link is Home - Bedfordshire, Luton and Milton Keynes (BLMK) Health (blmkhealthandcarepartnership.org)

7. The MK Health and Care Partnership, (formally MK Place) of which MKUH is a member, has a calendar of meetings and publishes its papers at CMIS > Calendar. This partnership group is focusing on these key strategic areas to improve the health and wellbeing of citizens in Milton Keynes:-
    - Discharge from hospital;
    - Child and adolescent mental health;
    - Patients with complex needs; and
    - Obesity

Meeting title	Trust Board	Date: 07/07/22
Report title:	Trust wide report – Q4 2021/22 Patient and Family Experience Report	Agenda item: 8
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	Quarterly reports
Next steps	Quarterly reporting detailing analysis and trends in patient experience feedback

1. Introduction and purpose

This report details the Trust's overall position regarding patient and family experience feedback and engagement activity for Q4 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

Friends and Family Test (FFT) achievements

During Q4, the team continued to work with the providers of the 'My Care' application to extend the service in respect of sending the FFT questionnaire to patients via a SMS message. During the previous quarter, all patients attending an appointment in an outpatient setting received a SMS invitation to complete a FFT questionnaire. This was very successful and resulted in the Trust receiving substantially more feedback. Following this success, the next phase, to include patients attending the Emergency Department (ED), went ahead in February 2022. The success of this is reported below, in the FFT data section**.**

On 1st December 2021, the collaborative work with the company Patient Experience Platform (PEP) Health came to fruition with the introduction of the PEP platform dashboard.

The dashboard offers unique insight into patient experience. The company collect all free text comments from patient feedback received through the FFT route, online sites such as the NHS website and Google reviews, and the hospital's social media accounts. PEP Health use their unique software package to theme the comments into eight quality domains. The comments and themes are available on a dashboard and can be filtered by date, theme, and division or individual service.

Staff can access the PEP dashboard via an icon on their desktop once they have obtained log in details. The dashboard can be searched by specific areas, dates, and themes to provide staff with an up-to-date view on patient feedback.

The availability of the platform and its benefits have been widely advertised to all staff as follows:

- Emails to all staff to explain launch of the platform and its dashboard and how to get access
- Articles in the CEO's newsletter
- Stall held outside the restaurant explaining the platform and how to get access
- PEP Healthcare have attended various Trust meetings to demonstrate the platform
- A user guide and a recorded demonstration on how to interpret the dashboard is available

Matron's update

The Matron for Patient and Family Experience has attended Appreciative Inquiry (AI) Action Learning Sets to develop her skills, using the tools of AI, on gaining meaningful feedback from patients and families about what matters to them. The role modelling of this approach will encourage and support Trust staff to feel confident in gaining valuable feedback from patients and families. Staff will then be able to use AI tools to share and learn from feedback within their staffing groups.

Collaborative work has taken place with the Patient and Family Experience team, the Trust's Learning Disability Nurse, and the Activities Coordinator. Visits were made to Litslade Farm Residential home, a home for adults who have a learning disability, and an Autism meeting held by Talkback, a learning disability and autism charity that supports its members to have an opportunity to thrive in society. The aim of the engagement work was to discover what is important for the residents and their carers when they attend the hospital. The discovery work was undertaken using the tools, as provided by the AI methodology.

Feedback from these visits will be used alongside feedback from other patients with a learning disability and/or autism to modify pathways and improve the experience of our patients who have a learning disability and/or autism. Forming relationships with stakeholders and service users, hearing their experiences, and working collaboratively will encourage sustainable changes.

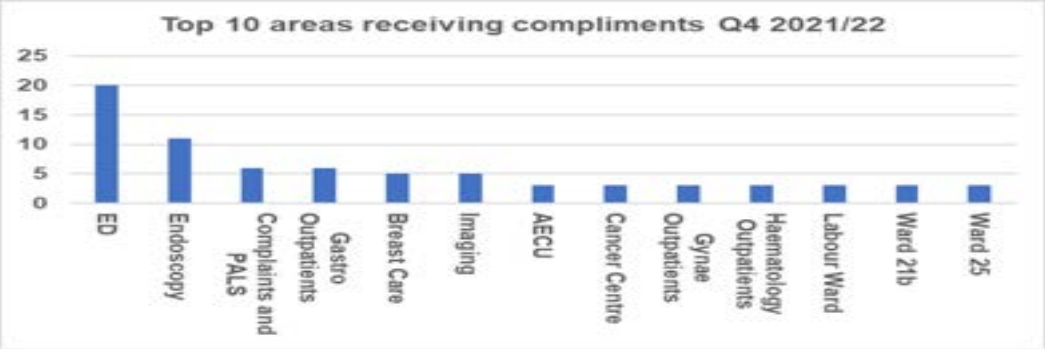
Matron Group

During Q4 the Matron group collectively worked on the following projects: -

- Improving Communication - the group are in the process co-creating, with ward staff, a guideline to improve communications with patients, their relatives, and carers.
- Improving the documentation of VIP (Visual Infusion Phlebitis) scores - the aim of this workstream is to prevent bacteraemia from intravenous (IV) cannulas by documenting the assessments of IV cannula sites. This work involved making improvements to eCare to make documentation easier for staff. A new dashboard has been created which identifies how many patients on each ward have a cannula inserted and whether the VIP score has been recorded. A multi-disciplinary team VIP focus group has been formed with representation from all wards to deliver training and improve standards. The matrons will be able to monitor documentation through the new dashboard and on Tendable (a nursing audit and ward accreditation tool).

3. Compliments

During Q4, the Trust received 126 compliments via email, letter, or telephone call via the PALS Office.



Compliment of the month

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

MONTH	INDIVIDUAL COMPLIMENT	TEAM COMPLIMENT
January 2022	Dr Milioto- Paediatrician *"The doctor went above and beyond, was very kind and had a really positive manner, she really listened and interacted in a positive way throughout"*	EPAU *"For all staff being so kind and empathetic and communicating in a sensitive manner"*

February 2022	Mr Andrew Hacker *"A fabulous service from Mr Hacker at every appointment, kind and interested and willing to listen"*	Fracture Clinic *"Appointments are prompt but if they do run late explanations are given"*
March 2022	Student Nurse Lea Beaili *"This student is quite possibly the most exceptional Student Nurse I've ever come across. From the off she was kind, considered, patient and understanding. Most importantly she listened and cared!"*	Hysteroscopy *"Staff made me feel very comfortable and at ease. They did what they had to do, very efficiently and with care".*

4. Patient Experience data

Friends and Family Test (FFT)

During quarter 4, the use of SMS messaging, to gain the feedback of patients from the FFT, has been rolled out for patients attending the Emergency Department, following the successful launch in outpatients during Q3. The success of these launches is demonstrated on the table below.

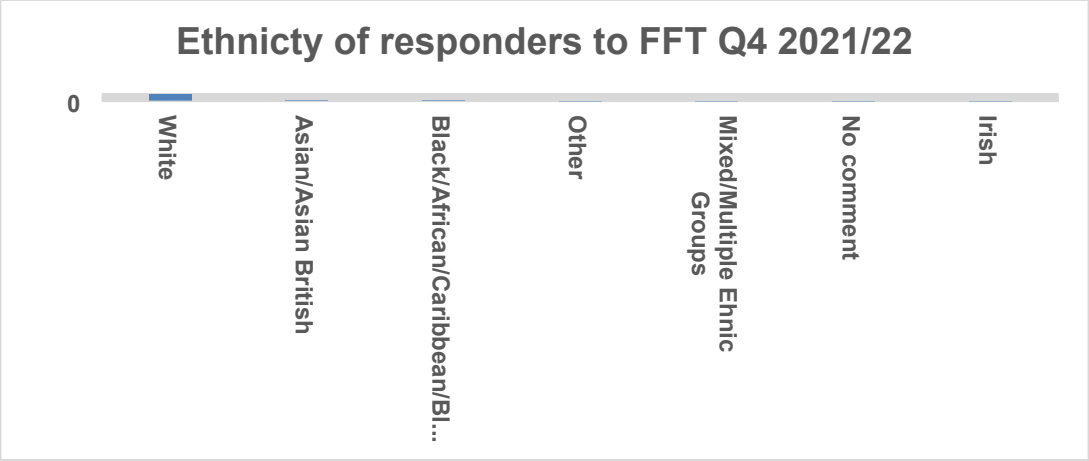
The table below details a comparison of the number of FFT responses received across the Trust for all quarters 2021/22.

Quarter	Total number of responses
Q1	3137
Q2	3600
Q3	16499
Q4	16059

In Q4 2021/22, 92% of responses rated the Trust's services as very good or good.

FFT- Ethnicity

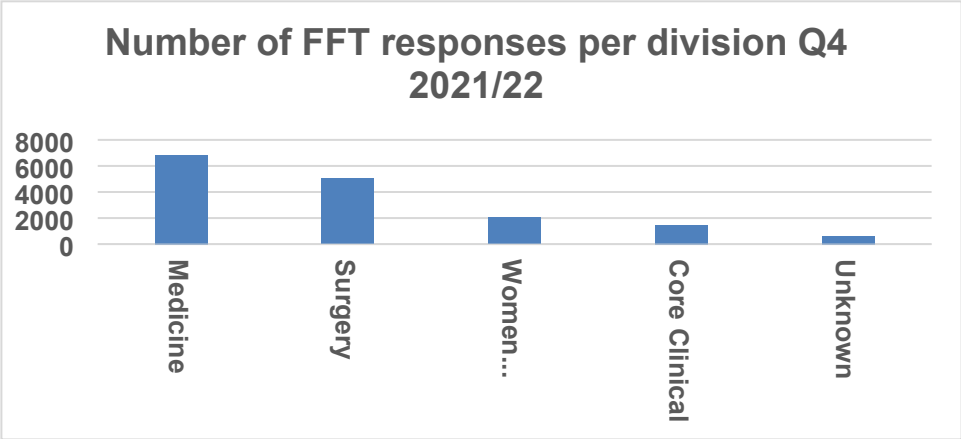
The chart below details the ethnicty of those responding to the FFT, where stated.



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

Divisonal FFT responses

The chart below deails the number of FFT responses per divison for Q4 2021/22.



FFT and comments for social media and online review sites

During Q4, the overall rating for the Trust in relation to positive comments from FFT and comments left on Google review, the NHS website and Twitter, was 4.6* out of 5*.

Below is a screenshot from the PEP Health Trust dashboard.

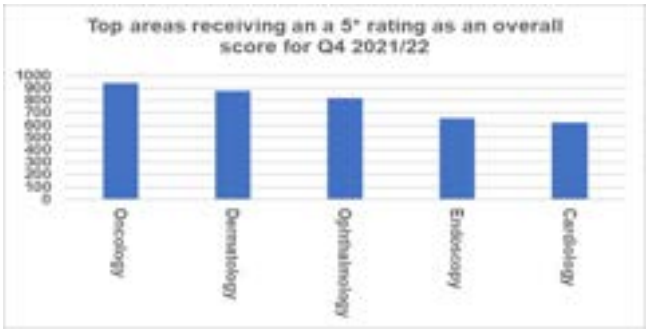
The top 5 best performing units in respect of postive feedback are:

Critical Care, Endoscopy, Anaesthetics, Physiotherapy and Breast Care

The top 5 services with the most comments are:

Obstetrics and Gynaecology, Emergency Care, Endoscopy, Oncology and Opthalmology

Each comment provided in free text form is themed by PEP health and given a star rating. Looking at the overall experience, 12915 comments ranked the service overall, on a ranking of 1 star to 5 stars, as 5 stars. The chart below demonstrates the top 5 services that received an overall rating of 5* for Q4.



Surveys

National

The 2021 Adult Inpatient patient sample was extracted during December 2021. The survey field work will take place during January to May 2022. The embargoed results from Picker, the contractor for the inpatient surveys, is due in June 2022 and the final report will be published by CQC in October 2022 with results being received after this time.

The 2022 Maternity Survey patient sample took place in March 2022. The survey field work will take place during April to August 2022 with embargoed results being

received in September 2022 and the final CQC report expected in January /February 2023.

5. Patient Experience and Engagement Activity

Volunteers

Volunteers who wished to return following the pandemic have either been placed into their original roles or have moved to non-clinical roles. This has been a smooth transition with staff and volunteers delighted to see each other after 2 years.

Training continues on the use of Assemble, the new volunteer software package, and once complete the system will 'go live'. This will ensure a more efficient recruitment process. Assemble has been populated with bespoke volunteer role profiles and as soon as training is complete the recruitment process will commence, and contact will be made with the 227 potential volunteers currently held on a waiting list.

Bereavement

The Bereavement team have dealt with 278 deaths in Q4 2021/22 compared to 302 in Q3, 20% of which needed to be referred to the coroner.

The team have continued to work with the growing medical examiner (ME) service and are preparing for the roll out of the ME service for community deaths. It is estimated that this will result in a 50-100% increase in workload for the ME office and two new MEs have joined the team to prepare for this.

The team continue provide training for new Health Care Assistants, using the SIM MK equipment to provide simulated examples of after death care, which has been well received. Work is ongoing to film training for after death care, to support staff.

Chaplaincy

During Q4, the Chaplaincy team continued to provide support to all areas across the hospital with 1095 patient contacts and 267 staff contacts. This totals, for the year, 3420 patient contacts and 1069 staff contacts in just over 5000 hours of chaplaincy for the Trust.

The team continue to embed the new partnership with Willen hospice, with one chaplain based at Willen 3 days a week, and the Head of Chaplaincy ensures she also has a visible presence. Collaborative work is ongoing to provide a new Quiet room in the new build and the integration of chaplaincy services for people of all faiths and worldviews. As part of this, the Spiritual Care Box resources, used at MKUH, are being introduced at Willen Hospice on the Inpatient Unit and work is ongoing to engage staff in how they might be involved in delivering person-centered spiritual care. The Spiritual Care Box resources are also being used at the Campbell Centre, with whom a service level agreement is held. The Chaplaincy team are finding the resources a helpful way to engage with those who are not sure what their spiritual needs might be.

During Q4, the team have attended the Islamic Centre in Coffee Hall and the Hindu Temple in Neath Hill to find out more about the communities who gather there. This has been an opportunity to find out what might be important for the people represented if they were to access our hospital and hospice services. The visits have helped the team to reflect on the changes they can make.

Visiting the Hindu Temple

Visiting the Islamic Centre

One of the considerations from the meetings has been around information. The team are therefore working on new leaflets and posters to help service users to understand what is available to them, and how their individual needs might be met. These will be developed using patient participation and feedback.

6. 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 cycle is illustrated below:

Focus group A and C did not take place this quarter due to the Trust being in Opel 4 escalation. Focus Group B met in February 2022 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.

7. Conclusion and upcoming events/future plans

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.

What to expect Quarter 1 2022/23

- Celebration of national Patient Experience week April 2022
- A video celebrating the difference all groups of staff make to patient experience
- The launch of SMS messages to gain FFT feedback from inpatient areas
- The launch of the Patient Experience trolley, named Buddy! A trolley which will be taken round wards and facilitate a discussion with patients and families. The trolley will contain items such information, activities for patients, items they may need to improve their experience i.e., eye masks, ear plugs, personal items such as sanitary towels
- The launch of the ward QR code - a unique QR code on bedside cupboards which will direct patients and their families through to a dedicated ward information page which will detail any information they may need to know i.e., visiting times, who’s who from a uniform perspective, how to access snacks/drinks etc.
- Perfect Ward audit tool being replaced by a new tool, Tendable, which will include questions in relation to patient experience. The Patient and Family Experience team with work collaboratively with the Quality team in the launch and use of Tenable
- Information in relation to all patient and family feedback received by the Patient and Family Experience team will be incorporated into the new Quality booklet, to be used as a quality tool on all wards, to ensure all areas are aware of the feedback they receive and celebrate /share that feedback or take forward leaning and action as a result of negative feedback.
- On the introduction of the ward accreditation scheme, the Patient and Family Experience team will contribute to the decision-making panel
- The webpages for patient and family experience to be enhanced by the addition of charity information directing patients and their families to where they may find support and assistance from charities and other organisations
- The launch of an intranet page specifically for using the tools and methodologies of AI when dealing with feedback
- The PALS meeting room being used to store and display information and advice in respect of using the AI tools

Meeting title	Trust Board (public)	7 July 2022
Report title:	Incident/serious incident (SI) report	Agenda item: 10
Lead director **Report author** **Sponsor(s)**	Tina Worth	Head of Risk & Clinical Governance
FoI status:	Public document	

Report summary	This report provides a monthly overview of Risk Management processes/systems in relation to serious incidents in the Trust.			
Purpose *(tick one box only)*	**Information** ☐	**Approval** X	**To note** ☐	**Decision** ☐
Recommendation	The 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 May and June 2022

There were 20 new SIs reported on STEIS in May and June 2022. See table below.

STEIS number	Category	Location	Details
2022/8630	New pressure ulcer	Ward 15	Deep tissue injury (DTI) heel
2022/9651	New pressure ulcer	Ward 18	Deep tissue injury (DTI) heel
2022/9652	Medication incident	Ward 8	Insulin infusion infused too quickly
2022/9653	Medication incident	Ward 25	Drug error
2022/9654	Safeguarding (adult)	Ward 3/Discharge Team	Patient discharged and no package of care commenced
2022/9655	Patient fall	Ward 25	Subdural haematoma (bleed)
2022/9656	Medication incident	Ward 20	Drug error
202/9657	Medication incident	Ward 21b/Pharmacy	Drug error
2022/10225	New pressure ulcer	Ward 19	Deep tissue injury (DTI) heels
2022/10668	Infection	Ward 19	MRSA
2022/10669	Medication incident	Ward 25	Drug error
2022/11699	Cooled baby	Maternity	A baby was born by a category 1 Emergency Lower Segment Caesarean Section (LSCS) and was transferred to a tertiary unit for therapeutic cooling.
2022/11701	New pressure ulcer	Ward 19	Deep tissue injury (DTI) heel
2022/12557	New pressure ulcer	Ward 23	Deep tissue injury (DTI) heel
2022/12558	New pressure ulcer	Ward 18	Deep tissue injury (DTI) heel
2022/13215	Drug error	Ward 15	Drug error
2022/13216	New pressure ulcer	Ward 20	Deep tissue injury (DTI) sacrum
2022/13218	New pressure ulcer	Ward 3	Deep tissue injury (DTI) sacrum
2022/13219	New pressure ulcer	Ward 15	Deep tissue injury (DTI) heel
2022/13267	Drug error	Theatres	Drug omission (pain relief)

Trends/concerns

Drug errors

- Thematic review underway, particularly looking at controlled drugs and pain relief in two areas; plus all drug errors over a 12 month period.

  Medicines safety review on Ward 25 due to a cluster of drug errors with plan to map out administration processes (including WOW (drug cart) management and scanning) and actions to address the safety of medicines on the ward

Deep tissue injuries

- Ongoing trend with new pressure ulcers, predominantly deep tissue injuries, and across medial wards, with a few related to surgery. Deep tissue injury (DTI) pressure ulcers are defined as *'purple or maroon localized area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear'*. In 2019 the guidance on pressure ulcer grading and classification changed

and the previously referenced Department of Health and Social Care's definition of avoidable/ unavoidable was removed and replaced with new or present on admission. This has resulted in all incidents needing to be investigated, resulting in more pressure ulcers being recorded/reported by individual providers. The 72-hour rule (previously if developed within 72 hours was seen to be attributable to the community/at home), was also removed, again leading to an increase in the reporting rate of pressure ulcers. From a benchmarking perspective, the Tissue Viability Nurses (TVN) have identified though their TVN informal network and there is an increase in DTIs overall, not just at MKUH. There is a Trust wide action plan addressing tissue viability.

Regulation 28 report/PFD

Following an inquest, the Trust received a Regulation 28 (preventing future death) report from HM Coroner. This will be responded to formally on 12 July.

The inquest related to a patient transferred to Milton Keynes Hospital Intensive Care Unit (ICU) from the John Radcliffe Hospital after being admitted following a road traffic collision (RTC). He had extensive polytrauma. He was found not breathing and in cardiac arrest. The tracheostomy inner tube was full of secretions. It was replaced and advanced life support was given but stopped given no reversible cause found or return of spontaneous circulation.

HM Coroner's concerns were:

> *During the inquest it became apparent that in the ICU the alarms that are operating on the monitors had been disengaged. This resulted in the staff not being alerted when the patient's saturations fell below an acceptable level and he went into cardiac arrest. My understanding is that if a patient is being monitored at all then it is essential that the alarms remain operational. I believe that all staff should be reminded of the need for the alarms to be active so that future deaths in similar circumstances do not arise.*
>
> In addition, a separate letter was sent to the CEO regarding two points:

- *Data that is stored by the monitoring machines used within the hospital, in particular on the intensive care unit. I understand that the machines themselves are able to record data relating to the monitoring of the patient, but this data is then lost when the machine is reallocated to another patient. In future we will require the recorded data to be saved or downloaded before the machine is reallocated so as to preserve that information for the use of the Court. We shall be grateful if this proposal can be considered by the hospital and a system put in place to ensure that this practice is implemented as soon as possible.*

- *Since the introduction of the electronic record system eCare, we have received by way of disclosure copies of all the records which are simply downloaded from the system. In the recent case this amounted to over 1500 sheets of records in no particular order. This makes it impossible for my staff to work with the records to put them in any coherent order which also makes the conduct of the inquest extremely difficult for the coroner concerned, and impossible for the family to understand. We would appreciate it in future if, when the electronic notes are forwarded to us they are sent in a paginated and indexed format. This will enable us to easily access and work through the notes and identify areas of concern. It would also assist witnesses in preparing their evidence and indeed statements to the court.*

Extensive actions have been taken and remain underway to address the issues raised by HM Coroner. The Director of Corporate Affairs is meeting with HM Coroner later this month on the matter of disclosures and the management of electronic records during disclosure for coronial proceedings.

Covid Nosocomial Infection

As previously reported through Trust Board (including in July 2021):

- From the start of the pandemic until 01 December 2022, 88 patients died having acquired COVID in hospital (probable or definite), 60 ‘of COVID’, and 28 ‘with COVID’.

- From 01 December 2022 until the present (31 May 2022), 20 patients died having acquired COVID in hospital (probable or definite), 5 ‘of COVID’, and 15 ‘with COVID’.

- Since 01 December, detailed case review (over and above scrutiny from the Medical Examiners) has only been undertaken for patients dying ‘of COVID’ (noted within Part 1 of the medical certificate of cause of death, MCCD).

Learning and Improvement

There was a two-day festival of curiosity at the end of June to share appreciative inquiry practice among wards and departments. There is a quality strategy planning day on 11 July as part of a review of the quality structure to support improvement, the implementation of the national patient safety strategy, and the implementation of harm prevention work. A new head of quality improvement began in post in June.

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NHS
Milton Keynes
University Hospital
NHS Foundation Trust

FALLS

2021/2022

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

ACTIVITY

	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22
Number of falls	163	254	340	233	222	273	254	267
Average	54	85	113	76	74	91	85	89

- Total number falls 21/22 was 1016
- An increase of 3% on previous year
- Q1 20/21 reported significantly lower number of falls
- Reflective of activity in Trust (COVID-Bed bound, acutely sick patients)

ACTIVITY- MODERATE HARM

- Decrease of 24% in 2021/2022

2020/2021	2021/2022
25 falls /moderate harm	19 falls/moderate harm

- Common injury- #NOF,# Humerus/Radius/Hand

Milton Keynes University Hospital NHS Foundation Trust

CATEGORIES

- Top 3 categories = 64% of all reported falls
  - Unwitnessed Fall
  - Lost Balance
  - Fall from Chair

THEMES

Milton Keynes University Hospital NHS Foundation Trust

- 32% of falls within frailty footprint- poor mobility/cognitive impairment/65 years +,Frailty Pt multiple falls
- Episodes of hypoxia in respiratory patients increasing falls risk
- Patient capacity and independence
- Deconditioning-reduced activity pre-admission

LEARNING

Milton Keynes University Hospital NHS Foundation Trust

- Holistic approach to assessing deconditioning
- Patient stimulation- e.g. Meaningful activities facilitator
- Minimising falls risk within ward environment- e.g. Bay based nursing, relocation of workstations
- Recognised link between mental capacity and falls -90% of patients sustaining moderate harm had capacity

ACTIONS

Milton Keynes University Hospital NHS Foundation Trust

- Strengthened approach to care planning- involving all MDT members
- Bespoke training-HCAs, Frailty course
- Quality rounds focusing on risk assessments and proactive prevention
- Robust digital platform to evidence outcomes

Milton Keynes University Hospital NHS Foundation Trust

MONITORING AND ASSURANCE

- Harm Prevention Group
- Patient Safety Board
- Serious Incident Review Group

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PRESSURE DAMAGE

2021/2022

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
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ACTIVITY

Milton Keynes University Hospital NHS Foundation Trust

PU Category	Q1		Q2		Q3		Q4		Total	
	20/21	**21/22**	20/21	**21/22**	20/21	**21/22**	20/21	**21/22**	20/21	**21/22**
Cat 2	37	**22**	16	**35**	22	**32**	45	**51**	120	**140**
Cat 3	2	**0**	2	**1**	1	**2**	1	**5**	6	**8**
DTI	13	**8**	12	**4**	19	**17**	9	**15**	53	**44**
TOTAL	**52**	**30**	**30**	**40**	**42**	**51**	**55**	**71**	**179**	**192**

2020/2021 Reflective of COVID /Hospital admission rates
Q2/3/4 2021/2022 Reflective of activity across organisation and nationally

THEMES
(2021/22)

Milton Keynes University Hospital NHS Foundation Trust

- COVID-ICU admissions, proning
- NIV device related skin damage
- Complexity of acute illness
- Multiple risk factors
- Decreased mobility due to illness/required positioning of patients
- Admission following long lie/fall at home
- Care/Social support prior to admission limited

LEARNING

- Accuracy of waterlow assessment to identify risk
- Proactive preventative care
- Early escalation
- Early validation of skin damage

ACTIONS

Milton Keynes University Hospital NHS Foundation Trust

- Successful roll out of new profiling beds with hybrid mattress
- Implementation of Repose topper mattress in ED
- Joint training and resources with Medstrom
- Implementation of digital photography-eCare
- Review Care planning function on eCare –to include body Mapping

ACTIONS

Milton Keynes University Hospital NHS Foundation Trust

- Focused senior nursing quality rounds
- Monthly ward quality reviews
- Patient Safety framework approach to reviews- AI
- Scoping partnership led quality conversations with care homes

MONITORING AND ASSURANCE

- Pressure Damage action plan
- Harm Prevention Group
- Patient Safety Board
- Serious Incident Review Group

Meeting title	**Trust Board Meeting in Public**	**Date: 7 July 2022**
Report title:	**Safeguarding Annual Report**	**Agenda item: 13**
Lead director **Report author** **Sponsor(s)**	**Name: Nicola Burns-Muir** **Name: Nadean Marsh** **Name:**	**Title: Chief Nurse** **Title: Head of Nursing Quality and Safeguarding**
FoI status:	**Public Document**	

Report summary							
Purpose *(tick one box only)*	**Information**	x	**Approval**		**To note**	x	**Decision**	
Recommendation							

Strategic objectives links	
Board Assurance Framework links	
CQC regulations	
Identified risks and risk management actions	
Resource implications	
Legal implications including equality and diversity assessment	

Report history	**1. Shared with Safeguarding Committee** **2. Quality and Clinical Risk Committee June 2022**
Next steps	
Appendices	

Executive Summary

The safeguarding annual report will cover activity spanning across Adult, Children and Maternity services and will focus on 6 main areas-

- Governance and Assurance
- Training and Education
- Profile of activity
- Dementia
- Learning Disability
- Future Recommendations

The Trust is committed to both having effective processes in place to safeguard those who access services in MKUHFT and working collaboratively in partnership with providers/agencies within Milton Keynes.

Over 2021-22 safeguarding activity has continued to increase as has case complexity, which reflects the reported national safeguarding picture. Covid-19 has impacted upon the safeguarding economy. Certain themes are starting to become more common as restrictions have been lifted.

- Families who were already vulnerable prior to lockdown have continued to struggle and are now at crisis point and are needing high level of interventions from services,
- Young people are finding reintegration into the community difficult, and we have noted a rise in the level of physical and verbal abuse.
- Family units that were unsteady have been put under pressure and the number of cases of domestic violence has increased.
- Access to some community services for families has been more challenging due to capacity within some of those services and COVID restrictions
- Noted that young people seem to be struggling with the new world. Finding it a challenge to communicate and socialise. Having been contained within a small social bubble.
- Noted increase in mental health and wellbeing support in children, young people and adults due to increased anxiety levels, experiences of social isolation during COVID.

Safeguarding training provision is currently under review. Specifically mapping safeguarding adult and children level 3 provision in line with the nationally update safeguarding intercollegiate frameworks.

Safeguarding training will be supplemented with supervision, bespoke learning events and face to face facilitated workshops.

A focused safeguarding action plan will be developed to include-

- Preparation to implement changes related to National Safeguarding Agendas
- Collaborative working with Mental Health Service Providers
- Continued embedding of safeguarding, using themes from data to influence practice.
- Workforce review of Safeguarding team

1. Introduction

Milton Keynes University Hospital NHS Foundation Trust (MKUHFT) recognises that Safeguarding is everybody's business and has specific responsibilities and duties in respect of safeguarding children and adults. MKUHFT is transparent in our safeguarding reporting.

This Annual Safeguarding Report provides assurance that the Trust has effective processes in place to safeguard the adults and children who access services in MKUHFT. The report reviews the safeguarding programme of work undertaken during 2020- 2021 and details both local activity developments identifying challenges and areas for improvement.

2. Safeguarding governance and assurance

The Trust's safeguarding responsibilities and compliance are guided by the statutory requirements detailed in the Working Together to Safeguard Children report (2015), the Care Act 2014 and the Care Quality Commission.

MKUHFT has a clear governance structure which includes the investigation of incidents and complaints. Incidents and complaints involving potential safeguarding concerns are dealt with in a timely manner, and where appropriate action plans formulated to improve practice and share lessons learnt. Incidents are monitored at the Trusts Safeguarding Committee.

As a key local safeguarding partner MKUH has an annual assurance meeting with the local independent safeguarding scrutineer, this took place in March 2022.The outcome of this meeting was very positive Themed feedback is provided below –

- Commended the structure and skill mix of the safeguarding team with reference to the newly appointed adult safeguarding lead with mental health expertise.
- Acknowledgement of increased safeguarding complexity and acuity and how this is being managed within the organisation
- System wide recognition of the challenges in relation to mental health, community support and specialist mental health inpatient availability. Including the additional pressure that this is placing on the acute provider.

The Trust assesses itself against the safeguarding self-assessment and assurance frameworks provided to the Trust (commissioned by the Clinical Commissioning Group (CCG) on an annual basis, the results of which are presented and discussed at the Trusts Safeguarding Committee.

2.1a CCG Safeguarding Assurance Framework

Safeguarding Adults Self-Assessment and Assurance Framework (SAAF)

The Trust assesses itself against the Safeguarding Self-Assessment Assurance Framework (SAAF). This is commissioned by the CCG and allows us to assess, monitor and improve safeguarding practice.

2021/2022 Safeguarding adults' self-assessment and assurance framework has been shared with the Designated safeguarding adult lead (CCG) and is currently awaiting approval. The agreed outcome assessment and action plan will be presented and discussed at the quarterly Safeguarding Committee for progress assurance.

2.1b Children Act 2004 – Section 11 Safeguarding Assurance Self-Assessment Framework

Within the legal self-assessment framework set out in the Children Act there are 8 standards. The standards relate to areas of safeguarding practices and providing assurance as an organisation that we are Safeguarding Vulnerable children and young people.

2021/2022 Section 11 Safeguarding assurance self-assessment framework has been shared with the Designated safeguarding children's lead (CCG) and is currently awaiting approval. The agreed outcome assessment and action plan will be presented and discussed at the quarterly Safeguarding Committee for progress assurance.

2.2 Safeguarding teams

The Milton Keynes University Hospital safeguarding teams work closely with all council Safeguarding Teams (across boundaries) though predominantly with Milton Keynes Council Safeguarding Team. The hospital and the council liaise regularly as to how investigations progress, other services that maybe required (multi-agency working) through to either the agreed point when risk is mitigated as much as possible or to the safe conclusion.

There is active participation within the partnership with representation across MK Together affiliate boards. MKUH is the partnership sponsor for the MKTogether Review Board. The Head of Nursing for Quality and Safeguarding chairs the Review Board and the Chief Nurse/Deputy Chief Nurse are members of the management Board.

Lead Nurse for safeguarding Adults has just taken up post in the hospital in April following the retirement of the previous post holder in August last year. This role is supported by Safeguarding Adult Specialist Nurse.

Lead Nurse for safeguarding Children is supported by a newly appointed Safeguarding Children Specialist Nurse who started last July following the resignation of the previous post holder.

Named Midwife for safeguarding and a new perinatal Midwife have recently been appointed to, following both these posts becoming vacant. Since February 2022 the Deputy Head of Midwifery has maintained oversight if both safeguarding and perinatal mental health. The new Named Midwife will be located within the safeguarding hub 2/3 days a week to strengthen the think family approach and enable joint working around specific complex cases.

2.3 Collaborative Working

During the year we have been supported by the Children and Adult Designated Nurses.

Both Designated Nurses for Safeguarding Children and Adults (CCG) also provide safeguarding supervision to the safeguarding team.

Partnership working has also been evident when supporting increased activity and complexity of safeguarding cases, particularly across the trust when dealing with mental illness. Also supporting the assessment and legal framework around adults who have fluctuating mental capacity and where their engagement with health professionals is poor.

Safeguarding Lead has also supported partnership agencies in multi-agency audits including-

- The voice of the child – A review of the Return from Missing Episode Reports completed by children's social care.

There has also been contribution to work with a task and finish group around teenage pregnancy and the concealed pregnancy. Reviewing how young person can be supported and approaches to also support unborn/born baby.

3. Training & Education

Successful provision of effective safeguarding clinical practices is dependent on all staff understanding their roles and responsibilities and the procedures they should follow to protect their patients with focus being on providing joint training as Safeguarding Think Family.

Training compliance is monitored at the Trust's Safeguarding Committee and by our Learning & Development Department.

The locally agreed safeguarding training compliance within MKUHFT is 90%. Clinical Service Units are requested to produce an action plan to address areas of noncompliance. These are monitored through the Trusts safeguarding committee.

Provision of current safeguarding training has been mapped against the revised Intercollegiate documents for both adults and children, with a proposal for 2022/23 training delivery to be presented for approval at Aprils safeguarding committee. This will include stronger links with other local agencies to ensure a multi-agency approach to aspects of the training, involvement from Social Care and police along with an emphasis on contextual safeguarding.

3.1 Safeguarding Children training

Safeguarding children training is mandatory for all staff. The level of training required depends on the staffs' level of contact with children within their roles in line with the guidance set out in the Intercollegiate Document 2018.

2021-2022	Quarter One	Quarter Two	Quarter Three	Quarter Four
Level One	97%	97%	98%	97%
Level Two	98%	97%	97%	96%
Level Three	87%	90%	93%	95%

3.2 Safeguarding Adults training

Safeguarding Adults training is mandatory for all staff and is completed on a 3-yearly basis.

Level 1 and level 2 safeguarding adults training has been consistently compliant, reporting above 90%

	Quarter One	Quarter Two	Quarter Three	Quarter Four
Level One	98%	97%	97%	96%
Level Two	98%	97%	98%	96%
MCA	96%	96%	95%	94%

A level 3 adults safeguarding training proposal has been drafted in line with safeguarding adults intercollegiate document and submitted to safeguarding committee for approval.

3.3 Mental Capacity Act and Deprivation of Liberty Training

Under the Mental Capacity Act, there may be requirement to deprive a patient of their liberty. The Deprivation of Liberty Safeguarding (DoLs) legislation provides a framework to maintain patients safety, reduce risk of harm to others or administer necessary treatment where someone is assessed as lacking mental capacity. An application is made when it is in the persons best interest and discussion with health professionals, family or advocates has been agreed.

Mental Capacity Act and Deprivation of Liberty Safeguarding training is delivered via eLearning and is mandatory for all clinical staff to undertake every three years.

With the introduction of Liberty Protection Safeguards 2022/2023 training will be required to be updated and currently the safeguarding team are collaborating with external safeguarding partners to ensure a consistent and robust approach is provided.

3.4 Prevent Training

Prevent is the United Kingdom’s counter-terrorism strategy. Its aim is to safeguard individuals who are at risk of exposure to extreme ideologies and radicalisation.

Basic Prevent Training is about providing staff with the knowledge and skills to identify and sign post individuals who are at risk of being radicalised.

Wrap Training is a Home Office training package designed for frontline staff in the private and public sector. It provides an overview of the prevent strategy and ways of identifying individuals who are at risk of radicalisation as well as those who radicalise.

2021-2022	Quarter One	Quarter Two	Quarter Three	Quarter Four
Basic Prevent	98%	97%	98%	94%
WRAP	92%	93%	92%	97%

3.5 Safeguarding Maternity Training

Safeguarding Children's level 3 compliance is reported as 92%, along with MCA compliance of 96% and Safeguarding Adults Level 2 98%, which are consistent with last year's figures.

In addition to the mandatory training, one hour bite sized sessions have been held on topics including Responding to Domestic Abuse, Responding to Mental Health, Cannabis use in Pregnancy with collaboration from Arc-MK, The Role of the Father in response to learning reviews, Early Help in collaboration with Family Centre's and WRAP.

4. Activity and Outcomes

4.1 Safeguarding Adults Activity

All Safeguarding Alerts, raised either by external services or by MKUHFT, go via the appropriate local council's safeguarding team who determine if it meets criteria for a safeguarding enquiry (section 42

In 2021/2022 MKUHFT raised **224** Adult safeguarding alerts compared to 243 in 2020/2021. This can be associated to the level of attendances within the organisation during COVID. Safeguarding advice continues to be requested by staff both appropriately and timely demonstrating confidence in their knowledge and accessing the safeguarding team.

A breakdown of safeguarding alerts by theme are shown in Table 1.

Table 1-

2021-2022	Quarter One	Quarter Two	Quarter Three	Quarter Four
Discriminatory	1	0	0	0
Domestic Abuse	7	5	5	5
Emotional/Psychological	4	0	4	8
Financial/Material	1	2	5	7
Neglect & Acts of Omission	15	17	10	13
Pressure Ulcer	2	14	6	9
Organisational	0	0	0	2
Physical abuse	8	5	2	4
Self-Neglect	18	13	17	12
Sexual	3	0	0	o

Top themes 2021/2022

1. Self-Neglect
2. Neglect &Acts of Omission
3. Pressure Ulcers (Neglect)
4. Domestic abuse

Recognising the increase in domestic abuse related referrals the trust has partnered with MKACT (Local MK charity) to host an Independent Domestic Violence Advisor onsite,5 days a week, offering support to both patients and staff.

4.1a Section 42 (Safeguarding Enquiry)

The Trust has a Section 42 Enquiries (safeguarding investigations) panel which meets weekly to establish the progress of any delegated enquiries and agree outcomes prior to local authority submission.

There have been **32 delegated enquiries since April 2021.** The outcomes of the 41 closed enquiries are shown in table below.

Outcome	Quarter One	Quarter Two	Quarter Three	Quarter Four
Substantiated	1	4	1	2
Partially Substantiated	2	3	4	4
Unsubstantiated	0	2	5	4

The two main themes from completed delegated enquiries are discharge process and pressure ulcers: specifically documented communication to primary care agencies, sharing of information of treatment plans regarding skin damage classification.

4.1b Domestic Homicide Reviews (DHRs)

Between April 2021 and March 2022 locally there has been 3 Adult Case Reviews and 1 Domestic Homicide Review undertaken. As part of the MK Together Partnership MKUH has contributed to the reviews and identified learning has been shared through SMART action plans and local learning bulletins.

4.1c Mental Capacity Act and Deprivation of Liberty Safeguarding Activity

In 2021/22.**177** Deprivation of Liberty Safeguarding (DoLs) applications were made, an increase of 33 referrals (20%) on the previous year. Fewer applications progressed to a Standard Authorisation which was due to the patient either being discharged or deceased. The breakdown of the reasons for the applications is shown in the table 2.

Table 2

DOLS	Quarter One	Quarter Two	Quarter Three	Quarter Four
Remain Hospital	19	15	24	24
Medication	3	2	2	6
Treatment	18	21	25	18

The Adult Safeguarding lead works closely with the council's DoLS Team in reviewing each DoLS to ensure they meet the legal framework of the Mental Capacity Act legislative timescales. Standards of practice are reviewed through appropriate safeguarding forums. During the pandemic changes have been made to the assessment process and no face-to-face assessments have been completed except where a situation has dictated due to its complexity.

4.2 Implementation of Hospital Navigator Scheme

This scheme is an initiative Thames Valley Police (TVP) have adopted to reduce violent crime across the region. MKUH is one of five hospitals across the Thames Valley region participating in the pilot. TVP are seeing a trend statistically with an increase of patients presenting at Emergency Departments (ED) or walk in centres due to incidents of serious violence. The main factors for this are violence within the under 25's demographic or domestic abuse related violence. The Hospital Navigator will seize this window to support the client to identify an alternative pathway by practical, achievable, and supported options.

Since implementation in august 2021 66 referrals have been made, with 24 cases being successfully closed and others being actively managed.

Positive feedback from both patient and staff has been received, including national recognition as the winner of the National crime beat awards.

Currently bids are being compiled across the network to secure funding for year 2.

4.3 Implementation of Hospital Independent Domestic Violence Advisor (HIDVA)

In December 2021 a hospital independent domestic violence advisor was recruited and commenced in post in January 2022. The post is funded by MKACT with MKUHFT as the host site.
This role supports clinical staff to identify people at risk of domestic abuse. Having identified those at risk of domestic abuse the HIDVA can offer support and advice directly to them.

4.2 Safeguarding Children Activity

The conditions created by COVID-19 pandemic have altered the access children and young people have to spaces outside of their home, increasing vulnerability and impacting access to social support and connections. National research led by the NSPCC (2020) [1] identified 3 areas of risk:

1. Increase in stressors to parents and care givers.
2. Increase in children's and young people's vulnerabilities.
3. Reduction in normal protective services.

The national concern regarding the safety of children and young people has been mirrored locally. Throughout the last year we have worked closely with colleagues and services across Milton Keynes to address this increased risk, liaising with local services to ensure that these vulnerable children and their families are identified and supported. Ensuring that through COVID Child Protection Plans were continually monitored to ensure the work being done with these vulnerable families continued.
Positives that have arisen from the Pandemic include-

- Rules around social distancing providing opportunities for disclosure of abuse to occur e.g., attending clinic appointments alone.
- Some young people have found it easier to communicate with professionals over social media.
- Care was less scripted as staff looked for solution focused, more joined up approaches to care delivery, providing quicker responses when supporting cases with increased complexity., resulting in quicker responses and more effective multiagency working.
- The rapid increase in the use of social media activity established a system of instant communication between the partnership agencies.

Pattern and number of safeguarding referrals

There were **744** multi-agency referrals (MARF) for children and young people originating from MKUH between April 2021 and March 2022. This number of referrals into the MASH is approximately the same as 2019(719) and 2020(776). The numbers reflecting attendance activity seen within the hospital during the pandemic.

Rationale for referral

65 % (484) of MARF referrals submitted April 2021 and March 2022 were predominantly created by the Emergency Department where there has been-

- Increase in the complexity of mental health challenges amongst children and young people.
- Increase in the number of young people who require Tier 4 Mental Health admission.
- Increase in the number of infants (under 2-year-olds) attending with injuries.
- Increase in contextual safeguarding e.g., the number of young people who have been physically assaulted either due to bullying in school or assaulted in the community.

Table 3: MARF referrals by department

Department	Quarter One	Quarter Two	Quarter Three	Quarter Four
Emergency Department	148	97	143	96
Maternity	37	26	35	47

Other	7	0	2	0
Paediatrics	9	12	11	6
Safeguarding	3	36	26	3

Of these **744** referrals **153** were for mental health concerns (20%). **110** referrals where for additional support for families (14%) which included housing support and early interventional work.

Table 4: MARF Referrals by Theme

Theme	Quarter One	Quarter Two	Quarte Three	Quarter Four
Child Behind Adult	27	35	9	26
Child Exploitation	23	10	3	13
Child Mental Health	64	38	20	31
Domestic Abuse	3	11	3	3
Maternity	26	11	0	21
Other	0	3	19	0
Parental Mental Health	2	0	0	4
Section 17	1	0	6	0
Section 20	3	3	1	4
Section 47	5	6	7	5
Sexual	0	0	1	0
Substance Misuse	22	15	1	12
Support	28	28	21	33

During Quarter 3 the Safeguarding Team worked in partnership with children's social care to raise awareness of the signs of safety utilising the framework when considering/submitting a referral ensuring consistency in ways of working across both acute trust and MK social care.

Supportive work along with the promotion of the Think family approach and focused work regarding domestic abuse undertaken within the Emergency Department by the safeguarding team has contributed to a rise in Child behind the Adult Referrals.

Referral Outcomes

To date **667** of these referrals have been triaged by the MASH and outcomes recorded:

Quarter 4 is not recorded as the data has not been produced at the time of writing the report. Under the Children Act 2004 Children Social Care have 40 working days to complete their investigation and assessment of the family. Therefore, some referrals made during months 11 and 12 are still being assessed.

Outcome	Quarter One	Quarter Two	Quarter Three	Quarter Four
Actioned & closed	48	18	100	?
Closed / No Action	69	48	44	?
Open to CFP	34	29	44	?
Open to CSC	57	84	92	?

In 2021/22 the trust did not make any direct referrals to the LADO. Although contact was made in regards to three children. One of the cases resulting in a management review of a nursery.

4.2a Sharing Information Forms 0- to 18-year-olds

The sharing information sheets are completed by the Emergency Department.
These forms are a communication form to the universal services 0 to 19. Health Visiting and School Nursing teams. The number of forms completed 2021 to 2022 is 2003. A break down can be seen in the table 5 below by Yearly Quarters.

The forms provide information to the universal services about children we have had safeguarding concerns that have attended our Emergency Department. Prior to being emailed across to the appropriate universal services the safeguarding team will check the information and ensure that appropriate action has been completed.

Table5

2021-2022	Quarter One	Quarter Two	Quarter Three	Quarter Four
Information Sharing form	560	451	490	502

One aspect that was noted during Covid-19 was an increase in children aged 1 to 2 years of age having accidents in the home. This information was shared with the CNWL team who provide safeguarding supervision for school nurses and health visitors. This provides them with the opportunity to work with us collaboratively on reducing harm in the home.

In quarter 4 there was a reduction in information sharing forms. This was because of the work completed by the safeguarding team together with children social care representative to look at assessment of risk using the signs of safety toolkits and Level of Needs document.

4.2b Child Protection medicals

There has been an increase in the number of Child Protection Medicals undertaken by the Trust in 2020-21. Consistent with the MARF referrals there was an increase in Child Protection medicals in July following the ceasing of lockdown and October once schools reopened. A review of the Child Protection Medical Process and procedures across Milton Keynes is continuing. The aim to improve the Journey of children and young people who require a Child Protection Medical.

Table 6: CP Medicals per month 2021/22

2021-2022	Quarter One	Quarter Two	Quarter Three	Quarter Four
Child Protection Medical	13	12	15	4

4.2c Case Reviews
Case reviews are undertaken when a child dies or is seriously harmed. They are undertaken by the MK Together multi agency panel and result in learning identified and a corresponding action plan.

In 2021/22 with MKTogether Partnership 2 child reviews were published and 1 case review met the threshold for child safeguarding practice review.
Specific themes drawn from the case reviews in 2021/22 include:

- Identification of parental responsibility
- The role of fathers and stepfathers
- Increased professional curiosity and questioning.
- Communication
- Identity of family members and the role they play in the child's life.

Themes from the learning reviews have been shared via joint agency learning bulletins and SMART action plans.

Internally MKUH undertook a learning review and internal debrief following a young person's admission requiring mental health care and a Tier 4 mental health admission. An action plan from identified learning themes was developed and presented at April 2022 safeguarding committee

4.3 Named Midwife Safeguarding Activity

Female Genital Mutilation (FGM) activity

An FGM- Information Sharing (FGM-IS) Indicator was introduced during 2018/2019, meaning that all female infants born to a mother who has undergone FGM has an indictor placed on their NHS Summary care records and this information can now be extracted to eCare alongside the Child protection – information Sharing Indicator (CP-IS).

From November 2021, a drop in the reporting of FGM was noted and no adverse incidents have been reported as a result. The FGM panel meets regularly and FGM continues to be part of safeguarding training and maternity protected week training.

2021-2022	Quarter One	Quarter Two	Quarter Three	Quarter Four
FGM Reported	9	4	2	4

The Trust moved from Datix to Radar and therefore, whilst the screening tool has been completed there remains a challenge with staff use of Radar. There is support available for staff and the community midwives have been reminded to complete and incident form on Radar when they have completed a FGM screening tool.

Data Challenges

As a trust MKUH continues to ensure we provide accurate data, through regularly reviewing and strengthening the data collection processes.

The Digital, Data and Inequalities Midwife is supporting with the development of KPI's to be collected for maternity safeguarding and how this data can be exported, presented and we be assured of its accuracy.

When the Woman's pregnancy is booked the booking form and social matrix form continue to be completed, improving and streamlining these processes will support with data collection and thematic analysis of the cases. This project is under way.

5. Dementia Activity

The Dementia Lead Nurse continues to promote awareness across the Trust in recognising symptoms of dementia and promotion of management strategies including This is me toolkit, supporting staff in promoting individualised care.

The number of dementia referrals received during the period 2021/22 are presented in Table 6

Table 6

2021/2022	Quarter One	Quarter Two	Quarter Three	Quarter Four
Total Number of Referrals	413	468	488	399
Number of Confirmed Dementia diagnosis	285	333	344	268

During 2021 to 2022 1,768 dementia referrals were made to the Dementia Lead nurse. These included 1,230 where there was a confirmed diagnosis of Dementia, 48 with a mild cognitive impairment and 28 patients who were still under investigations by the memory clinic.

Referrals to the Dementia nurse over this period have come from a variety of sources including:

- eCare (electronic patient records system),
- The Dementia and Delirium Screen
- Either list created by IT team (Business Intelligence list, D
- Staff (i.e., the Safety Huddle, Ward teams, Social Workers)
- from Safeguarding Team (Falls Nurse and Learning Disability (LD) Nurse
- from Datix
- family members

5.1 Training

Dementia Awareness (Tier 1) training is provided as an e-learning for health (e-lfh) module. Dementia Awareness is now available on ESR as essential to role and Tier 2 is also available however this training is 7.5hrs long and currently not mandatory.

6.Learning Disability Activity

Milton Keynes University Hospital (MKUH) recognises that we have a duty to ensure the necessary reasonable adjustments are in place to promote a person-centred approach to care.

Most people with a Learning Disability who access our service have a mild to moderate Learning Disability. The Majority also live in supported living settings

From 1st April 2021 to 31st March 2022 a total of 585 people with a Learning Disability have been admitted into the trust through various departments.

Admissions were broken down to Outpatient Department 290(49%), Emergency Department 188(32%) and Inpatient 107(18%).

Work to benchmark practice against the National Learning Disability standards commenced March 2022. This will be progressed over the coming year and a detailed trust action plan produced, that will be monitored through the Patient Experience board, maintaining close links with the safeguarding committee.

Learning from patient feedback and complaints is also being considered as part of this work and a Learning disability and Autism steering group is being established to progress the actions and any service development recommendations. This will include service users as well as specialist partner agencies.

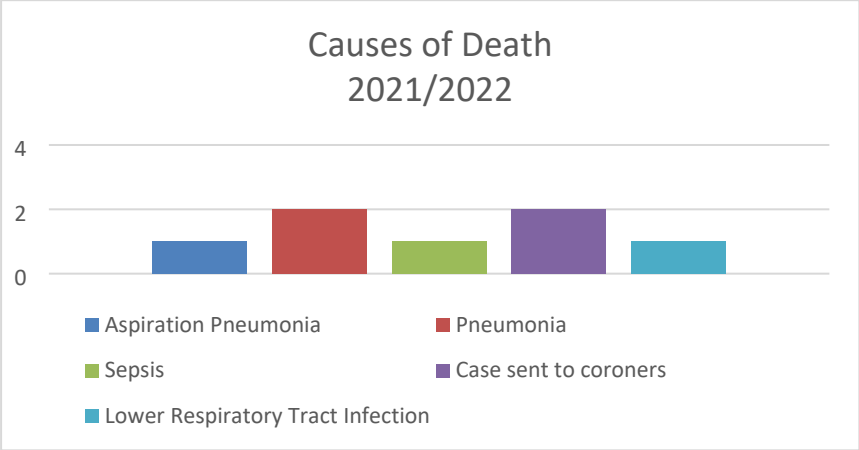
The Head of Nursing for Safeguarding and Quality attends the LeDeR review assurance panel and along with the safeguarding leads ensures learning from any recommendations informs local safeguarding practices.

Deaths and Covid-19

This year saw a significant reduction in recorded Learning Disability deaths. 6 Learning Disability deaths were recorded in 2021/2022 in comparison to 18 in 2020/2021.

Comparing causes of death to last year it is noted that no COVID related deaths have been reported by MKUHFT in 2021/22.

The causes of death are illustrated on the graph below.



6.1 Communication -Flagging System

From the 1st of August 2016 onwards, all NHS organisations providing care had a legal obligation to ensure they identify, record, share information in a way that meets the needs of those with communication difficulties. At MKUH we have upheld this standard by having an electronic flagging system that generates an alert prompting professionals to consider reasonable adjustments.

6.2 What matters to me

The Trust has introduced a document called “What Matters to Me” that aims to ensure the needs of those requiring additional support for example communication difficulties are highlighted and at the forefront of all care. It is important to highlight that at MKUH recognise that some people with a Learning Disability may already have their own documents that illustrate their needs, these documents are encouraged to be brought in.

6.3 Stimulation and Distraction activities.

Since the closure of community support day services due to Covid-19 many people with Learning Disabilities have had reduced opportunities to socialise and develop skills.

There has been focused worked to enhance stimulation by equipping wards with a selection of activities, including colouring activities, reading books, music books and arts and crafts to give to patients. The uptake of these activities has been very positive and feedback from both patients and staff has also been positive.

This has been supported by the introduction of a meaningful activities’ facilitator. A post being funded by the MK Hospital Charity.

7. Future Developments for 2022/2023

7.1 Implementation of National and Local Safeguarding agendas

- Preparation for impending change to Liberty Protection Safeguards
- Strengthening partnership links across Safeguarding to ensure Patient voice is heard.
- Strong emphasis on Contextualised Safeguarding across Milton Keynes

7.2 Increased collaboration with Mental Health Providers

- Review of care pathways for children and young people who attend hospital due to mental health needs.
- Strengthened partnership to support families and children with complex care needs.
- Strengthen Trauma Informed Care within Maternity
- Safeguarding and Perinatal Mental Champions shall be trained within the community midwifery team to ensure that there is resilience within the services in times of scheduled and unscheduled absence.

7.3 Workforce review of Safeguarding Team

- Work with MK Charity to extend the time in post for the Meaningful Activities Facilitator.
- Continue to review the capacity of the safeguarding team in line with safeguarding activity and level of case complexity.
- Continue to host the HIDVA for a second year in partnership with MKACT
- Strengthen the availability of safeguarding supervision across the organisation for Children, Adults and Maternity.

7.4 Continued Embedding of Safeguarding practice to reflect current data and activity analysis.

- Shared learning from Serious Safeguarding Reviews (Adults /Children's) Domestic Homicide Reviews and Local learning reviews.
- Implementation of Level 3 Safeguarding Adults training
- Provision of quarterly bespoke safeguarding learning events to compliment eLearning training packages.
- To include autism within the benchmarking and recommendations for learning disability service developments.

Milton Keynes University Hospital NHS Foundation Trust

Nursing Workforce Report June 2022

Author: Emma Thorne, Workforce Matron

International Nurse Recruitment

The Trust has now Interviewed and offered 123 international nurses.

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:

- 137 nurses have been interviewed and offered employment with the Trust subject to satisfactory pre-employment checks.
- 123 nurses have accepted our employment offer.
- 62 have commenced in the Trust across 5 cohorts.
- Nurses continue to arrive in Cohorts of 16, every 4 weeks. Our latest Cohort (Cohort 5) arrived on Thursday 19th May 2022.
- June 2022 cohort however has been postponed to July due to the delay in nurses receiving their visas to travel.
- 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. To date, 15 experienced Theatre Nurses have been offered employment.
- Nurses continue to 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.
- 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
	Offered To Date	137
	Started	62
	Currently Active	61

	Declined offer	14
	At Risk of Dropping	0

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	Completed OSCE training, Awaiting OSCE	20
4	Completed OSCE training, Awaiting OSCE	11
5	OSCE Training programme.	9

Nurses in Cohort 1,2 & 3 are beginning to undertake their NMC Test of Competence OSCE examination dates. A total of 5 nurses have now successfully passed the OSCE examination and will now move into the permanent area of work. Some international nurses are awaiting OSCE re-sits and they will be assisted in the areas identified for improvement.

Securing OSCE dates continues to be a challenge nationally due to the rise in international nurse recruitment across the country. Our recruitment team continue to liaise with the national team regarding this.

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.

To date, Cohorts 1 to 4 have now all received their career conversations. The international nurses will move to their permanent ward base once they have passed their OSCE examination.

Student Nurses to Staff Nurse Initiative

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

In May/June 2022, the Workforce Maron met with both Paediatric and Adult Nursing

students due to qualify in September 2022 for a ‘Career Workshop’ and to offer them the opportunity of employment.

A total of 23 nurses attended and were delighted to be offered this opportunity. Several students had already secured their first job at MKUH and so chose not to attend the workshop.

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

Vacancies

Table 3: Shows Total vacancies across Nursing

Division	B2 HCSW	B5 Staff Nurse	B6 Sister/Charge Nurse
Medicine	38	73	4.85
Surgery	23	26	9
Paediatrics	0.96	17	4

NB:

- Numbers do not include successful candidates in pre-employment. There are currently:
  - 15.06 WTE Band 2 HCSW in clearance
  - 33 WTE Band 5 Nurses in clearance
  - 2.65 WTE Band 6 Sisters/Charge nurses in clearance
- Numbers do not include the placement of our international nurse colleagues.
- Numbers do not include Student Nurses and Nursing Associates due to qualify that require allocation.
- There is a current freeze on Outpatient Staff Nurses, within the Surgical Division while a Workforce review is undertaken. This equates to 4.32wte.
- There was an increase in HCA vacancies and Band 6 Sister, Charge Nurse posts across Surgery because of an approved business case following the reconfiguration of Ward 21 and Ward 24.
- Table 3 does not include vacancies across Maternity.

Healthcare Assistant Recruitment

To address Healthcare Assistant vacancies across the organisation, regular Trust wide recruitment campaigns have been undertaken.

A total of 24 HCSW have been offered employment, subject to satisfactory pre-employment checks, with further HCSW interviews scheduled.

Further recruitment plans currently being explored include an ‘Open Day’ to optimise recruitment and showcase the opportunities for HCSW at MKUH.

To ensure accuracy of all vacancies the Workforce Matron, HR Information Analyst and Finance are undertaking a data cleansing exercise to review establishments and vacancies across the nursing workforce.

Nursing Associates

As previously reported, MKUH are currently supporting 30 Trainee Nurse Associates across the organisation. 9 of which are due to qualify in October 2022. To ascertain the trainee’s interest in securing a roles here at MKUH, a questionnaire has been

sent to gauge interest and preferred areas of work for those due to qualify in September 2022. Following this the Workforce Matron, in conjunction with both the Chief Nurse and Divisional Chief Nurses, will work collectively to plan where the Nursing Associates will be best placed to embrace and embed the Nursing Associate workforce and model of care.

Shift Fill Rates

Table 4 illustrates the fill rate percentages for both day and night duties across the organisation for May 2022.

Key Points:

- Fill rates are higher on nights duties. This is very likely to be associated to the enhanced rates that night duties attract.
- Wards with fill rates greater than 100% are likely to have used additional staff to support the dependency/acuity of patients and Enhanced Observation.

Table 4.

	Days		Night	
	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)
Total	**73%**	**85%**	**99%**	**108%**
A & E	92%	61%	101%	55%
AMU	66%	144%	108%	114%
DOCC	74%	46%	94%	-
MAU 2	77%	101%	121%	113%
NNU	79%	70%	98%	90%
Phoenix Unit/ Ward 14	70%	91%	90%	121%
Ward 15	80%	108%	104%	131%
Ward 16	76%	124%	106%	119%
Ward 17	72%	113%	105%	124%
Ward 18	75%	99%	111%	120%
Ward 19	78%	90%	105%	139%
Ward 20	82%	66%	103%	100%
Ward 21	69%	90%	101%	100%
Ward 22	77%	88%	117%	144%
Ward 23	89%	94%	119%	127%
Ward 24	75%	76%	96%	94%
Ward 3	83%	73%	116%	110%
Ward 5	66%	88%	91%	179%
Ward 7	74%	90%	106%	103%
Ward 8	68%	59%	116%	106%
Ward 9	62%	75%	74%	90%
Ward 25	69%	78%	121%	117%
Ward 4	61%	53%	78%	90%

Meeting Title	**Trust Executive Committee**	**Date: July 2022**
Report Title	**Workforce Report**	**Agenda Item: 15**
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 previous 12 months up to 31 May 2022 (Month 2) 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
Appendices/Attachments	

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators as at 31 May 2022 (Month 2), covering the preceding 13 months.

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

Indicator	Measure	Target	05/2021	06/2021	07/2021	08/2021	09/2021	10/2021	11/2021	12/2021	01/2022	02/2022	03/2022	04/2022	05/2022
Staff in post (as at report date)	WTE		3304.1	3310.7	3328.5	3321.9	3328.6	3342.5	3347.7	3349.0	3390.5	3410.0	3414.4	3418.4	**3418.8**
	Headcount		3793	3797	3810	3799	3807	3823	3827	3830	3878	3904	3900	3902	**3904**
Establishment *(as per ESR)*	WTE		3677.7	3681.7	3675.1	3714.0	3724.7	3730.4	3725.7	3718.1	3722.9	3727.6	3716.9	3723.9	**3839.8**
	%, Vacancy Rate	10%	10.2%	10.1%	9.4%	10.6%	10.6%	10.4%	10.1%	9.9%	8.9%	8.5%	8.1%	8.2%	**11.0%**
Staff Costs (12 months) *(as per finance data)*	%, Temp Staff Cost (%, £)		11.3%	11.4%	11.6%	11.7%	11.9%	12.1%	12.3%	12.5%	12.7%	12.9%	13.1%	13.4%	**13.7%**
	%, Temp Staff Usage (%, WTE)		11.8%	12.0%	12.2%	12.4%	12.6%	12.7%	12.8%	12.9%	13.0%	13.1%	13.2%	13.5%	**13.7%**
Absence (12 months)	%, 12 month Absence Rate	5.5%	4.4%	4.5%	4.6%	4.7%	4.8%	5.0%	5.0%	5.0%	5.0%	5.1%	5.3%	**5.4%**	*5.4%*
	- %, 12 month Absence Rate - Long Term		*2.7%*	*2.7%*	*2.8%*	*2.8%*	*2.8%*	*2.9%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	***3.0%***	*3.0%*
	- %, 12 month Absence Rate - Short Term		*1.8%*	*1.8%*	*1.8%*	*1.9%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.1%*	*2.3%*	***2.4%***	*2.4%*
	%,In month Absence Rate - Total	5.5%	4.2%	4.4%	4.6%	5.0%	5.4%	6.1%	5.5%	6.0%	6.3%	5.4%	5.6%	**5.0%**	*4.3%*
	- %, In month Absence Rate - Long Term		*2.9%*	*2.8%*	*3.3%*	*3.2%*	*3.0%*	*3.5%*	*3.3%*	*3.3%*	*3.0%*	*2.8%*	*2.5%*	***2.3%***	*2.6%*
	- %, In month Absence Rate - Short Term		*1.3%*	*1.6%*	*1.3%*	*1.9%*	*2.4%*	*2.5%*	*2.3%*	*2.7%*	*3.3%*	*2.6%*	*3.1%*	***2.7%***	*1.7%*
	- %, In month Absence Rate - COVID-19 Sickness Absenc	1.5%	0.4%	0.3%	0.5%	0.6%	0.6%	0.6%	0.6%	1.2%	2.3%	1.6%	2.2%	**1.5%**	*0.5%*
Starters, Leavers and T/O rate (12 months)	WTE, Starters		321.3	330.7	331.7	327.9	333.0	349.4	347.1	362.3	390.3	376.5	382.0	409.1	**427.3**
	Headcount, Starters		367	376	377	374	376	393	395	411	441	428	431	459	**481**
	WTE, Leavers		215.6	219.7	223.0	216.8	227.7	232.0	241.5	254.8	277.9	296.9	329.4	364.6	**380.6**
	Headcount, Leavers		255	259	264	258	271	276	289	304	332	357	395	435	**456**
	%, Leaver Turnover Rate	9%	7.4%	7.5%	7.7%	7.5%	7.8%	7.9%	8.3%	8.8%	9.5%	10.2%	11.2%	12.3%	**12.9%**
	%, Stability Index		87.5%	87.1%	86.6%	86.5%	86.2%	85.6%	85.2%	85.9%	85.5%	85.3%	84.8%	83.7%	**82.9%**
Statutory/Mandatory Training	%, Compliance	90%	95%	96%	96%	95%	96%	95%	96%	96%	95%	94%	94%	94%	**94%**
Appraisals	%, Compliance	90%	93%	92%	89%	90%	91%	91%	91%	91%	91%	90%	92%	90%	**90%**
Time to Hire (days)	General Recruitment	35	44	47	48	46	59	53	56	52	72	65	72	58	**52**
	Medical Recruitment (excl Deanery)	35	68	62	68	52	53	81	65	43	52	49	68	47	**79**
Employee relations	Number of open disciplinary cases		14	9	6	6	7	9	10	9	10	7	9	4	**4**

2.1. The Trust's **vacancy rate** (11%) has increased due the increase in establishment in the new financial year by 115.9 wte. Headcount (3904) and staff in post (3418.8 wte) are the highest they have been for over a year. Further fluctuations in establishment are expected in M3.

2.2. **Staff absence** decreased in month to 4.3% with a smaller proportion of this due to Covid (0.5%). 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. There is a predicted increase of covid absence in M3.

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 82.9%. **Staff turnover** has increased to 12.9%. Deep dives into some CSUs (Pharmacy and Maternity) has been undertaken by the HRBPs to understand leaver trends. Anecdotally, neighbouring Trusts are also reporting an increase in the number of leavers. The Trust has seen a large number of suitable applicants for roles, adding credence to the belief that many people are seeking to move roles post covid.

2.4. **Time to hire**, which had increased significantly in Q4 of last year due to the mandatory vaccination status checks temporarily required by the Trust, continues to decrease, and is reporting as 52 days for general recruitment in M2. Peaks in Medical Staffing Time to hire are due to two medics in Core Clinical requiring visas.

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 90%. Divisions are addressing any underperformance against these KPIs locally. Corporate Services and Women's and Children's are both below tolerance for appraisal at M2.

3. Continuous Improvement, Transformation and Innovation

3.1. The Apprentice Team are reviewing the current offering of **paid apprenticeships and career development courses** to support the implementation of career pathways from entry-level posts. There has been an increase in the variety of courses available as apprenticeships and the HRBPs will be supporting managers to identify band 2 and band 3 posts that could be advertised as an apprenticeship or as a career development pathway. Summer is the perfect opportunity to attract young apprentices into the Trust.

3.2. The Organisational Development team have completed the **nightworkers' survey** to get feedback on additional support nightworkers may need and to understand whether

the benefits offering at night meets their needs. Next steps are to start looking at implementing the Trust-wide improvements identified and review trends on the returning data for department-specific improvements.

4. Culture and Staff Engagement

4.1. The **Staff Survey** heatmaps with department-level data (where available) are being rolled out with a revised toolkit for Listening Events to support managers with facilitating feedback sessions. The HRBPs will be working with line managers to support them with action planning from their local results to ensure we are progressing change and making improvements. An exercise to improve department-level results is starting in M3 to combine areas that have small staff numbers for the next staff survey and HRBPs will be approaching Managers directly to take this forwards.

4.2. A **Benefits Survey** is currently running to ask all staff which new benefits they would like to see at the Trust. The results will form the next phase of benefits offering for the Trust.

5. Current Affairs & Hot Topics

5.1. The Equality, Diversity and Inclusion Team are reaching out to all the networks for feedback on **making the recruitment process more inclusive**. This will form a review of all of our recruitment practices and paperwork to ensure the Trust is leading on the Cultural Inclusion agenda.

6. Recommendations

Members are asked to note the report.

Meeting Title	**Trust Board**	**Date: 07/07/22**
Report Title	2022-23 Executive Summary M2	**Agenda Item: 16**
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: M2 (May 2022)

1.0 Summary

This report summarises performance in May 2022 against 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 due to post-pandemic recovery plans, some local transitional or phased targets have been agreed to measure progress in recovering performance. It should however be noted that NHS Constitutional Targets remain, as highlighted in the table below:

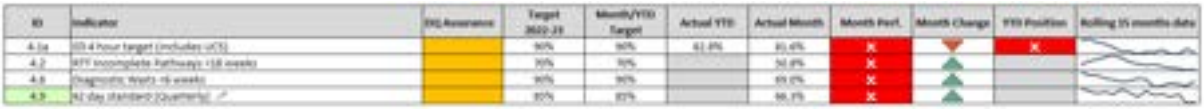
Indicator ID	Indicator Description	Transitional Target	Constitutional Target
4.1a	ED 4 hour target (includes UCS)	90%	95%
4.2	RTT Incomplete Pathways <18 weeks	70%	92%
4.5a	RTT Patients waiting over 52 weeks (Total)	755	0
4.6	Diagnostic Waits <6 weeks	90%	99%

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

2.0 Key Priorities: Operational Performance Targets

Performance Improvement Trajectories

May 2022 and year-to-date performance against transitional targets and recovery trajectories:



ED performance showed a deterioration in May 2022, declining to 81.6% from 84.1% in April 2022. However, MKUH performance exceeded both the national overall performance of 73.0% and every other trust within its Peer Group (see Appendix 1).

The Trust's RTT Incomplete Pathways <18 weeks performance was 50.8% at the end of May 2022, with the total volume of open pathways now at 31,403. The Trust has robust recovery plans in place to support an improvement in RTT performance, while the cancellation of any non-urgent elective activity and treatment for patients on an incomplete RTT pathway is being proactively managed.

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.

In Q4 2021/22, the Trust's 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) was 66.3% against a national target of 85%. This was an improvement when compared to Q3, reflecting the positive impact of recovery plans. The percentage of patients to begin cancer treatment within 31 days of a decision to treat dropped to 94.0%, below the national target of 96%. The percentage of patients to attend an outpatient appointment within

two weeks of an urgent GP referral for suspected cancer was 87.1% against a national target of 93%. This was a modest improvement when compared to the previous quarter.

3.0 Urgent and Emergency Care

In May 2022, two the six key performance indicators measured in urgent and emergency care demonstrated a month-on-month improvement:

Cancelled Operations on the Day

In May 2022, there were 21 operations that were cancelled on the day for non-clinical reasons, representing 0.87% of all planned operations. The majority of these cancellation reasons were due to insufficient time, staffing, emergency priorities and bed availability.

Readmissions

The Trust's 30-day emergency readmission rate increased slightly from 7.0% in April 2022 to 7.2% in May 2022.

Delayed Transfers of Care (DTOC)

The number of DTOC patients reported at midnight on the last Thursday of May 2022 was 33 patients: 30 in Medicine and three in Surgery.

This was an improvement in performance when compared to 43 DTOC patients reported at the closing position in April 2022.

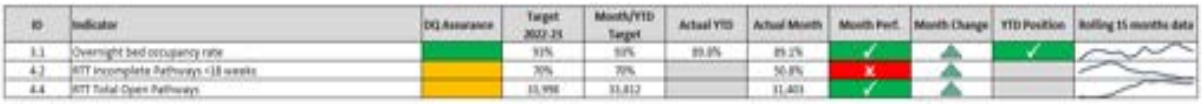
Length of Stay (Stranded and Super Stranded Patients)

The number of super stranded patients (e.g. with a length of stay of 21 days or more) at the end of the month was 108. This was an increase for the fifth consecutive month and the highest volume of super stranded patients reported since April 2017 (118).

Ambulance Handovers

In May 2022, the percentage of ambulance handovers to the Emergency Department taking less than 30 minutes was 84.3%. This was a deterioration in performance when compared to 90.0% in April 2022.

4.0 Elective Pathways



Overnight Bed Occupancy

Overnight bed occupancy was 89.1% in May 2022. This was an improvement for the second month; falling from a two-year high of 93.0% in March 2022.

RTT Incomplete Pathways

The Trust's RTT Incomplete Pathways <18 weeks at the end of May 2022 was 50.8% and the number of patients waiting over 52 weeks was 1,422 against a trajectory of 755. These patients were distributed across Surgery (1,324 patients), Women and Children (84) and Medicine (14).

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 May 2022, with a performance of 69.0%. This was an improvement in performance compared to 61.9% at the end of April 2022.

The Trust has robust recovery plans in place to support improvement in diagnostic performance and demand is being proactively monitored across modalities to ensure that the plans can be managed.

5.0 Patient Safety

Infection Control

In May 2022 the following infections were reported:

Infection	Number of Infections	Division/ Ward
C.Diff	1	Medicine (Ward 14)
MRSA	1	Medicine (Ward 19)
Klebsiella Spp	1	Medicine (Ward 22)
P.aeruginosa	1	Medicine (Ward 3)
E-Coli	0	
MSSA	0	

Note, MRSA has breached its zero-tolerance threshold for 2022-23.

ENDS

Appendix 1: ED Performance - Peer Group Comparison

The following NHS Trusts have historically been considered 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

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 in the MKUH peer group, are two of those and therefore data for these trusts is not published on the NHS England statistics website.

March to May 2022 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	Mar-22	Apr-22	May-22
Milton Keynes University Hospital NHS Foundation Trust	80.5%	84.1%	81.6%
Homerton University Hospital NHS Foundation Trust	83.9%	84.0%	81.5%
Southport and Ormskirk Hospital NHS Trust	74.9%	80.5%	77.0%
Buckinghamshire Healthcare NHS Trust	69.7%	67.8%	74.0%
The Hillingdon Hospitals NHS Foundation Trust	71.9%	72.7%	71.6%
Barnsley Hospital NHS Foundation Trust	64.8%	63.2%	69.1%
North Middlesex University Hospital NHS Trust	68.2%	68.3%	67.8%
Oxford University Hospitals NHS Foundation Trust	64.3%	66.5%	67.4%
Northampton General Hospital NHS Trust	64.9%	64.8%	66.4%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	57.3%	61.0%	62.2%
The Princess Alexandra Hospital NHS Trust	63.8%	64.1%	61.7%
Mid Cheshire Hospitals NHS Foundation Trust	56.2%	55.8%	59.9%
Bedfordshire Hospitals NHS Foundation Trust	-	-	-
Kettering General Hospital NHS Foundation Trust	-	-	-

Board Performance Report 2022/23
May 2022 (M02)

Milton Keynes University Hospital NHS Foundation Trust

OBJECTIVE 1 - PATIENT SAFETY										
ID	Indicator	DQ Assurance	Target 2022-23	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
1.1	Mortality - (HSMR) ★		96.6	96.6		104.0	✗			
1.2	Mortality - (SHMI)		100.0	100.0		107.9	✗			
1.3	Never Events		0	0	0	0	✓		✓	
1.4	Clostridium Difficile		10	<2	3	1	✗		✗	
1.5	MRSA bacteraemia (avoidable)		0	0	1	1	✗		✗	
1.6	Falls with harm (per 1,000 bed days)		0.12	0.12	0.15	0.21	✗		✗	
1.7b	Midwife to birth ratio (Actual for Month)					33				
1.8	Incident Rate (per 1,000 bed days)		50	50	46.30	50.49	✓		✗	
1.9	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓		✓	
1.10	E-Coli		15	<3	0	0	✓		✓	
1.11	MSSA		8	<2	2	0	✓		✗	
1.12	VTE Assessment		95%	95%	96.9%	96.6%	✓		✓	
1.14	Klebsiella Spp		15	<3	2	1	✓		✓	
1.15	P.aeruginosa		10	<2	2	1	✗		✗	

OBJECTIVE 2 - PATIENT EXPERIENCE										
ID	Indicator	DQ Assurance	Target 2022-23	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.2	RED Complaints Received		0	0	0	0	✓		✓	
2.3	Complaints response in agreed time		90%	90%	Not Available					
2.4	Cancelled Ops - On Day		1%	1%	0.70%	0.87%	✓		✓	
2.5	Over 75s Ward Moves at Night		1,500	250	253	130	✗		✗	
2.6	Mixed Sex Breaches		0	0	0	0	✓		✓	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS										
ID	Indicator	DQ Assurance	Target 2022-23	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%	89.8%	89.1%	✓		✓	
3.2	Ward Discharges by Midday		25%	25%	15.1%	15.6%	✗		✗	
3.3	Weekend Discharges		63%	63%	65.0%	64.8%	✓		✓	
3.4	30 day readmissions		7%	7%	7.1%	7.2%	✗		✗	
3.5	Patients not meeting Criteria to Reside		TBC			77	Not Available			
3.6a	Number of Stranded Patients (LOS>=7 Days)		184			229	✗			
3.6b	Number of Super Stranded Patients (LOS>=21 Days)		50			108	✗			
3.7	Delayed Transfers of Care		25			33	✗			
3.8	Discharges from PDU (%)		12.5%	12.5%	9.2%	9.9%	✗		✗	
3.9a	Ambulance Handovers <30 mins (%)		95%	95%	87.0%	84.3%	✗		✗	
3.9b	Ambulance Handovers <60 mins (%)		100%	100%	98.1%	97.2%	✗		✗	

OBJECTIVE 4 - KEY TARGETS										
ID	Indicator	DQ Assurance	Target 2022-23	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1a	ED 4 hour target (includes UCS)		90%	90%	82.8%	81.6%	✗		✗	
4.1b	Total time in ED no more than 8 hours (Admitted)		100%	100%	59.4%	54.8%	✗		✗	
4.2	RTT Incomplete Pathways <18 weeks		70%	70%		50.8%	✗			
4.4	RTT Total Open Pathways		33,998	33,812		31,403	✓			
4.5a	RTT Patients waiting over 52 weeks (Total)		0	755		1,422	✗			
4.5b	RTT Patients waiting over 52 weeks (Non-admitted)		0	TBC		1,029	Not Available			
4.6	Diagnostic Waits <6 weeks		90%	90%		69.0%	✗			
4.7	All 2 week wait all cancers (Quarterly)		93%	93%		87.1%	✗			
4.8	31 days Diagnosis to Treatment (Quarterly)		96%	96%		94.0%	✗			
4.9	62 day standard (Quarterly)		85%	85%		66.3%	✗			

OBJECTIVE 5 - SUSTAINABILITY										
ID	Indicator	DQ Assurance	Target 2022-23	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
5.1	GP Referrals Received		Not Available		10,924	5,604	Not Available		Not Available	
5.2	A&E Attendances		104,759	17,231	17,278	9,163	✗		✗	
5.3	Elective Spells		25,821	4,395	3,986	2,232	✓		✗	
5.4	Non-Elective Spells		34,421	5,792	5,069	2,696	✓		✓	
5.5	OP Attendances / Procs (Total)		407,339	66,463	64,461	33,017	✗		✗	
5.6	Outpatient DNA Rate		6%	6%	7.4%	7.4%	✗		✗	
5.7	Virtual Outpatient Activity		25%	25%	14.3%	12.9%	✗		✗	
5.8	Elective Spells (% of 2019/20 performance)		110%	110%	98.2%	99.9%	✗		✗	
5.9	OP Attendances (% of 2019/20 performance)		104%	104%	98.2%	100.0%	✗		✗	

OBJECTIVE 7 - FINANCIAL PERFORMANCE										
ID	Indicator	DQ Assurance	Target 2022-23	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
7.1	Income £'000		322,064	51,579	50,962	25,520	✗		✗	
7.2	Pay £'000		(205,566)	(36,105)	(35,892)	(17,922)	✗		✓	
7.3	Non-pay £'000		(100,214)	(17,386)	(16,860)	(8,318)	✓		✓	
7.4	Non-operating costs £'000		(25,114)	(3,096)	(2,997)	(1,496)	✓		✓	
7.5	I&E Total £'000		(8,831)	(5,007)	(4,787)	(2,216)	✓		✓	
7.6	Cash Balance £'000			45,457		46,815	✓			
7.7	Savings Delivered £'000		12,049	647	647	370	✓		✓	
7.8	Capital Expenditure £'000		(18,288)	(2,396)	(1,034)	(758)	✗		✗	

OBJECTIVE 8 - WORKFORCE PERFORMANCE										
ID	Indicator	DQ Assurance	Target 2022-23	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
8.1	Staff Vacancies % of establishment		10.0%	10.0%		11.0%	✗			
8.2	Agency Expenditure %		5.0%	5.0%	6.5%	6.0%	✗		✗	
8.3	Staff Sickness % - Days Lost (Rolling 12 months)		5.5%	5.5%		5.4%	✓			
8.4a	Appraisals (excluding doctors)		90%	90%		90.0%	✓			
8.4b	Doctors due appraisal in the given month who have completed that appraisal by month end	TBC				37.5%				
8.4c	Doctors who have completed appraisal since 01 April 2022	TBC				6.3%				
8.5	Statutory Mandatory training		90%	90%		94.0%	✓			
8.6	Substantive Staff Turnover		9.0%	9.0%		12.9%	✗			
8.7	Percentage of employed consultants with (at least one) fully signed off (3-stage) job plan since 01 April 2021					81.5%				

OBJECTIVES - OTHER										
ID	Indicator	DQ Assurance	Target 2022-23	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
O.1	Total Number of NICE Breaches		8	8		3	✓			
O.2	Rebooked cancelled OPs - 28 day rule		90%	90%	95.5%	100.0%	✓		✓	
O.4	Overdue Incidents >1 month		TBC			360	Not Available			
O.5	Serious Incidents		75	<13	21	11	✗		✗	

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

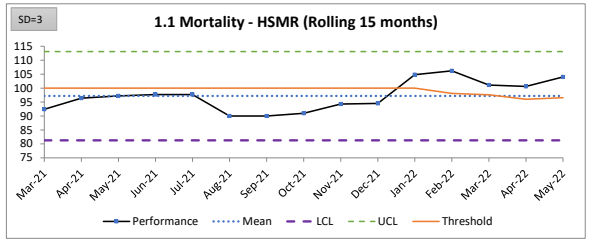
✓	Achieving YTD Target
	Within Agreed Tolerance*
✗	Not achieving YTD Target
✗	Annual Target breached

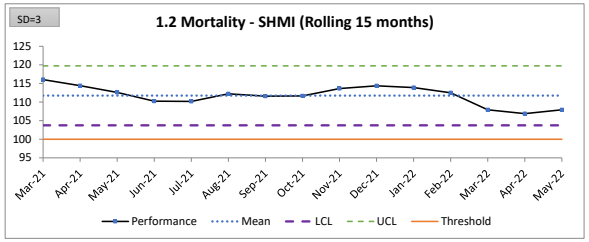
Data Quality Assurance Definitions

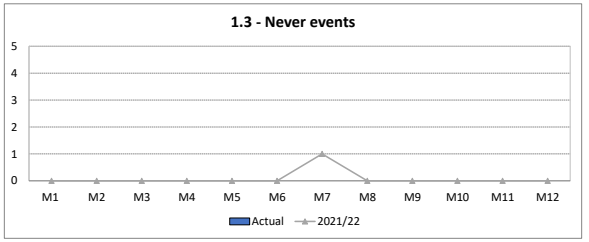
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory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

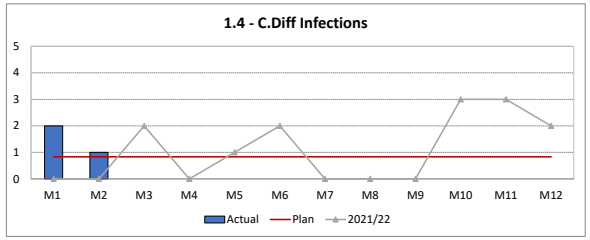
* Independently Audited – refers to an independent audit undertaken by either the Internal Auditor, External Auditors or the Data Quality Audit team.

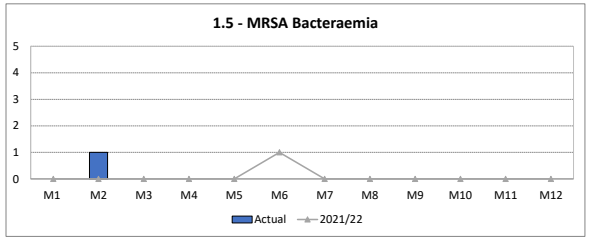
OBJECTIVE 1 - PATIENT SAFETY

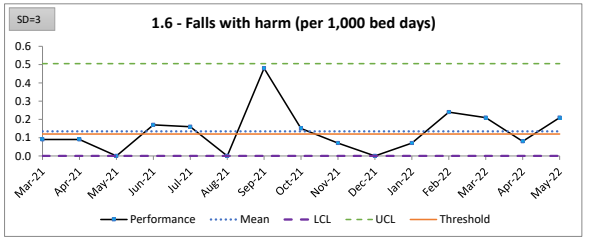


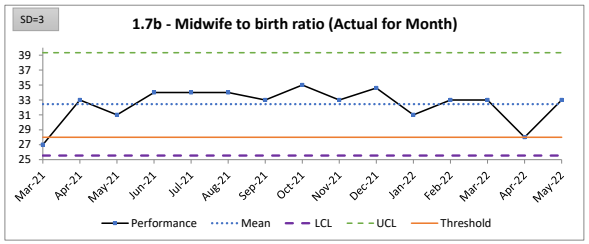


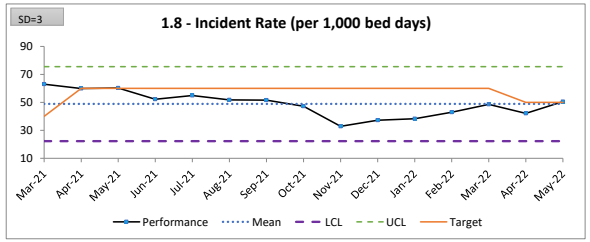


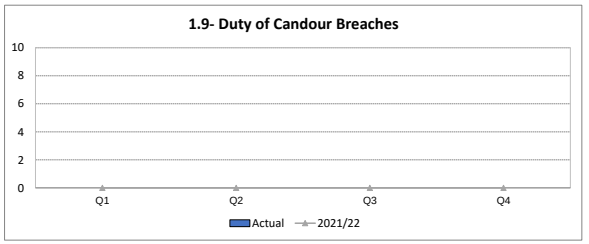


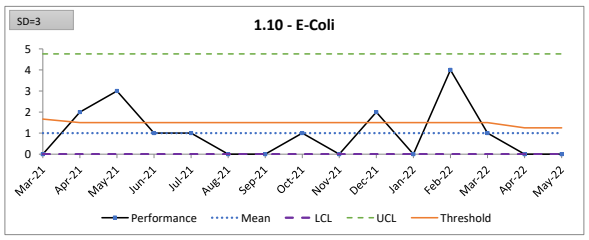


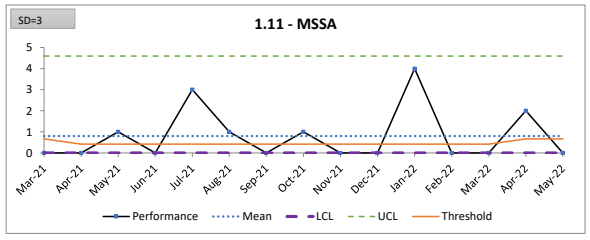


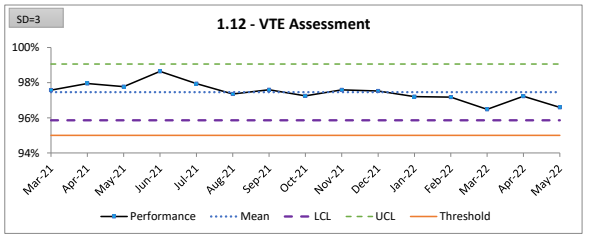


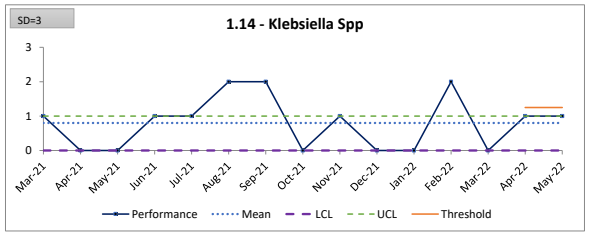


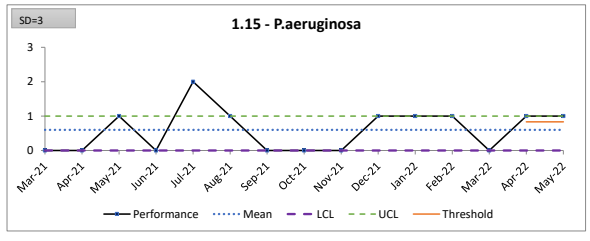












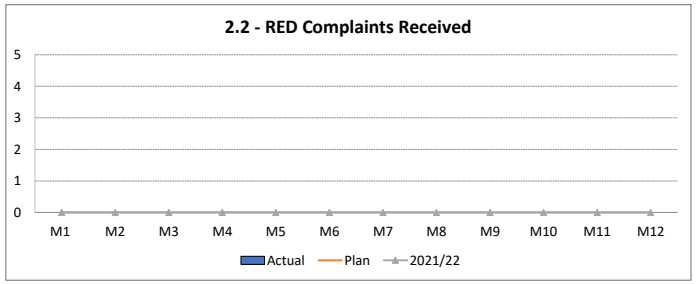
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

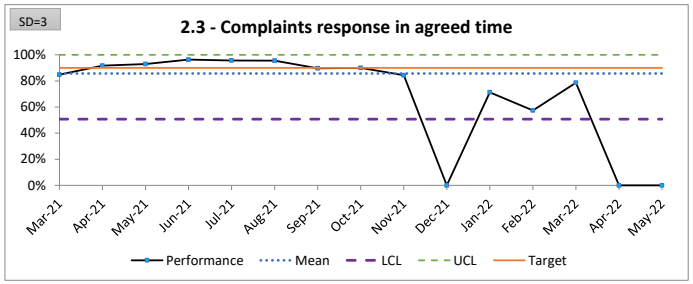
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

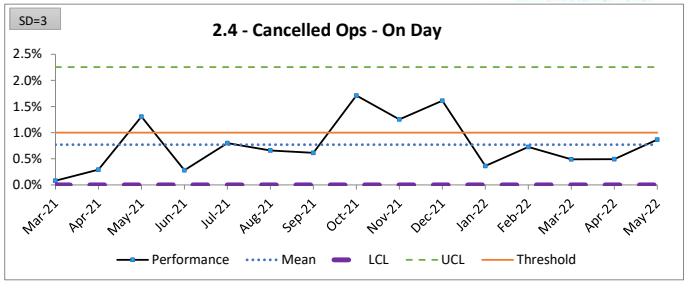
Board Performance Report 2022/23

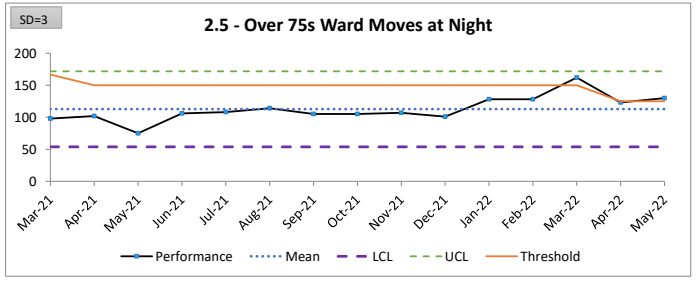
OBJECTIVE 2 - PATIENT EXPERIENCE

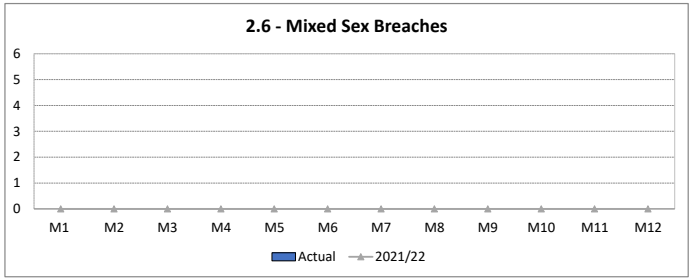
Milton Keynes University Hospital NHS Foundation Trust











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

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

Board Performance Report 2022/23

OBJECTIVE 3 - CLINICAL EFFECTIVENESS

Milton Keynes University Hospital NHS Foundation Trust

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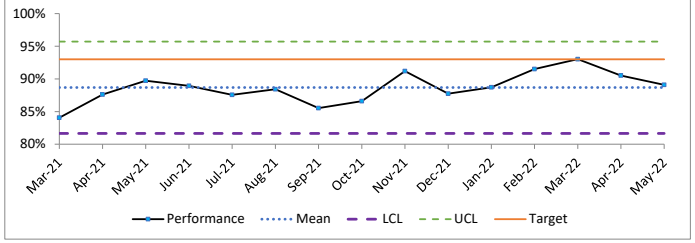
3.1 - Overnight bed occupancy rate



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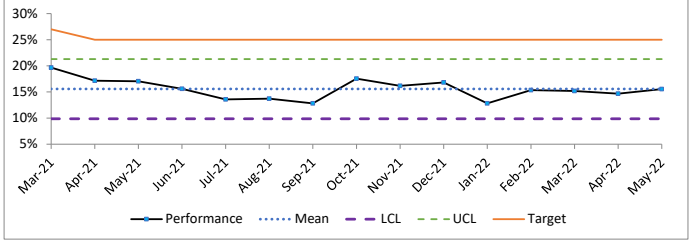
3.2 - Ward Discharges by Midday



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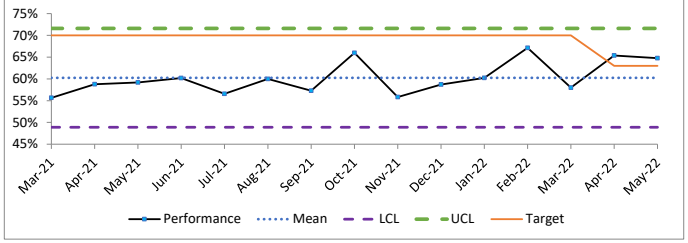
3.3 - Weekend Discharges



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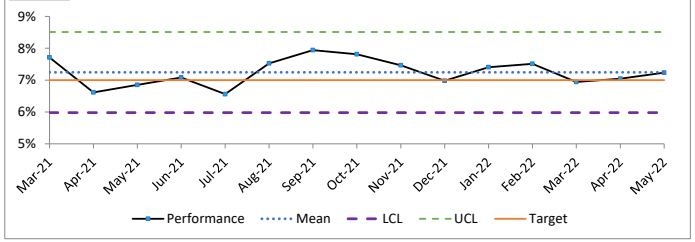
3.4 - 30 Day Readmissions



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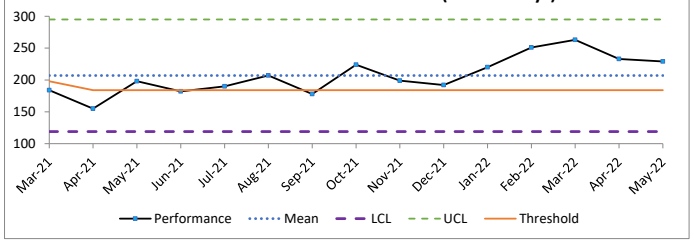
3.6a Number of Stranded Patients (LOS>=7 Days)



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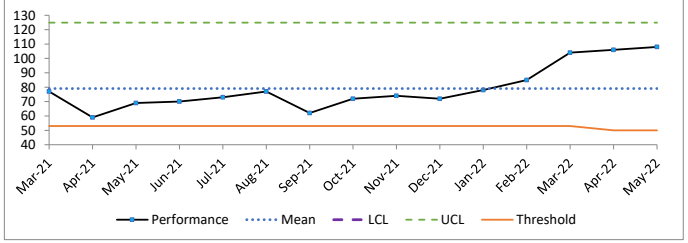
3.6b Number of Super Stranded Patients (LOS>=21 Days)



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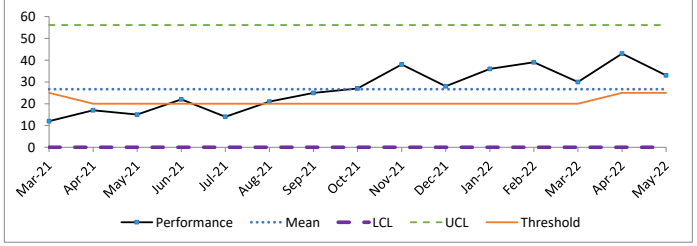
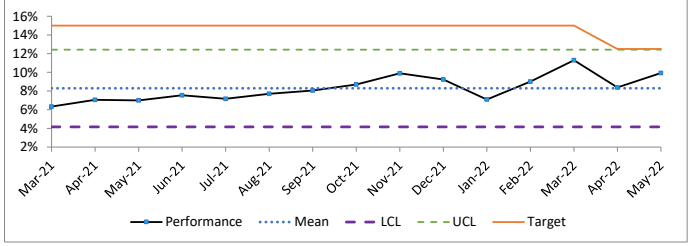
3.7 - Delayed Transfers of Care



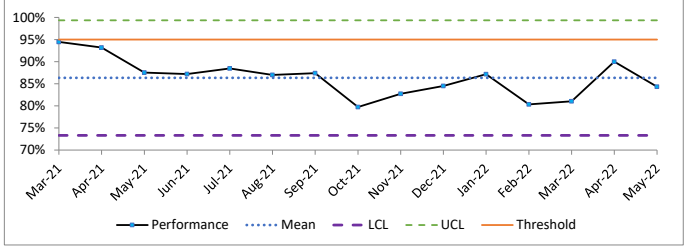
SD=3

3.8 - Discharges from PDU (%)



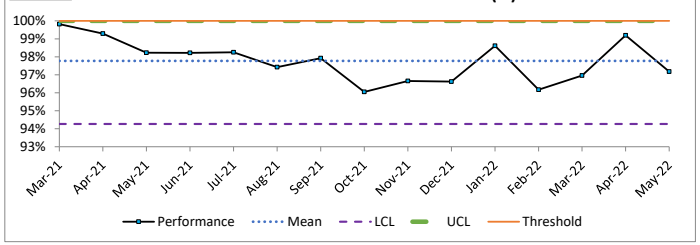
SD=3

3.9a - Ambulance Handover < 30 mins(%)



SD=3

3.9b - Ambulance Handover < 60 mins(%)



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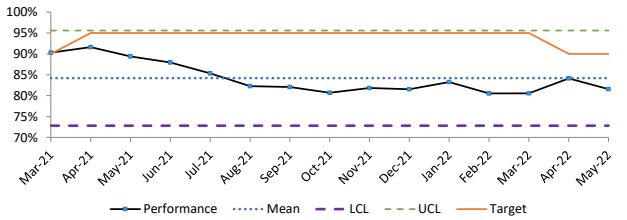
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

OBJECTIVE 4 - KEY TARGETS

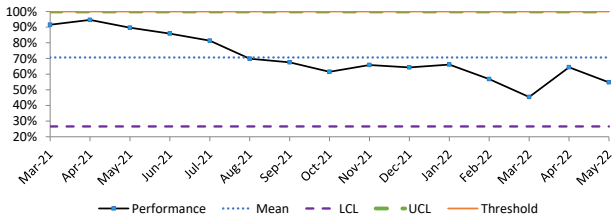
SD=3

4.1a - ED Hour Target (includes UCS)



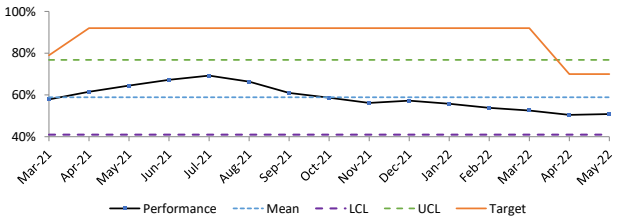
SD=3

4.1b - Total time in ED no more than 8 hours (Admitted)

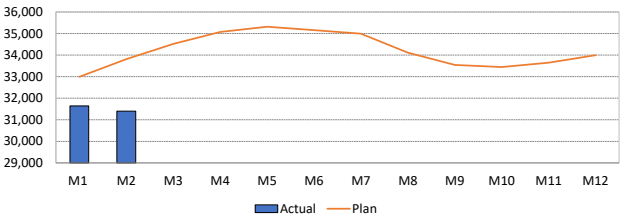


SD=3

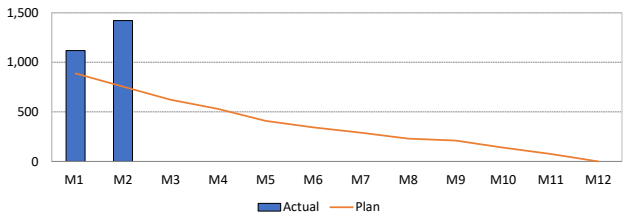
4.2 - RTT Incomplete Pathways <18 weeks



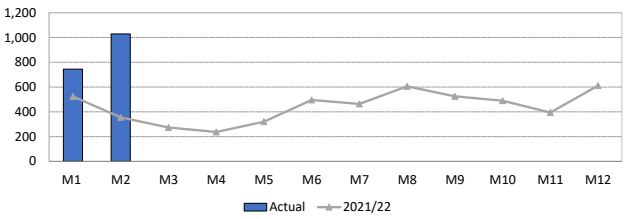
4.4 - RTT Total Open Pathways



4.5a - RTT Patients Waiting Over 52 weeks (Total)

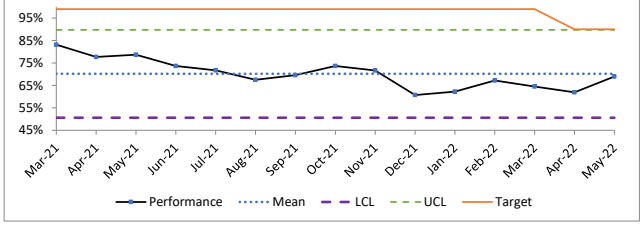


4.5b - RTT Patients Waiting Over 52 weeks (Non-Admitted)



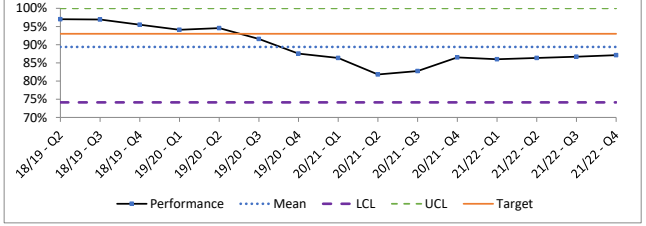
SD=3

4.6 - Diagnostic Waits < 6 weeks



SD=3

4.7 - 2 Week Wait - Cancer



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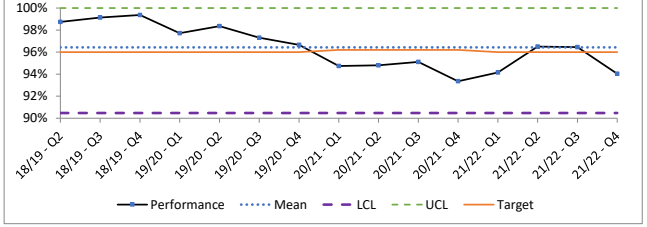
4.8 - 31 day diagnosis to treatment - Cancer



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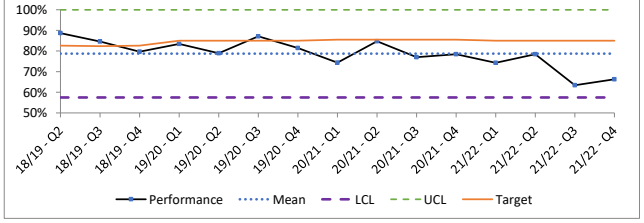
4.9 - 62 day standard - Cancer



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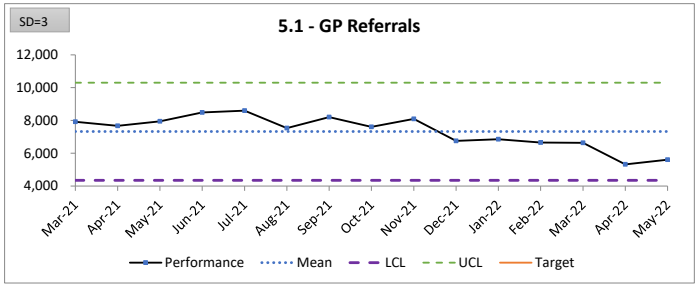
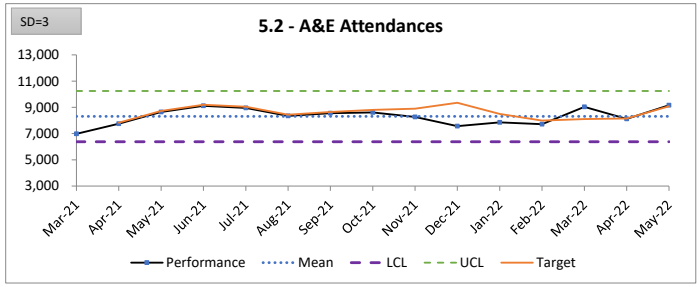
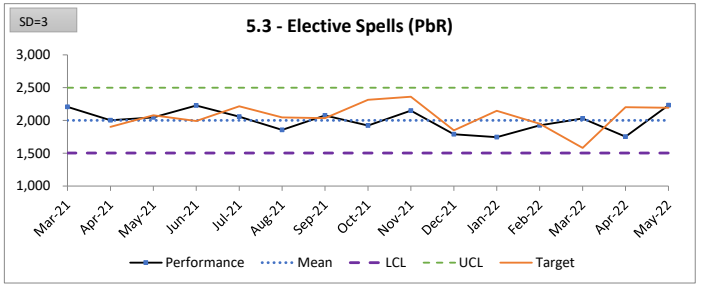
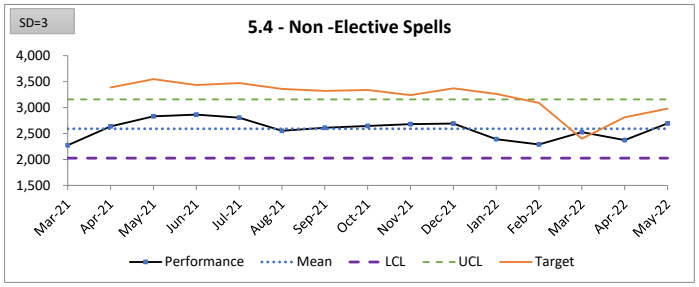
Board Performance Report 2022/23

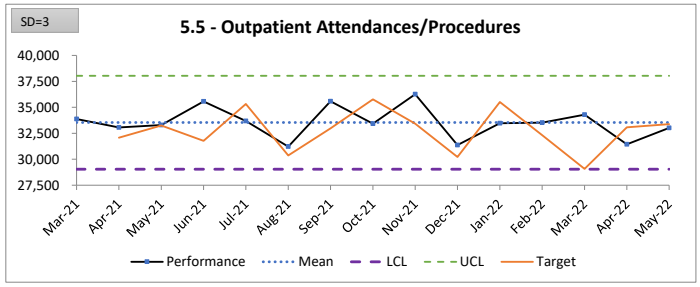
OBJECTIVE 5 - SUSTAINABILITY

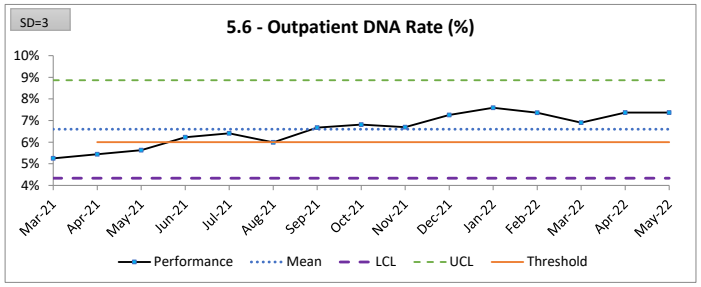












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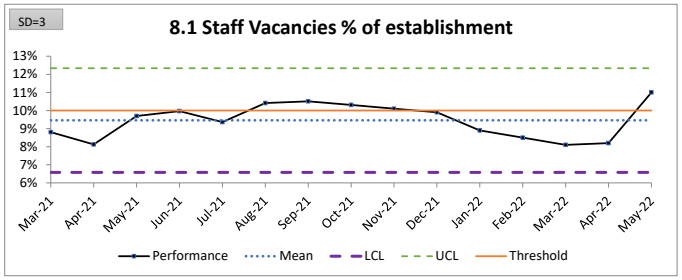
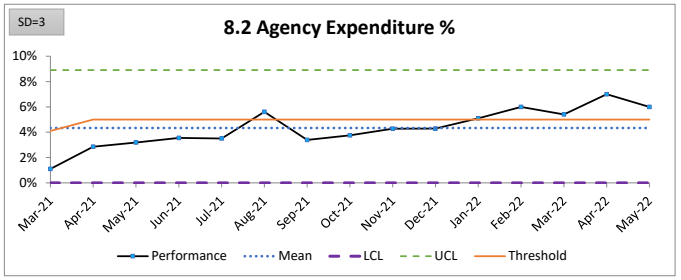
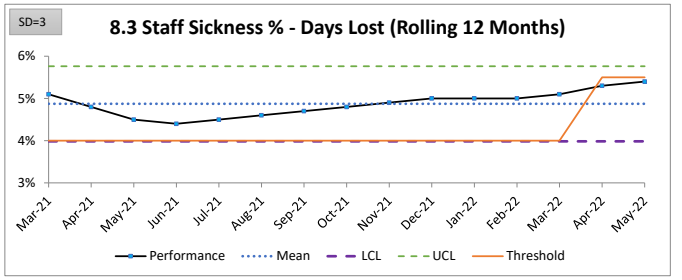
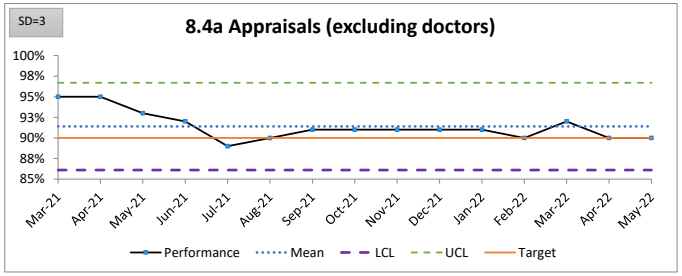
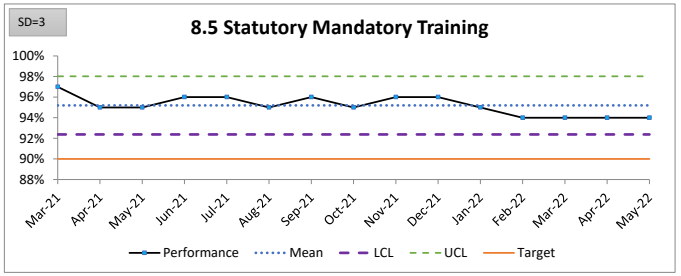
OBJECTIVE 8 - WORKFORCE PERFORMANCE

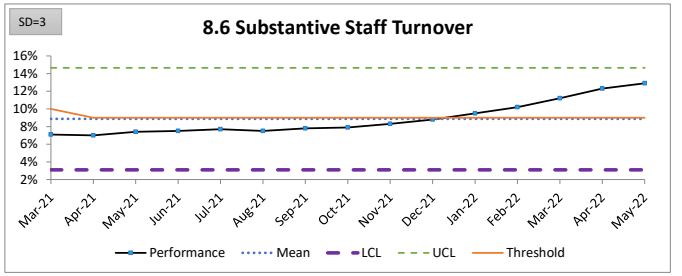












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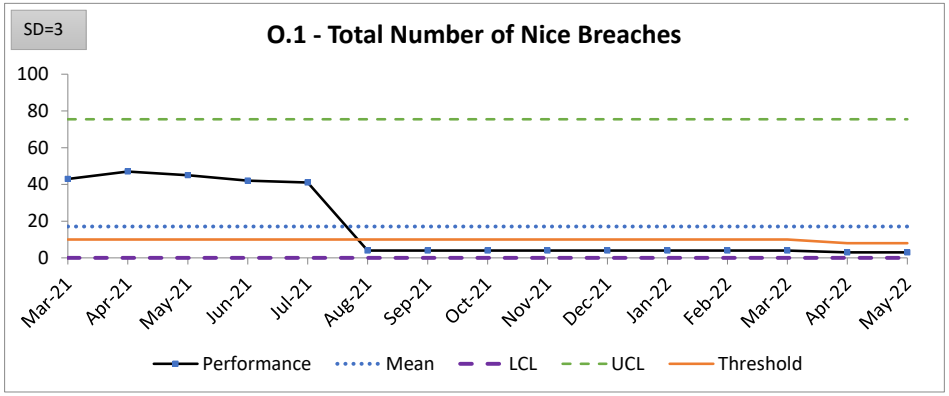

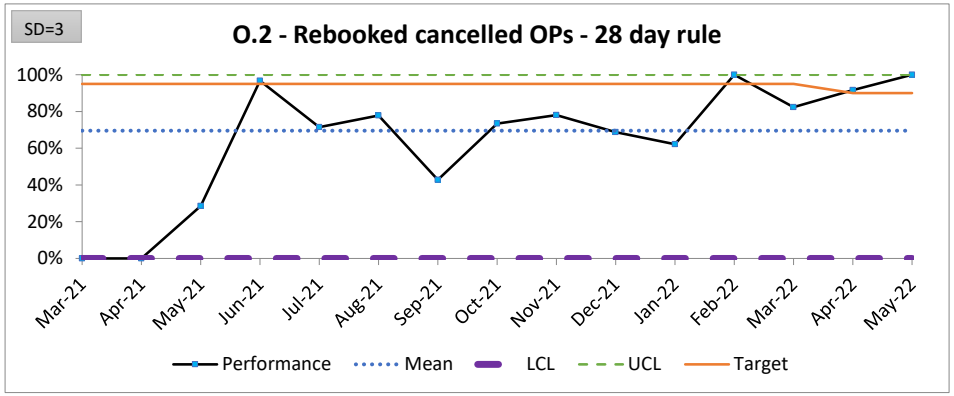

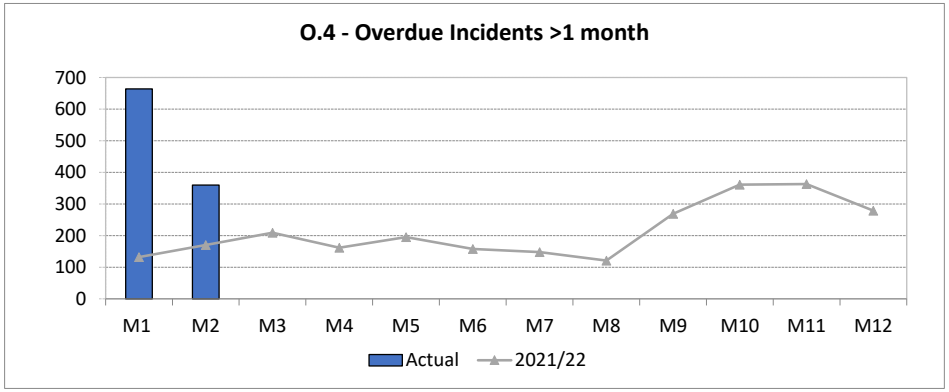

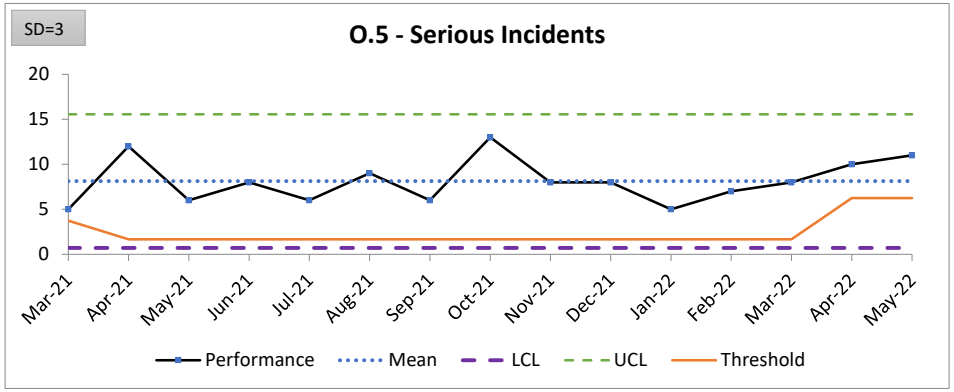

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Performance activity on a rolling 15 months/quarterly
Average on a rolling 15 months/quarterly
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- For Internal Circulation Only

Meeting title	**Trust Board**	**Date:** 7th July 2022
Report title:	**Finance Paper Month 2 2022-23**	**Agenda item: 17**
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 2 (May 2022). Please note that			
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 May and the proposed actions and risks therein. Please note that the annual plan values for the full year position have been adjusted for the 20th June 2022 resubmission to reflect a break-even position at control total level. Plan figures for April and May have not been adjusted as these periods have already been reported. The plan will be adjusted cumulatively in month 3 to reflect the revised profile.			
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 17-32

FINANCE REPORT FOR THE MONTH TO 31st MAY 2022

Trust Board

CONTENTS

EXECUTIVE SUMMARY

(1. & 2.) Revenue – Clinical revenue is paid as part of a block contract. Clinical revenue is below plan due to unrecognised income for elective recovery. Non-clinical revenue is slightly above plan due to income received for education and training.

(3. & 4.) Operating expenses – Pay is below plan with higher temporary staffing costs offset by substantive vacancies. Non-pay is also below plan due to reduced clinical activity and associated spend on clinical consumables.

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

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

(10.) Financial Efficiency– The Trust has achieved savings required up to month 2. The Trust has a shortfall compared to the full year savings required and is working to mitigate the gap (via additional savings/ERF/cost control).

(11.) Cash – The Trust cash balance is £47m, equivalent to 55 days cash to cover operating expenses. Balances include £28m for capital schemes.

(12.) Capital – The Trust is slightly behind plan. This is due to the timing of expenditure for the car park and Maple Centre. The Trust is forecasting to be within its approved CDEL allocation.

(13.) Elective Recovery Fund– Lower than planned levels of ERF has been recorded in months 1&2 (April and May) equating to approximately £0.9m as activity is lower than plan.

(14.) ICS Financial Position – BLMK ICS is on plan at a breakeven position as at month 2.

Ref	All Figures in £'000	Month 2 YTD Plan	Month 2 YTD Actual	Month 2 YTD Var	Full Year Plan	Full Year Forecast	Full Year Var	RAG
1	Clinical Revenue	48,307	47,579	(729)	307,824	307,824	-	
2	Other Revenue	3,272	3,383	111	24,340	24,340	-	
3	Pay	(36,127)	(35,892)	236	(208,343)	(208,343)	-	
4	Non Pay	(17,363)	(16,859)	504	(98,408)	(98,408)	-	
5	Financing & Non-Ops	(3,185)	(3,093)	92	(20,804)	(20,804)	-	
6	Surplus/(Deficit)	(5,096)	(4,882)	214	4,608	4,608	-	
7	Control Total Surplus/(Deficit)	(5,007)	(4,787)	220	-	-	-	
8	Inc. COVID expenditure	(2,983)	(1,133)	1,850	(5,776)	(5,776)	-	
9	High Cost Drugs	(3,537)	(3,574)	(37)	(21,201)	(21,201)	-	
10	CIP Delivery	647	647	-	12,049	12,049	-	
11	Cash	45,457	46,815	1,358	29,900	29,900	-	
12a	Capital Plan (ICS CDEL)	(2,169)	(953)	1,216	(15,905)	(15,905)	-	
12b	Capital Plan (including National funding)	(2,396)	(1,034)	1,362	(18,288)	(18,288)	-	
13	ERF Delivery	1,230	308	(922)	7,381	7,381	-	
14	ICS Financial Position	-	-	-	-	-	-	

Key message

The Trust is reporting a £4.8m deficit for the period to May, this position is favourable to the plan. The Trust has reported reduced income for elective recovery due to operational pressures in April and May. Funding was adequate to cover cost pressures (e.g., premium pay costs) associated with the current operating environment. The Trust has a shortfall in the level of annual financial efficiency savings required, but is identifying additional measures and mitigations to safeguard achievement of the plan.

The Trust has a robust cash position and is paying creditors promptly. The capital programme is behind plan due to timing of expenditure. The Trust is expecting to spend the full capital allocation this year.

FINANCIAL PERFORMANCE- OVERVIEW MONTH 2

2. **Summary Month 2**

For the month of May 2022, financial performance (on a Control Total basis) is a 2.2m deficit, this is favourable to the draft plan by £0.1m.

All Figures in £'000	Month 2 Plan	Month 2 Actual	Month 2 Var	Month 2 YTD Plan	Month 2 YTD Actual	Month 2 YTD Var	Plan Plan	Plan Forecast	Plan Var
Clinical Revenue	24,103	23,791	(312)	48,307	47,579	(729)	307,824	307,824	0
Other Revenue	1,621	1,729	108	3,272	3,383	111	19,169	19,169	0
Total Income	25,724	25,520	(204)	51,579	50,962	(618)	326,993	326,993	0
Pay	(17,866)	(17,922)	(56)	(36,127)	(35,892)	236	(208,343)	(208,343)	0
Non Pay	(8,613)	(8,318)	295	(17,363)	(16,859)	504	(98,408)	(98,408)	0
Total Operational Expenditure	(26,478)	(26,239)	239	(53,491)	(52,751)	740	(306,751)	(306,751)	0
EBITDA	(754)	(719)	35	(1,911)	(1,789)	122	20,242	20,242	0
Financing & Non-Op. Costs	(1,548)	(1,497)	51	(3,096)	(2,997)	98	(20,242)	(20,242)	0
Control Total Deficit (excl. top ups)	**(2,302)**	**(2,216)**	**86**	**(5,007)**	**(4,787)**	**220**	**0**	**0**	**0**
Donated income	0	0	0	0	0	0	5,171	5,171	0
Depreciation	(44)	(48)	(4)	(89)	(96)	(6)	(563)	(563)	0
Impairments & Rounding	0	0	0	0	0	0	0	0	0
Reported deficit/surplus	**(2,346)**	**(2,264)**	**82**	**(5,096)**	**(4,882)**	**214**	**4,608**	**4,608**	**0**

3. Clinical Income
Clinical income shows a negative variance of £0.3m which is due to lower than plan ERF funding. The notification of ERF income earned is likely to be 2-3 months in arrears and as our internal reporting shows that we have undertaken lower than planned activity and we have assumed no ERF earned at present.

4. Other Income
Other income shows a favourable variance of £0.1m. Higher than planned income for education and training was received which is offset by pay costs.

5. Pay
Pay spend is below plan with additional temporary staffing costs offset by substantive vacancies. Further detail is included in Appendices 1 and 4.

6. Non-Pay
Non pay is below plan due to a reduction in clinical supplies and services relating to reduced activity. 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.

Key message
For the month of May 2022, the position on a Control Total basis is a £2.2m deficit, which is favourable to the draft plan. Underspends in-month are offset by lower clinical income and reduced depreciation costs.

FINANCIAL PERFORMANCE- OVERVIEW YTD

8. **Summary Year to Date**

Cumulative financial performance (April and May) on a Control Total basis is a deficit of £4.8m. This is slightly better than plan. Underspends on pay costs and clinical supplies are offset by reduced clinical income.

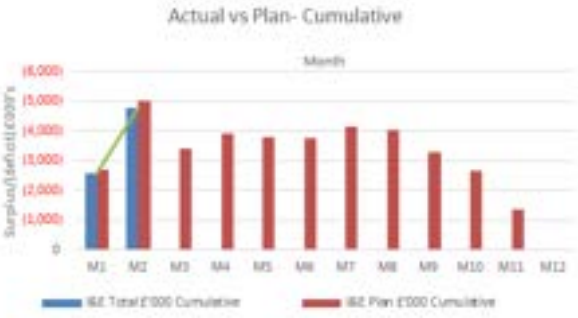
9. Clinical Income YTD
Clinical income shows a negative variance of £0.7m which is due to lower ERF funding. Further detail is included in Appendix 1.

10. Other Income YTD
income shows a favourable variance of £0.1m. A reduction in car park income is offset by an increase in education and training revenue.

11. Pay YTD
Pay spend is below plan with additional temporary staffing costs offset by substantive vacancies. Further detail is included in Appendices 1 & 4.

12. Non-Pay YTD
Non pay is below plan due to a reduction in clinical supplies and services relating to reduced activity. Further detail is included in Appendices 1 & 5.

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



Key message
Up to May 2022, the position on a Control Total basis is a deficit of £4.8m. This is slightly better than plan. Underspends on pay and non-pay are offset by lower clinical income. The plan for month 3 shows a surplus due to adjusting the cumulative position to come in line with the revised break-even plan.

FINANCIAL PERFORMANCE- FOT

14. Summary of key forecast assumptions

The Trust is currently forecasting delivery of the recently revised annual business plan – at breakeven performance. A forecast of current run-rate and expected future changes will be undertaken for month 3 given the early stage of the financial year.

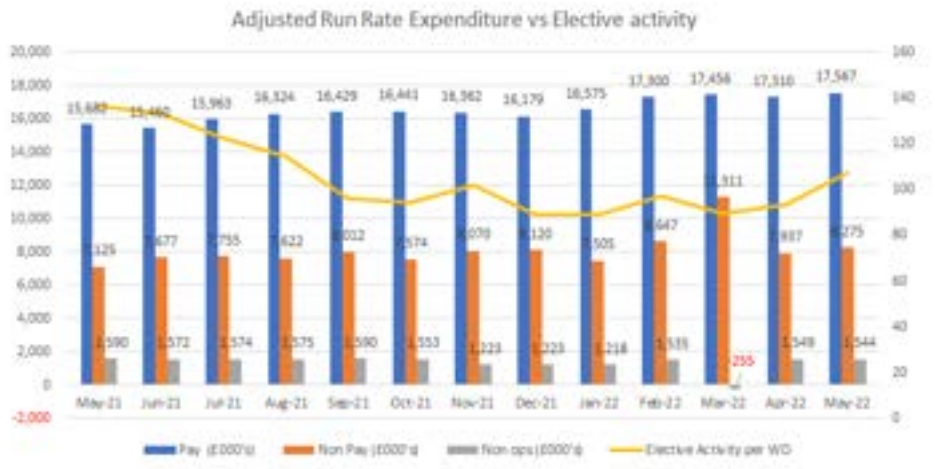
Key message
At this early point in the year, the forecast is in line with the updated plan of breakeven on a control total basis.

FINANCIAL PERFORMANCE- RUN RATE

15. Adjusted expenditure run rate

The graph shows adjusted run-rate expenditure (excl. direct COVID costs and material non recurrent expenditure) by category vs elective activity per day.

Although spend on Covid related resource has reduced the monthly cost is £0.4m which relates mainly to pay cost of £0.3m for escalation and sickness backfill and £0.1m of non-pay costs.



Key message

The expenditure run rate has increased over time due to the cost of additional activity undertaken to support backlog recovery and cost to mitigate staff absence (e.g., sickness)

The Trust will need to monitor and analyse costs closely to understand the root cause of variation in particular inflationary pressures, CIP delivery and investment in resources to support recovery.

ACTIVITY PERFORMANCE & ERF

16. The Trust has recognised 25% of the expected ERF income available for the month on this basis that this is the minimum “floor” and there has been reduced elective activity due to operational Covid activity. This is expected to recover in later months and the revised budget includes full achievement of the £7.6m of ERF allocated to MKUH which requires achievement of 104% of activity versus 2019-20 baselines. A request has been made by providers to NHS England to provide relief on ERF for months 1 and 2 due to operational pressures that hindered achievement of planned levels of elective activity.

17. Activity vs Plan (as per CIVICA excluding accelerator target)

Day case activity-
Day cases have increased since Month 1 and are now marginally up against the 22/23 plan and 21/22 actuals.

Elective Inpatient Activity-
Inpatient activity has increased since Month 1 and is down against the 22/23 plan but in line with 21/22 actuals.

Outpatient Activity-
Outpatient activity has increased since Month 1 and is marginally down against the 22/23 plan but up against 21/22 actuals.

Non-Elective Spells-
Non elective activity has increased since Month 1 and continues to be down against the 22/23 plan and 21/22 actuals.

A&E activity-
A&E activity has increased since Month 1 and is marginally above 21/22 activity and 22/23 plan.

Key message
Day case and outpatient care activity increased in May. 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 only 25% of the monthly income was recognised which is the minimum “floor” value.

EFFICIENCY SAVINGS

18. As of May, the Trust has reported a favourable position to plan, included within this position is £0.6m of efficiency target. The Trust has offset the planned efficiency target by managing the incremental cost of operational pressures.

19. The Trust is increasing the focus on financial efficiency through the Better Value programme. The Trust has identified circa £4m from schemes against the total plan level of £12m.

Division	Target	Plan	% of target	FYE	Risk Adjusted Plan PYE	% of target	Risk Adjusted Plan FYE
	£000's	£000's		£000's	**£000's**	%	£000's
Medicine	3,399	1,758	52%	2,312	**1,282**	38%	1,704
Surgery	2,709	925	34%	1,585	**722**	27%	924
W&C	1,451	398	27%	326	**398**	27%	928
Core Clinical	2,716	1,636	60%	1,926	**1,094**	40%	1,168
Corporate	1,629	752	46%	784	**616**	38%	641
Central Ops	103	0	0%	0	**0**	0%	0
Latest position	**12,007**	**5,469**	**46%**	**6,933**	**4,112**	**34%**	**5,365**

Key message
YTD the Trust has delivered its £0.6m 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

20. The YTD spend on capital after accounting for donated assets and derecognised assets is £1.03m, which is below the Trust's capital plan (excluding national funding) by £1.2m. This is mainly due to the timing of expenditure relating to the car park scheme and maple centre as part of the Strategic pre-commitments.

21. The Trust's ICS CDEL allocation is £15.9m and there is further approved national funding for NHP of £1.06m and Endoscopy £0.14m. The Trust is awaiting approval for additional funding of £0.9m for NHP and £0.3m for the impact of the new leases under IFRS16. There is a final allocation of £1.82m for the BLMK IT Integrated Care Board (ICB) which is still be determined. The full breakdown of all funding and sources of application is shown in the table below.

	ICS Approved CDEL Allocation 2022/23	National CDEL Allocation 2022/23		
Scheme Subcategory	Internally Funded	Planned	Approved	Awaiting Approval
	£m	£m	£m	£m
Depreciation	15.04			
Self Funded	0.86			
PDC Funded				
New Hospital Programme		1.94	1.06	0.88
Endoscopy		0.14	0.14	
New Lease impact (IFRS16)		0.31		0.31
Sub Total CDEL	**15.90**	**2.38**	**1.20**	**1.19**
CDEL Allocation Approved	**17.10**			**1.19**
Total Planned CDEL	**18.28**			

Other funding - Still to be determined and held at ICB level

IT	Total for ICB £m
Levelling up digital Maturity	1.71
Critical Cybersecurity infrastructure	0.11
Total	**1.82**

Capital Item	YTD Plan up to end of May £m	Actual up to end of May 22 £m	YTD Variance to Plan £m	Status	Comments
Pre-commitments					
CBIG	0.33	0.22	- 0.12		
Strategic	1.69	0.61	- 1.07		Actuals relate to Maple Centre and
Total Pre-commitments	**2.02**	**0.83**	**- 1.19**		
Proposed Scheme Allocations (TBC)					
CBIG including IT	0.00	0.12	0.12		Actuals relate to prior year approved schemes
Strategic Radiotherapy	0.15	0.00	- 0.15		
Allocation TBC	0.00	0.00	0.00		
Total Proposed Scheme Allocations	**0.15**	**0.12**	**- 0.03**		-
Total Pre-commitments and Proposed Scheme Allocations (ICS CDEL Alloction)	**2.17**	**0.95**	**- 1.22**		-
Nationally approved schemes					
NHP	0.31	0.08	- 0.23		
Endoscopy	0.00	0.00	0.00		
Total Nationally approved schemes	0.31	0.08	- 0.23		-
Draft CDEL Approved capital plan	**2.48**	**1.03**	**- 1.45**		-
Donated Assets (excluded from CDEL)					
Maple Centre	1.70	0.00	-1.70		
Pathlake	0.00	0.00	0.00		
Staff Rooms	0.03	0.00	-0.03		
Total Donated Assets	**1.73**	**0.00**	**-1.73**		-
Adjustment for Donated assets vs Donated Income	- 0.09	0.00	0.09		
Awaiting Approval					
New Leases Impact under IFRS 16 (applied but not confirmed)	0.00	0.00	0.00		
NHP - external fees	0.00	0.00	0.00		
Total awaiting approval	**0.00**	**0.00**	**0.00**		
Draft Submitted CDEL capital plan	**2.40**	**1.03**	**-1.37**		

Key message
Capital expenditure is below plan by £1.2m, after excluding national funding relating to NHP which relates to the timing of the expenditure on the car park and maple centre which is expected to catch up in future months. As part of the resubmission of the annual plan in June the phasing of the capital plan will be revisited.

CAPITAL – FOT

22. The Trust is forecasting to spend its ICS allocation and nationally approved allocations in full and be within the £17.1m CDEL allocation.

23. The Trust's plan includes £0.9m of additional funding relating to NHP for external design fees which will only be committed to once approval is received from the national team. The trust is also expecting the £0.3m impact of the new leases under IFRS16 to be nationally funded and not to be part of the current ICS CDEL allocation. If these items are approved the trusts approved CDEL will be £18.3m for 2022/23.

24. The CBIG proposed schemes have been reviewed and signed off by the trust's internal approval processes during June.

25. The Strategic radiotherapy scheme includes a notional allocation of £4.5m for radiotherapy which will be reviewed once the GMP and cashflow are confirmed. The timing of these is expected before the end of July.

Key message
Capital is forecasting to be within the CDEL allocation of £18.28m which includes nationally funded schemes £2.39m for NHP £1.9m, Endoscopy £0.14m and impact of new leases under IFRS16.

Capital Item	22/23 Submitted Plan £m	22/23 Forecast £m	Variance to Plan £m	Status
Pre-commitments				
CBIG	2.24	2.24	0.00	
Strategic	5.72	5.72	0.00	
Total Pre-commitments	**7.96**	**7.96**	**0.00**	
Proposed Scheme Allocations (TBC)				
CBIG including IT	3.00	3.00	0.00	
Strategic Radiotherapy	4.50	4.50	0.00	
Allocation TBC	0.44	0.44	0.00	
Total Proposed Scheme Allocations	**7.94**	**7.94**	**0.00**	
Total Pre-commitments and Proposed Scheme Allocations (ICS CDEL Alloction)	**15.90**	**15.90**	**0.00**	
Nationally approved schemes				
NHP	1.06	1.06	0.00	
Endoscopy	0.14	0.14	0.00	
Total Nationally approved schemes	1.20	1.20	0.00	
Draft CDEL Approved capital plan	**17.10**	**17.10**	**0.00**	
Donated Assets (excluded from CDEL)				
Maple Centre	5.00	5.00	0.00	
Pathlake	0.14	0.14	0.00	
Staff Rooms	0.03	0.03	0.00	
Total Donated Assets	**5.17**	**5.17**	**0.00**	
Adjustment for Donated assets vs Donated Income				
Awaiting Approval				
New Leases Impact under IFRS 16 (applied but not confirmed)	0.31	0.31	0.00	
NHP - external fees	0.88	0.88	0.00	
Total awaiting approval	**1.19**	**1.19**	**0.00**	
Draft Submitted CDEL capital plan	**18.28**	**18.28**	**0.00**	

CASH

26. Summary of Cash Flow

The cash balance at the end of May was £46.8m, this was £1.3m higher than the planned figure of £45.5m. This is a decrease on last month's figure of £50m. (see opposite).

See appendices 6-8 for the cashflow detail.

27. 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.

28. Better Payment Practice

The Trust has fallen below the national target of 95% of all bills paid within the target timeframe in terms of value and volume. This is mainly due to the repatriation of SBS AP services, and the ongoing issues with agency invoicing. Both issues are being addressed and action plans are in progress to resolve them. This metric will continue to be monitored in accordance with national guidance and best practice

Better payment practice code	Actual M2 YTD Number	Actual M2 YTD £'000	Actual M1 YTD Number	Actual M1 YTD £'000
Non NHS				
Total bills paid in the year	11,454	39,128	3,832	22,615
Total bills paid within target	10,138	35,839	3,386	22,061
Percentage of bills paid within target	**88.5%**	**91.6%**	**88.4%**	**97.5%**
NHS				
Total bills paid in the year	319	889	109	554
Total bills paid within target	249	706	96	508
Percentage of bills paid within target	**78.1%**	**79.4%**	**88.1%**	**91.5%**
Total				
Total bills paid in the year	**11,773**	**40,017**	**3,941**	**23,170**
Total bills paid within target	**10,387**	**36,544**	**3,482**	**22,569**
Percentage of bills paid within target	**88.2%**	**91.3%**	**88.4%**	**97.4%**

Key message

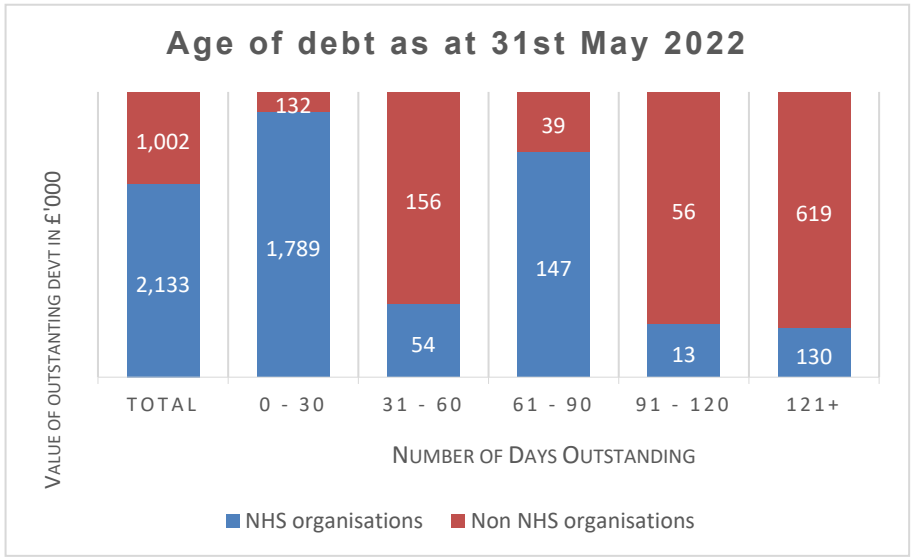
Cash is above plan by £1.3m, and the Trust has fallen below the 95% target for BPPC, mainly due to issues experience by SBS during their repatriation of AP services, and ongoing agency invoicing issues. Management is working to rectify payment performance to levels required.

BALANCE SHEET

29. 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 22 by £8.2m; this is driven by the inclusion of Right of Use assets related to the adoption of IFRS 16 1 April 2022.
- Current assets have decreased by £9.9m, this is mainly due to the decrease in cash £11.2m offset by an increase in receivables (£1.3m).
- Current liabilities have decreased by £3.5m, this is mainly due to the decrease in Trade Payables £9.8m offset by the increase in deferred income £4.7m and the inclusion of Right of Use assets related to the adoption of IFRS 16 1 April 2022 (£1.6m)
- Non-Current Liabilities have decreased from March 22 by £10.2m, this is due to the inclusion of Right of Use assets (£11.7m) related to the adoption of IFRS 16 1 April 2022, offset by the reduction in deferred income £1.5m



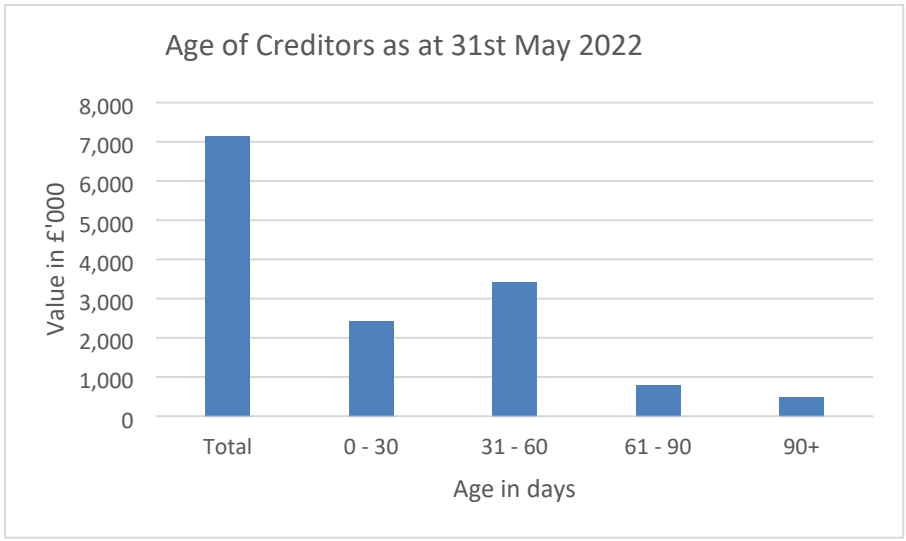
30. Aged debt

The debtors position as of 31st May is £3.1m, which is an increase of £1.2m from the April'22 position. Of this total £0.8m is over 121 days old, the detail is shown in Appendix 10.

The three largest NHS debtors are Bedford Hospitals NHS Foundation Trust £0.02m for salary recharges, NHS England £0.1m for Diabetic Retinopathy and training recharges and Health Education England £1.5m relating to 22/23 Q1 education contract. 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.

31. Creditors

The creditor's position is £7.1m, which is a decrease of £0.7m from the April' 22 position. Of this £4.7m is over 30 days, with £3.7m approved for payment. The breakdown of creditors is shown in Appendix 12.



Key message

Main movements on the statement of financial position related to the inclusion of Right of Use Assets related to the adoption of IFRS 16 1 April 22; 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

32. Utilisation of provisions

At the beginning of April, the Trust had £4.2m in provisions with £3.3m being current provisions, the largest of these being for legal cases £1.9m. During April the Trust has utilised £4k. Details of the provisions are shown in the provisions table opposite.

33. Deferred Income

The Trust has increased its deferred income during April by £0.03m which is mainly due to Health Education England, Cancer Alliance, various NHS & non-NHS project income streams offset by amounts released. The total deferred income is £24.2m as detailed below.

Deferred Income	As at 1st April 2022 (pre audit adjustments)	Additional in Year	Utilised in Year	As at 31st May 2022
	£000	£000	£000	£000
NHS				
Cancer Alliance	(612.5)	(104.0)		(716.5)
CCG	(1,704.9)	-	5.3	(1,699.6)
Health Eduction England	(877.6)	(24.2)	5.5	(896.3)
ICS	(14,813.6)	(1.0)	21.5	(14,793.1)
Other NHS	(3,170.7)	(442.1)	678.9	(2,933.9)
Total NHS	(21,179.2)	(571.3)	711.2	(21,039.3)
Non NHS				
MK Council	(500.0)	-	-	(500.0)
R&D	(326.9)	(149.4)	56.8	(419.5)
UOBMS	0.0	-	-	-
Sensyne	(2,000.0)	-	-	(2,000.0)
Other Non NHS	(150.7)	(52.6)	20.7	(182.6)
Total Non NHS	(2,977.6)	(202.0)	77.5	(3,102.1)
Total Deferred Income	**(24,156.8)**	**(773.3)**	**788.7**	**(24,141.4)**

Provisions	As at 1st April 2022	Arising	Utilised in Year	As at 31st May 2022
Current	£000	£000	£000	£000
LTPS	(52.4)		5.3	(47.1)
Injury Benefit	(33.8)		7.8	(26.0)
Pension Compensation	(2.9)		0.5	(2.4)
Legal Claim Provision				
Legal- HR Pension	(40.0)			(40.0)
Legal - Other	(1,870.0)			(1,870.0)
Coroners costs	(126.3)			(126.3)
Other				
HMRC VAT - LIMS	(306.0)			(306.0)
Total Current Provisons	**(2,431.5)**	-	**13.6**	**(2,417.8)**
Non Current	£000	£000	£000	£000
Injury Benefit Provision	(834.6)			(834.6)
Pension Compensation	(15.8)			(15.8)
Pension Tax Provision	(330.5)			(330.5)
Modular Ward	(418.9)			(418.9)
WG Dilapidation	(132.3)			(132.3)
Off site storage Dilapidation costs 20-21	(43.0)			(43.0)
White house dilapidation costs 21-22	(36.0)			(36.0)
Total Non Current Provisons	**(1,811.0)**	-	-	**(1,811.0)**
Total Provisions	**(4,242.5)**	-	**13.6**	**(4,228.9)**

Key message

The Trust has £4.2m in provisions, of which £4k has been utilised during the period. In addition, there is deferred income of £24.2m. Management of the deferred income is being discussed with counterparties.

BAF

34. Financial risk register and the BAF
There are currently 11 risks on the Financial Risk Register which are reviewed monthly, there has a new risk added relating to Sensyme health and one relating to insufficient cash has been removed. Two risks remain rated as a significant risk [16] which relate to current funding and transformation delivery. All the other risks have been reviewed and remain at the same level.

35. Full details of all risks on the FRR can be found in Appendix 13

Key message
There has been one new risk added this month relating to Sensyne Health and one relating to insufficient cash has been removed. Of the current eleven finance risks there are two risks that are rated as a significant risk (BAF).

INTERGRATED CARE SYSTEM (ICS) KEY METRICS

Not available for M1-2 as no reporting has been required nationally.

RECOMMENDATIONS TO BOARD

36. Finance & Investment Committee is asked to note the financial position of the Trust as of 31st May and the proposed actions and risks therein.

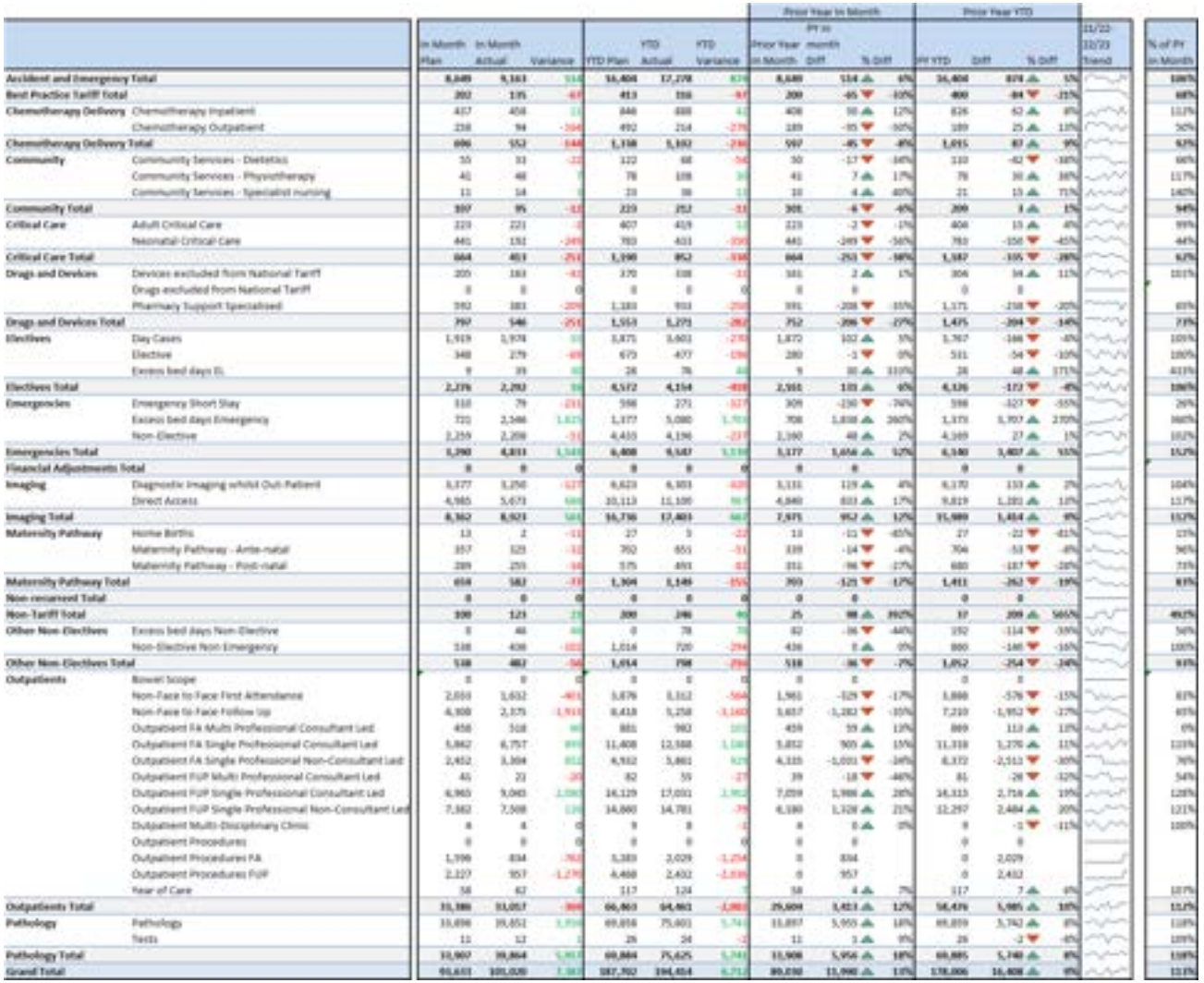
APPENDICIES

Appendix 1

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

	FY23	M2 CUMULATIVE			M2			PRIOR MONTH	
	Annual Budget	Budget	Actual	Variance	Budget	Actual	Variance	M1 Actual	Change
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME									
Outpatients	57,168	9,368	9,088	(280)	4,987	5,363	376	3,725 ▲	1,638
Elective admissions	32,293	5,587	4,015	(1,572)	3,133	1,983	(1,150)	2,032 ▼	(49)
Emergency admissions	79,685	12,561	13,352	789	6,013	7,505	1,491	5,847 ▲	1,658
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	18,348	3,040	3,185	146	1,532	1,680	148	1,505 ▲	174
Other Admissions	2,835	561	288	(276)	328	172	(156)	114 ▲	58
Maternity	23,336	3,979	2,876	(1,103)	2,111	1,362	(749)	1,514 ▼	(152)
Critical Care & Neonatal	6,979	1,108	822	(287)	535	313	(221)	508 ▼	(195)
Imaging	6,142	1,013	1,012	(1)	546	607	61	404 ▲	203
Direct access Pathology	4,674	736	797	61	380	415	34	382 ▲	32
Non Tariff Drugs and Devices (high cost/individual drugs)	21,201	3,537	3,574	37	1,792	1,919	127	1,655 ▲	264
Other (inc. home visits and best practice tariffs)	16,338	1,046	1,287	244	981	1,041	102	245 ▲	798
CQUIN	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	18,836	5,771	7,284	1,513	1,804	1,429	(375)	5,856 ▼	(4,427)
MKCCG Block adj	0	0	0	0	0	0	0	0 ▲	0
Clinical Income	**307,824**	**48,307**	**47,579**	**(729)**	**24,335**	**21,791**	**(313)**	**23,788** ▲	**3**
Non-Patient Income	19,169	3,272	3,383	111	1,621	1,729	108	1,655 ▲	74
PSF Income	0	0	(0)	(0)	0	0	0	(0) ▲	0
Donations	5,171	0	0	0	0	0	0	0 ▲	0
Non-Patient Income	**24,340**	**3,272**	**3,383**	**111**	**1,621**	**1,729**	**108**	**1,654** ▲	**75**
TOTAL INCOME	**332,164**	**51,579**	**50,962**	**(618)**	**25,726**	**25,520**	**(204)**	**25,442** ▲	**78**
EXPENDITURE									
Pay - Substantive	(189,711)	(31,581)	(29,955)	2,026	(16,000)	(14,988)	1,012	(14,567) ▼	(21)
Pay - Bank	(9,194)	(2,240)	(2,819)	(579)	(993)	(1,458)	(465)	(1,361) ▼	(97)
Pay - Locum	(3,388)	(492)	(861)	(209)	(226)	(345)	(119)	(316) ▼	(29)
Pay - Agency	(5,901)	(1,343)	(2,322)	(979)	(592)	(1,068)	(477)	(1,253) ▲	185
Pay - Other	(758)	(130)	(135)	(5)	(93)	(82)	9	(73) ▲	11
Pay CIP	41	7	0	(7)	3	0	(3)	0 ▲	0
Vacancy Factor	69	11	0	(11)	6	0	(6)	0 ▲	0
Pay	**(208,141)**	**(36,127)**	**(35,892)**	**236**	**(17,866)**	**(17,922)**	**(56)**	**(17,970)** ▲	**48**
Non Pay	(77,208)	(13,826)	(13,285)	541	(6,820)	(6,399)	422	(6,887) ▲	488
Non Tariff Drugs (high cost/individual drugs)	(21,201)	(3,537)	(3,574)	(37)	(1,792)	(1,919)	(127)	(1,655) ▼	(264)
Non Pay	**(98,408)**	**(17,363)**	**(16,859)**	**504**	**(8,613)**	**(8,318)**	**295**	**(8,542)** ▲	**224**
TOTAL EXPENDITURE	**(306,549)**	**(53,491)**	**(52,751)**	**740**	**(26,478)**	**(26,240)**	**239**	**(26,512)** ▲	**272**
EARNINGS BEFORE INTEREST, TAXATION, DEPRECIATION AND AMORTISATION (EBITDA)	**25,612**	**(1,911)**	**(1,789)**	**122**	**(754)**	**(719)**	**35**	**(1,070)** ▲	**350**
Interest Receivable	0	0	66	66	0	31	31	35 ▼	(4)
Interest Payable	(358)	(58)	(51)	6	(28)	(21)	7	(30) ▲	9
Depreciation, Impairments & Profit/Loss on Asset Disposal	(14,474)	(2,164)	(2,157)	27	(1,092)	(1,078)	13	(1,078) ▼	(0)
Donated Asset Depreciation	(561)	(89)	(96)	(6)	(44)	(48)	(4)	(48) ▲	0
Profit/Loss on Asset Disposal & Impairments	0	0	0	0	0	0	0	0 ▲	0
DEL Impairments	0	0	0	0	0	0	0	0 ▲	0
AME Impairments	0	0	0	0	0	0	0	0 ▲	0
Unwinding of Discounts	0	0	0	0	0	0	0	0 ▲	0
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**10,017**	**(4,240)**	**(4,026)**	**214**	**(1,918)**	**(1,836)**	**83**	**(2,190)** ▲	**355**
Dividends Payable	(5,429)	(856)	(856)	(0)	(428)	(428)	(0)	(428) ▲	0
OPERATING SURPLUS/(DEFICIT) AFTER DIVIDENDS	**4,608**	**(5,096)**	**(4,882)**	**214**	**(2,346)**	**(2,264)**	**82**	**(2,618)** ▲	**355**

Clinical Activity Summary
For the period ending 31st May 2022

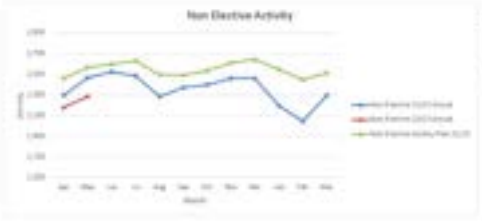


		In Month Plan	In Month Actual	Variance	YTD Plan	YTD Actual	YTD Variance	Prior Year In Month	PY vs month Diff	% Diff	Prior Year YTD	Diff	% Diff	21/22 - 22/23 Trend	% of PY in Month
Accident and Emergency Total		**8,049**	**9,163**	114	**16,404**	**17,278**	874	**8,689**	**114** ▲	6%	**16,404**	**874** ▲	5%		**106%**
Best Practice Tariff Total		**202**	**135**	-67	**413**	**316**	-97	**200**	**-65** ▼	-33%	**400**	**-84** ▼	-21%		**68%**
Chemotherapy Delivery	Chemotherapy Inpatient	437	458	21	846	888	42	408	50 ▲	12%	826	62 ▲	8%		112%
	Chemotherapy Outpatient	238	94	-144	492	214	-278	189	-95 ▼	-50%	189	25 ▲	13%		50%
Chemotherapy Delivery Total		**696**	**552**	-144	**1,338**	**1,102**	-236	**597**	**-45** ▼	-8%	**1,015**	**87** ▲	9%		**92%**
Community	Community Services - Dietetics	55	33	-22	122	68	-54	50	-17 ▼	-34%	110	-42 ▼	-38%		66%
	Community Services - Physiotherapy	41	48	7	78	109	31	41	7 ▲	17%	78	30 ▲	38%		117%
	Community Services - Specialist nursing	11	14	3	23	36	13	10	4 ▲	40%	21	15 ▲	71%		140%
Community Total		**107**	**95**	-12	**223**	**252**	-31	**301**	**-6** ▼	-6%	**209**	**3** ▲	1%		**94%**
Critical Care	Adult Critical Care	223	221	-2	407	419	12	223	-2 ▼	-1%	404	15 ▲	4%		99%
	Neonatal-Critical Care	441	192	-249	783	433	-350	441	-249 ▼	-56%	783	-350 ▼	-45%		44%
Critical Care Total		**664**	**413**	-251	**1,190**	**852**	-338	**664**	**-251** ▼	-38%	**1,187**	**-335** ▼	-28%		**62%**
Drugs and Devices	Devices excluded from National Tariff	205	183	-41	370	338	-32	181	2 ▲	1%	304	34 ▲	11%		101%
	Drugs excluded from National Tariff	0	0	0	0	0	0	0	0		0	0			
	Pharmacy Support Specialised	592	383	-209	1,183	933	-250	591	-208 ▼	-35%	1,171	-238 ▼	-20%		65%
Drugs and Devices Total		**797**	**546**	-251	**1,553**	**1,271**	-282	**752**	**-206** ▼	-27%	**1,475**	**-204** ▼	-14%		**73%**
Electives	Day Cases	1,919	1,974	55	3,871	3,601	-270	1,872	102 ▲	5%	3,767	-166 ▼	-4%		105%
	Elective	348	279	-69	673	477	-196	280	-1 ▼	0%	531	-54 ▼	-10%		100%
	Excess bed days EL	9	39	30	28	76	48	9	30 ▲	333%	28	48 ▲	171%		433%
Electives Total		**2,276**	**2,292**	16	**4,572**	**4,154**	-418	**2,161**	**131** ▲	6%	**4,326**	**-172** ▼	-4%		**106%**
Emergencies	Emergency Short Stay	110	79	-31	598	271	-327	309	-230 ▼	-74%	598	-327 ▼	-55%		26%
	Excess bed days Emergency	721	2,546	1,825	1,377	5,080	3,703	708	1,838 ▲	260%	1,373	3,707 ▲	270%		360%
	Non-Elective	2,259	2,208	-51	4,433	4,196	-237	2,190	48 ▲	2%	4,169	27 ▲	1%		102%
Emergencies Total		**3,290**	**4,833**	1,543	**6,408**	**9,547**	3,139	**3,177**	**1,656** ▲	52%	**6,140**	**3,407** ▲	55%		**152%**
Financial Adjustments Total		**0**	**0**	0	**0**	**0**	0	**0**	**0**		**0**	**0**			
Imaging	Diagnostic Imaging whilst Out-Patient	1,377	1,256	-121	6,623	6,303	-320	1,131	119 ▲	4%	6,170	133 ▲	2%		104%
	Direct Access	4,985	5,673	688	10,113	11,109	997	4,840	833 ▲	17%	9,819	1,291 ▲	13%		117%
Imaging Total		**8,362**	**8,923**	561	**16,736**	**17,401**	665	**7,971**	**952** ▲	12%	**15,989**	**1,414** ▲	9%		**112%**
Maternity Pathway	Home Births	13	2	-11	27	5	-22	13	-11 ▼	-85%	27	-22 ▼	-81%		15%
	Maternity Pathway - Ante-natal	357	323	-33	702	655	-31	339	-14 ▼	-4%	704	-53 ▼	-8%		96%
	Maternity Pathway - Post-natal	289	259	-30	575	493	-82	311	-96 ▼	-27%	680	-187 ▼	-28%		73%
Maternity Pathway Total		**659**	**582**	-77	**1,304**	**1,145**	-159	**703**	**-125** ▼	-17%	**1,411**	**-262** ▼	-19%		**83%**
Non-recurrent Total		**0**	**0**	0	**0**	**0**	0	**0**	**0**		**0**	**0**			
Non-Tariff Total		**100**	**123**	23	**200**	**296**	96	**25**	**98** ▲	392%	**37**	**259** ▲	565%		**49%**
Other Non-Electives	Excess bed days Non-Elective	0	46	46	0	78	78	82	-36 ▼	-44%	192	-114 ▼	-59%		56%
	Non-Elective Non-Emergency	518	436	-82	1,014	720	-294	436	0 ▲	0%	860	-140 ▼	-16%		100%
Other Non-Electives Total		**518**	**482**	-36	**1,014**	**798**	-216	**518**	**-36** ▼	-7%	**1,052**	**-254** ▼	-24%		**93%**
Outpatients	Bowel Scope	0	0	0	0	0	0	0	0		0	0			
	Non-Face to Face First Attendance	2,010	1,632	-401	3,876	3,312	-564	1,961	-329 ▼	-17%	3,888	-576 ▼	-15%		83%
	Non-Face to Face Follow Up	4,308	2,375	-1,933	8,413	5,258	-3,155	3,617	-1,242 ▼	-35%	7,210	-1,952 ▼	-27%		65%
	Outpatient FA Multi Professional Consultant Led	458	518	60	881	982	101	459	59 ▲	13%	869	113 ▲	13%		113%
	Outpatient FA Single Professional Consultant Led	5,862	6,757	895	11,408	12,588	1,180	5,852	905 ▲	15%	11,318	1,270 ▲	11%		115%
	Outpatient FA Single Professional Non-Consultant Led	2,452	3,304	852	4,932	5,861	929	4,335	-1,031 ▼	-24%	8,372	-2,511 ▼	-30%		76%
	Outpatient FUP Multi Professional Consultant Led	41	23	-18	82	55	-27	39	-18 ▼	-46%	81	-28 ▼	-32%		54%
	Outpatient FUP Single Professional Consultant Led	6,965	9,043	2,078	14,129	17,031	2,902	7,059	1,984 ▲	28%	14,313	2,718 ▲	19%		128%
	Outpatient FUP Single Professional Non-Consultant Led	7,382	7,508	126	14,880	14,781	-79	6,180	1,328 ▲	21%	12,297	2,484 ▲	20%		121%
	Outpatient Multi-Disciplinary Clinic	8	8	0	9	8	-1	8	0 ▲	0%	9	-1 ▼	-11%		100%
	Outpatient Procedures	0	0	0	0	0	0	0	0		0	0			
	Outpatient Procedures FA	1,396	834	-562	3,283	2,029	-1,254	0	834		0	2,029			
	Outpatient Procedures FUP	2,227	957	-1,270	4,468	2,432	-2,036	0	957		0	2,432			
	Year of Care	58	62	4	117	124	7	58	4 ▲	7%	117	7 ▲	6%		107%
Outpatients Total		**31,386**	**33,057**	1,671	**66,863**	**64,861**	-2,002	**29,604**	**3,453** ▲	12%	**58,476**	**5,985** ▲	10%		**112%**
Pathology	Pathology	33,896	35,651	1,755	69,656	75,401	5,745	33,897	5,755 ▲	18%	69,659	5,742 ▲	8%		118%
	Tests	11	12	1	28	24	-4	11	1 ▲	9%	28	-2 ▼	-6%		109%
Pathology Total		**33,907**	**35,664**	1,757	**69,684**	**75,425**	5,741	**33,908**	**5,756** ▲	18%	**69,685**	**5,740** ▲	8%		**118%**
Grand Total		**93,603**	**101,020**	7,387	**187,702**	**194,414**	6,712	**89,030**	**11,990** ▲	13%	**178,006**	**16,408** ▲	9%		**113%**

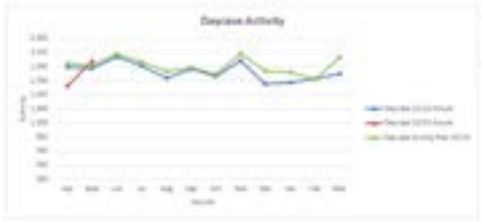
Appendix 3

Clinical Activity Run Rates
For the period ending 31st May 2022

A&E activity has increased since Month 1, and is marginally above 21/22 activity and 21/23 plan.



Non-elective activity has increased since Month 1, and continues to be down against the 21/23 plan and 21/22 actuals.



Daycases have increased since Month 1 and are now marginally up against the 21/23 plan and 21/22 actuals.

Inpatient activity has increased since Month 1 and is down against the 21/23 plan but in line with 21/22 actuals.

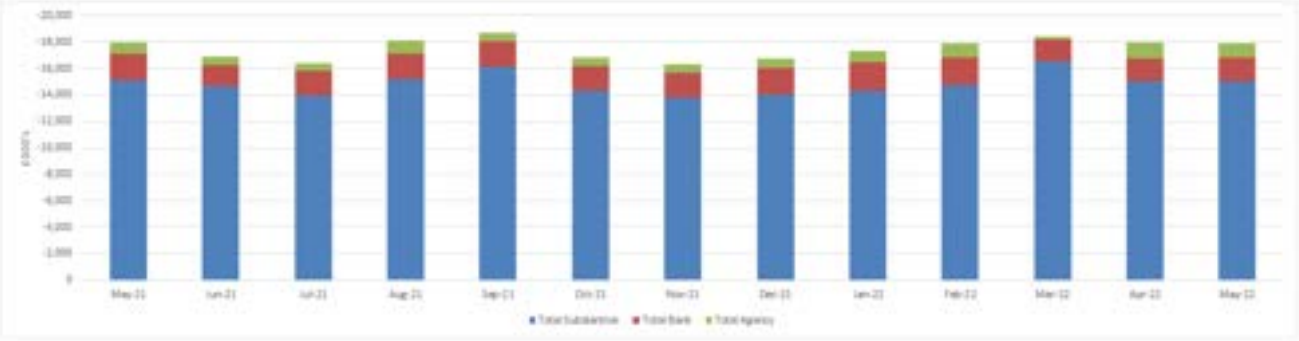
Outpatient activity has increased since Month 1 and is marginally down against the 21/23 plan but up against 21/22 actuals.

Appendix 4

Pay Expenditure
For the period ending 31st May 2022

Year to date pay expenditure is £17.9m, this is favourable to plan by £0.2m. The in-month variance is driven by additional bank and agency costs.

TRUST		May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Month Budget £'000	Month Actual £'000	Variance £'000	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Month Change £'000	Month Actual WTE	Month Change WTE	Trend WTE
Substantive	Med Staff	-5,250	-4,578	-4,660	-5,092	-5,040	-4,527	-4,509	-4,675	-4,619	-4,810	-1,897	-5,048	-4,891	(4,980)	(4,891)	89	(9,962)	(9,939)	23	157	418	(83)	
	Nurses and Midwives	-3,775	-3,985	-3,689	-4,052	-4,330	-3,811	-3,707	-3,714	-3,761	-3,796	-2,418	-3,841	-3,934	(4,422)	(3,934)	488	(8,840)	(7,775)	1,065	(92)	905	(7)	
	Sci Tech & Ther	-1,813	-1,934	-1,810	-1,884	-2,197	-1,964	-1,936	-1,896	-1,993	-1,965	-1,484	-1,930	-1,976	(2,129)	(1,976)	153	(4,250)	(3,906)	344	(47)	518	5	
	Healthcare assistants, etc	-1,520	-1,466	-1,403	-1,440	-1,606	-1,414	-1,389	-1,362	-1,430	-1,518	-1,135	-1,557	-1,640	(1,533)	(1,640)	(106)	(3,067)	(3,196)	(129)	(83)	643	13	
	Admin & Clerical	-2,270	-2,486	-2,193	-2,451	-2,688	-2,300	-2,059	-2,167	-2,274	-2,384	-1,654	-2,403	-2,367	(2,728)	(2,367)	361	(5,447)	(4,770)	677	36	734	(2)	
	Other	-478	-228	-221	-231	-246	-276	-237	-231	-240	-237	-7,920	-262	-245	(266)	(245)	21	(533)	(507)	26	16	16	0	
Total Substantive		**-15,106**	**-14,657**	**-13,976**	**-15,150**	**-16,107**	**-14,292**	**-13,837**	**-14,045**	**-14,337**	**-14,710**	**-16,508**	**-15,040**	**-15,053**	**(16,059)**	**(15,053)**	**1,006**	**(32,099)**	**(30,093)**	**2,006**	**(13)**	**3,234**	**(74)**	
Bank	Med Staff (Locums)	-523	-389	-409	-528	-313	-289	-222	-335	-295	-366	278	-316	-345	(226)	(345)	(119)	(452)	(661)	(209)	(29)	8	(12)	
	Nurses and Midwives	-756	-547	-649	-695	-725	-691	-662	-704	-801	-747	-733	-577	-625	(565)	(625)	(60)	(1,381)	(1,201)	180	(48)	142	1	
	Sci Tech & Ther	-74	-64	-90	-58	-94	-114	-106	-112	-186	-148	-269	-113	-165	(42)	(165)	(122)	(85)	(278)	(193)	(52)	34	2	
	Healthcare assistants, etc	-444	-441	-474	-489	-627	-572	-579	-583	-611	-583	-630	-506	-501	(363)	(501)	(138)	(726)	(1,007)	(278)	5	176	(5)	
	Admin & Clerical	-176	-186	-201	-179	-215	-210	-240	-254	-259	-255	-297	-166	-168	(23)	(168)	(146)	(46)	(334)	(288)	(3)	60	60	
Total Bank		**-1,972**	**-1,627**	**-1,823**	**-1,948**	**-1,974**	**-1,876**	**-1,808**	**-1,988**	**-2,132**	**-2,100**	**-1,651**	**-1,677**	**-1,803**	**(1,219)**	**(1,803)**	**(585)**	**(2,692)**	**(3,480)**	**(788)**	**(126)**	**459**	**46**	
Agency	Med Staff	-548	-297	-218	-419	-282	-170	-169	-169	-266	-202	383	-193	-270	(90)	(270)	(180)	(180)	(462)	(282)	(77)	16	4	
	Nurses and Midwives	-171	-118	-165	-423	-183	-284	-372	-434	-463	-601	-401	-812	-517	(360)	(517)	(157)	(880)	(1,329)	(449)	296	67	(36)	
	Sci Tech & Ther	-36	-80	-93	-45	-69	-66	-68	-46	-52	-73	-81	-66	-128	(78)	(128)	(50)	(155)	(194)	(39)	(62)	13	6	
	Healthcare assistants, etc	-42	-19	-22	-22	-18	-26	-19	-4	-31	-41	-31	-81	-31	(16)	(31)	(14)	(33)	(112)	(79)	50	15	(2)	
	Admin & Clerical	-15	-17	-16	-54	-38	-44	-15	-6	-29	-75	-42	-45	-48	(13)	(48)	(35)	(25)	(93)	(68)	(3)	6	1	
	Other	-118	-69	-65	-53	-46	-39	-58	-60	-50	-75	-78	-56	-72	(35)	(72)	(38)	(70)	(129)	(59)	(16)	10	2	
Total Agency		**-929**	**-600**	**-580**	**-1,017**	**-635**	**-630**	**-700**	**-719**	**-892**	**-1,067**	**-249**	**-1,253**	**-1,065**	**(592)**	**(1,065)**	**(474)**	**(1,343)**	**(2,318)**	**(975)**	**188**	**127**	**(26)**	
Total		**-18,007**	**-16,884**	**-16,379**	**-18,115**	**-18,716**	**-16,798**	**-16,345**	**-16,752**	**-17,361**	**-17,877**	**-18,409**	**-17,970**	**-17,922**	**(17,869)**	**(17,922)**	**(52)**	**(36,134)**	**(35,892)**	**241**	**48**	**3,780**	**(53)**	



Appendix 5

Non-Pay Expenditure
For the period ending 31st May 2022

Year to date non-pay expenditure is £9.9m, this is £0.3m better than plan. The in-month variance due to reduced clinical supplies and services relating to reduced activity.

Trust		May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Month Budget	Month Actual	Month Variance	YTD Budget	YTD Actual	YTD Variance	Month Change	Trend
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
Non Pay	Drug expense (excl. HCD)	76	(419)	(382)	(343)	(420)	(496)	(320)	(445)	(496)	(344)	(503)	(530)	(450)	(456)	(430)	6	(886)	(960)	(75)	101	
	High Cost Drugs	(2,024)	(2,024)	(1,881)	(1,881)	(1,757)	(1,757)	(1,913)	(1,786)	(1,802)	(1,580)	(1,995)	(1,655)	(1,919)	(1,792)	(1,919)	(127)	(3,557)	(3,574)	(37)	(264)	
	Clinical supplies and services	(2,307)	(1,899)	(1,722)	(2,283)	(1,833)	(1,571)	(1,544)	(1,654)	(1,697)	(2,109)	(759)	(1,755)	(1,835)	(2,026)	(1,835)	191	(4,148)	(3,590)	558	(80)	
	General supplies and services	(468)	(385)	(360)	(338)	(349)	(387)	(414)	(428)	(455)	(320)	(703)	(418)	(556)	(386)	(356)	30	(773)	(775)	(1)	63	
	Establishment Expenses	(1,064)	(1,061)	(1,065)	(1,073)	(1,066)	(1,060)	(1,122)	(1,205)	(1,191)	(1,197)	(4,917)	(1,218)	(1,112)	(1,249)	(1,112)	137	(2,499)	(2,350)	149	106	
	Premises and fixed plant	(1,528)	(1,356)	(1,529)	(1,418)	(1,481)	(1,306)	(1,480)	(1,463)	(1,563)	(1,550)	(8,432)	(1,728)	(1,523)	(1,557)	(1,523)	33	(3,141)	(3,251)	(108)	205	
	Outsource to Commercial sector	(900)	(580)	(508)	(824)	(718)	(541)	(599)	(436)	(105)	(684)	(1,306)	(642)	(702)	(654)	(702)	(49)	(1,310)	(1,345)	(34)	(60)	
	Education and Training Expenses	(120)	(101)	(183)	(82)	(155)	(77)	(156)	(98)	(96)	594	(208)	(146)	(159)	(149)	(159)	(9)	(299)	(305)	(6)	(12)	
	Consultancy expenses	(8)	(7)	(3)	(2)	(1)	0	(2)	2	(1)	9	(2)	(4)	(4)	(1)	(4)	(2)	(3)	(8)	(5)	1	
	Miscellaneous Operating Expenses	(340)	(328)	(434)	(351)	(304)	(371)	(292)	(708)	(175)	(415)	(822)	(443)	(279)	(382)	(279)	103	(766)	(723)	43	164	
	Non Pay Savings Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total Non Pay		(8,482)	(8,140)	(8,065)	(8,594)	(8,084)	(7,576)	(7,822)	(8,222)	(7,599)	(7,595)	(17,446)	(8,542)	(8,318)	(8,613)	(8,318)	295	(17,363)	(16,859)	504	224	
Non-operating costs	Depreciation and Amortisation	(1,146)	(1,129)	(1,130)	(1,131)	(1,134)	(1,131)	(779)	(778)	(778)	(778)	(246)	(1,126)	(1,126)	(1,126)	(1,126)	10	(2,273)	(2,253)	20	(0)	
	Impairment - owned and donated	0	0	0	0	0	0	0	0	0	(320)	0	0	0	0	0	0	0	0	0	0	
	Profit/Loss on Asset Disposal					(48)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Interest Payable	(22)	(22)	(23)	(23)	(44)	(0)	(22)	(22)	(22)	(22)	(22)	(30)	(21)	(28)	(21)	7	(56)	(51)	6	9	
	Restructuring Cost																0			0	0	
	PDC Dividend Payable	(422)	(422)	(422)	(422)	(365)	(422)	(422)	(422)	(422)	(422)	552	(428)	(428)	(428)	(428)	(0)	(856)	(856)	(0)	0	
	Unwinding of discounts	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total Non Operating costs		(1,590)	(1,572)	(1,574)	(1,575)	(1,590)	(1,553)	(1,223)	(1,223)	(1,218)	(1,535)	306	(1,549)	(1,544)	(1,582)	(1,544)	40	(3,185)	(3,093)	92	46	
TOTAL NON-PAY & NON OPERATING COSTS		(10,072)	(9,712)	(9,639)	(10,168)	(9,674)	(9,129)	(9,045)	(9,445)	(8,817)	(9,130)	(17,140)	(10,090)	(9,862)	(10,205)	(9,862)	343	(20,548)	(19,952)	596	228	

Statement of Cash Flow
As of 31st May 2022

	Audited Mth12 2021-22 £000	Mth 2 £000	Mth 1 £000	In Month Movement £000
Cash flows from operating activities				
Operating (deficit) from continuing operations	2,699	(4,042)	(2,197)	4,896
Operating (deficit)	**2,699**	**(4,042)**	**(2,197)**	**4,896**
Non-cash income and expense:				
Depreciation and amortisation	11,278	2253	1,126	10,152
Impairments	715	0	0	715
(Increase)/Decrease in Trade and Other Receivables	5,405	(1,586)	(1,069)	6,474
(Increase)/Decrease in Inventories	(375)	(2)	3	(378)
Increase/(Decrease) in Trade and Other Payables	12,124	(2,952)	(5,543)	17,667
Increase/(Decrease) in Other Liabilities	5,945	(16)	36	5,909
Increase/(Decrease) in Provisions	(338)	(13)	(4)	(334)
NHS Charitable Funds	(561)	0	0	(561)
Other movements in operating cash flows	(817)	(4)	0	(817)
NET CASH GENERATED FROM OPERATIONS	**36,075**	**(6,362)**	**(7,648)**	**43,723**
Cash flows from investing activities				
Interest received	36	66	36	0
Purchase of financial assets	0	0	0	0
Purchase of intangible assets	(3,134)	(1,588)	264	(3,398)
Purchase of Property, Plant and Equipment, Intangibles	(34,425)	(3,158)	(2,267)	(32,158)
De-recognition of PPE	0			0
Net cash generated (used in) investing activities	**(37,523)**	**(4,680)**	**(1,967)**	**(35,556)**
Cash flows from financing activities				
Public dividend capital received	15,273	0	0	15,273
Capital element of finance lease rental payments	(201)	(72)	107	(308)
Interest element of finance lease	(267)	(46)	(30)	(237)
PDC Dividend paid	(4,663)	0	0	(4,663)
Receipt of cash donations to purchase capital assets	516	0	0	516
Cash flows from (used in) other financing activities	0	0	0	0
Net cash generated from/(used in) financing activities	**10,658**	**-118**	**77**	**10,581**
Increase/(decrease) in cash and cash equivalents	**9,210**	**(11,160)**	**(9,538)**	18,748
Opening Cash and Cash equivalents	**48,765**	**57,975**	**57,975**	
Closing Cash and Cash equivalents	**57,975**	**46,815**	**48,437**	**18,748**

Appendix 7

Cash Flow Forecast Table for 12 months to May 2023

Month	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
BANK balance b/f	**48,437**	**46,815**	**46,076**	**45,082**	**41,835**	**47,128**	**44,585**	**40,839**	**41,602**	**38,671**	**36,417**	**29,943**	**30,375**
Activity SLA's, inc Over performance	25,900	24,563	24,536	24,996	24,731	24,416	24,800	25,426	24,909	25,393	25,109	22,938	22,938
Non activity SLAs	-	246	110	110	110	110	110	110	110	110	110	-	136
Other non patient related income	1,779	3,528	729	729	2,729	699	759	2,679	834	679	2,621	2,572	2,572
Grant for capital assets	0	430	0	0	0	0	0	0	0	0	0	0	0
Donations for Capital Assets	-	-	5,020	45	46	10	10	10	10	10	10	-	-
Interest receivable	-	41	0	0	-	0	0	0	0	0	0	-	-
TOTAL RECEIPTS	**27,680**	**28,807**	**30,395**	**25,880**	**27,616**	**25,235**	**25,679**	**28,225**	**25,863**	**26,192**	**27,850**	**25,510**	**25,646**
Pay (Substantive + Bank)	(16,659)	(17,120)	(17,120)	(17,120)	(8,643)	(16,659)	(17,581)	(17,120)	(17,120)	(16,659)	(17,581)	(15,677)	(15,677)
Direct debits & standing orders	(487)	(556)	(380)	(380)	(241)	(379)	(381)	(382)	(378)	(377)	(521)	(380)	(380)
NHS creditors	(2,188)	(2,786)	(2,301)	(2,301)	(2,301)	(2,301)	(2,301)	(2,301)	(2,301)	(2,301)	(2,301)	(2,301)	(2,301)
Non NHS creditors	(9,137)	(6,907)	(5,798)	(6,149)	(6,016)	(6,441)	(6,649)	(6,649)	(6,649)	(5,837)	(8,681)	(6,519)	(6,519)
Capital BAU	-	(777)	(2,388)	(1,240)	(1,556)	(1,248)	(1,763)	(1,011)	(2,346)	(3,272)	(2,671)	(201)	(121)
Donated/Government Granted assets	-	(900)	(1,834)	(937)	-	(750)	(750)	-	-	-	-	-	-
Capital Other	(831)	(483)	(1,568)	(1,000)	(1,000)	-	-	-	-	-	-	-	-
Capital Pathway Unit (PDC)	-	(16)	-	-	-	-	-	-	-	-	-	-	-
PDC	-	-	-	-	(2,566)	-	-	-	-	-	(2,567)	-	-
TOTAL PAYMENTS	**(29,302)**	**(29,546)**	**(31,389)**	**(29,127)**	**(22,324)**	**(27,778)**	**(29,425)**	**(27,463)**	**(28,794)**	**(28,446)**	**(34,323)**	**(25,079)**	**(24,998)**
NET PAYMENTS / RECEIPTS	**(1,622)**	**(739)**	**(994)**	**(3,247)**	**5,293**	**(2,543)**	**(3,746)**	**762**	**(2,931)**	**(2,254)**	**(6,473)**	**431**	**648**
Bank balance b/f													
Bank balance c/f	**46,815**	**46,076**	**45,082**	**41,835**	**47,128**	**44,585**	**40,839**	**41,602**	**38,671**	**36,417**	**29,943**	**30,375**	**31,022**

Appendix 8

13-week Cash Flow Forecast up to the 26th August 2022

Week number for Cash Flow Forecast	1	2	3	4	5	6	7	8	9	10	11	12	13
Week ending: (Friday)	03-Jun-22	10-Jun-22	17-Jun-22	24-Jun-22	01-Jul-22	08-Jul-22	15-Jul-22	22-Jul-22	29-Jul-22	05-Aug-22	12-Aug-22	19-Aug-22	26-Aug-22
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
Bank balance b/f	**48,372**	**47,355**	**46,281**	**66,369**	**55,245**	**45,384**	**47,037**	**66,757**	**57,427**	**45,078**	**42,888**	**40,326**	**61,346**
Activity SLA's, inc Over performance & Cquin	-	-	24,563	-	-	-	24,536	-	-	-	-	24,996	-
Other non patient related income	1,803	995	207	661	-	124	445	30	130	124	45	430	130
Other Income RBS	-	-	-	30	-	4	10	10	10	4	10	10	10
Other Income Citi	233	43	168	100	-	100	-	-	100	100	-	-	100
Cash Sheet Income	4	2	3	32	-	-	15	-	-	-	15	-	-
Credit Card Income	25	103	35	40	-	20	20	20	20	20	20	20	20
TOTAL RECEIPTS	**1,803**	**995**	**24,810**	**797**	**540**	**5,134**	**25,091**	**40**	**130**	**169**	**45**	**25,536**	**130**
Payroll costs	(181)	(540)	(461)	(7,261)	(8,678)	(461)	(461)	(7,261)	(8,938)	(461)	(461)	(461)	(7,261)
Direct debits & standing orders	(74)	(192)	(147)	(11)	(214)	(4)	(152)	(4)	(140)	(81)	(128)	(29)	(5)
NHS creditors	(251)	-	(1,955)	(580)	(609)	-	(1,692)	-	-	(609)	-	(1,692)	-
Non NHS creditors	(2,308)	(878)	(2,077)	(3,334)	-	(1,208)	(1,704)	(1,677)	(1,208)	(1,208)	(1,208)	(2,024)	(1,708)
Capital Clinical Urgent and Essential Maintenance	-	(6)	(36)	(736)	-	(1,105)	(428)	(428)	(428)	-	(310)	(310)	(310)
Capital Donation Funded	-	-	-	-	(900)	-	(934)	-	(900)	-	-	-	(937)
Capital External Loan Funded	-	-	-	-	-	-	-	-	-	-	-	-	-
Capital Other	(5)	(450)	(30)	-	-	(703)	-	-	(865)	-	(500)	-	(500)
PDC	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL PAYMENTS	**(2,819)**	**(2,069)**	**(4,722)**	**(11,922)**	**(10,401)**	**(3,481)**	**(5,371)**	**(9,370)**	**(12,479)**	**(2,360)**	**(2,607)**	**(4,516)**	**(10,721)**
NET PAYMENTS / RECEIPTS	**(1,016)**	**(1,074)**	**20,088**	**(11,125)**	**(9,861)**	**1,653**	**19,720**	**(9,330)**	**(12,349)**	**(2,190)**	**(2,562)**	**21,020**	**(10,591)**
Bank balance c/f	**47,355**	**46,281**	**66,369**	**55,245**	**45,384**	**47,037**	**66,757**	**57,427**	**45,078**	**42,888**	**40,326**	**61,346**	**50,755**

Statement of Financial Position as of 31st May 2022

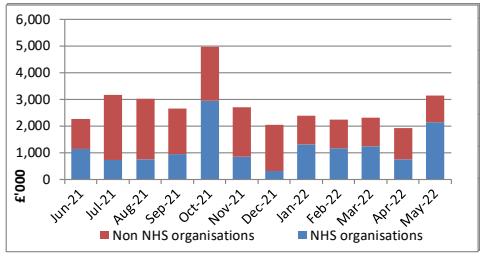
	Audited Mar-22	May-22 YTD Actual	YTD Mvmt	% Variance
Assets Non-Current				
Tangible Assets	189.6	184.8	(4.8)	(2.5%)
Intangible Assets	22.3	21.9	(0.4)	(1.8%)
ROU Assets	0.0	13.3	13.3	100.0%
Other Assets	1.0	1.1	0.1	6.8%
Total Non Current Assets	**212.9**	**221.1**	**8.2**	**3.8%**
Assets Current				
Inventory	4.1	4.1	0.0	0.0%
NHS Receivables	3.5	4.7	1.2	34.3%
Other Receivables	7.2	7.3	0.1	1.4%
Cash	58.0	46.8	(11.2)	(19.3%)
Total Current Assets	**72.8**	**62.9**	**(9.9)**	**(13.6%)**
Liabilities Current				
Interest -bearing borrowings	(0.2)	(1.8)	(1.6)	800.0%
Deferred Income	(19.4)	(24.1)	(4.7)	24.2%
Provisions	(2.4)	(2.4)	0.0	0.0%
Trade & other Creditors (incl NHS)	(60.4)	(50.6)	9.8	(16.2%)
Total Current Liabilities	**(82.4)**	**(78.9)**	**3.5**	**(4.2%)**
Net current assets	**(9.6)**	**(16.0)**	**(6.4)**	**66.7%**
Liabilities Non-Current				
Long-term Interest bearing borrowings	(5.4)	(17.1)	(11.7)	216.7%
Deferred Income	(1.5)	0.0	1.5	(100.0%)
Provisions for liabilities and charges	(1.8)	(1.8)	0.0	0.0%
Total non-current liabilities	**(8.7)**	**(18.9)**	**(10.2)**	**117.2%**
Total Assets Employed	**194.6**	**186.2**	**(8.4)**	**(4.3%)**
Taxpayers Equity				
Public Dividend Capital (PDC)	275.1	275.1	0.0	0.0%
Revaluation Reserve	52.6	48.7	(3.9)	(7.4%)
Financial assets at FV through OCI reserve	(2.3)	(2.3)	0.0	0.0%
I&E Reserve	(130.8)	(135.3)	(4.5)	3.4%
Total Taxpayers Equity	**194.6**	**186.2**	**(8.4)**	**(4.3%)**

Debtor Analysis as of 31st May 2022

Top ten debtors £'000	Total	0 - 30	31 - 60	61 - 90	91 - 120	121+
HEALTH EDUCATION ENGLAND	1,541	1,541	0	0	0	0
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	168	168	0	0	0	0
BEDFORD BOROUGH COUNCIL	142	8	0	0	0	134
NHS ENGLAND	136	0	0	136	0	0
OXFORD HEALTH NHS FOUNDATION TRUST	102	8	0	0	0	94
NHS PROPERTY SERVICES LTD	99	93	0	0	0	6
UNIVERSITY OF BUCKINGHAM	97	17	0	0	0	80
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FT	95	56	4	9	4	22
NORTH NORTHAMPTONSHIRE COUNCIL	89	89	0	0	0	0
NORTHAMPTONSHIRE COUNTY COUNCIL	88	0	0	0	0	88
OTHER	578	-59	206	41	65	325
Total	**3,135**	**1,921**	**210**	**186**	**69**	**749**

Debtors by category £'000	Total	0 - 30	31 - 60	61 - 90	91 - 120	121+
NHS CLINICAL COM GROUPS	-97	-97	0	0	0	0
NHS COM BOARD COM SUPPORT UNIT	136	0	0	136	0	0
NHS DH SPECIAL HEALTH AUTH	1,541	1,541	0	0	0	0
NHS ENGLISH TRUSTS	136	64	46	2	9	15
NHS FOUNDATION TRUSTS	417	281	8	9	4	115
NON NHS COMPANY	41	-84	50	3	51	21
NON NHS DH PUB CORP TRADE FNDS	98	93	0	0	0	5
NON NHS HEALTH BODIES	85	43	1	25	2	14
NON NHS INDIVIDUAL	112	5	2	5	2	98
NON NHS INSURANCE COMPANIES	59	20	27	1	0	11
NON NHS LOCAL AUTHORITIES	12	0	0	0	0	12
NON NHS OVERSEAS VISITORS	135	13	1	0	1	120
NON NHS PRIVATE PATIENT	2	1	0	0	0	1
NON NHS PUBLIC BODIES	455	41	75	5	0	334
STAFF	3	0	0	0	0	3
Total	**3,135**	**1,921**	**210**	**186**	**69**	**749**

Debtors by type £'000	Total	0 - 30	31 - 60	61 - 90	91 - 120	121+
NHS organisations	2,133	1,789	54	147	13	130
Non NHS organisations	1,002	132	156	39	56	619
Total	**3,135**	**1,921**	**210**	**186**	**69**	**749**



Debtors' comments

The debtor's position as of 31st Mayl'22 stands at £3.1m, which is an increase of £1.2m from the April'22 position relating to 22/23 Q1 education contract recharge to Health Education England.

- Health Education England has just 1 outstanding invoice relating to 22/23 Q1 education contract recharge of which is under 30 days of ageing. Full payment has been receipted in Jun'22.
- Bedfordshire Hospitals NHS Foundation Trust has 4 pending invoices relating to salary recharges. With debt tallying £168k under 30 days of ageing. All debt is being actively chased for Jun'22 payment.
- Bedfordshire Borough Council has 21 overdue invoices all relating to Sexual Health cross recharges which are currently under dispute and monitored by the Divisional Business partner
- NHS England has 2 overdue invoices relating to salary, training, and Diabetic retinopathy recharges. All debt is being actively chased for Jun'22 payment.
- Oxford Health NHS Foundation Trust has 5 pending invoices mainly relating to rates recharges of which are under review and actively being chased for Jun'22 payment. Receipts of £15k have been recorded in Jun'22 to date.
- NHS Property Services has just 12 overdue invoices relating to utility recharges. Debt totalling £93k is under 30 days of ageing and being actively chased. Receipts of £85k have been recorded in Jun'22 to date.
- University of Buckingham has 4 overdue invoices including 20/21 Q4 salary recharges which is currently under review by the Deputy director of Finance and the Finance Business Partner (£0.1m). All debt is being actively chased for Jun'22 settlement.
- University Hospitals Southampton NHS FT has 7 overdue invoices relating to salary recharges. Debt totalling £56k is under 30 days of ageing. All debt is being actively chased for Jun'22 payment.
- North Northamptonshire County Council has 9 pending invoices. All debt being under 30 days of ageing and relating to Sexual Health recharges which have been created to replace recharge invoices which were created to Northamptonshire County Council in error.
- Northamptonshire County Council has 10 overdue invoices all relating to Sexual Health cross recharges which are currently under dispute and monitored by the Divisional Business partner. All invoices to be cancelled in Jun'22 as raised to wrong debtor and to be reraised to correct debtor.
- A schedule of large invoices over £5k and over 60 days old is shown in **Appendix 11**

Appendix 11

Debtor Invoices >60 days old and >£5,000 in value as of 31st May 2022

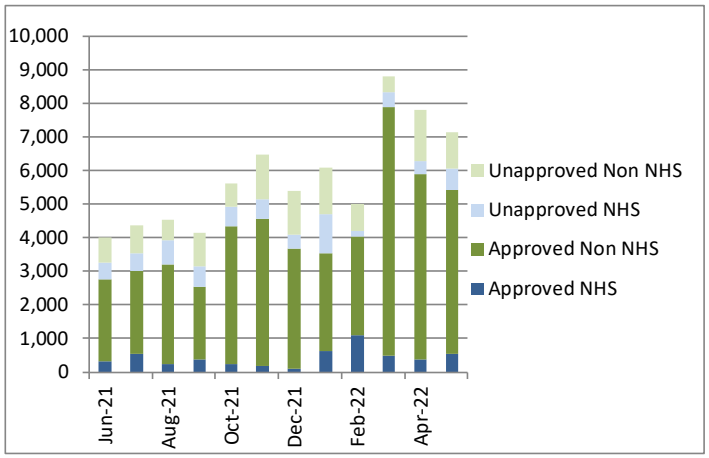
	Debtor	Total Amt over 60 days+	No. of Invoices	Date of Invoices	Total Amt over 90 days+	Status
1	NHS ENGLAND	£136K	1	Jan'22		Maternity Services Recharges. All invoices being actively chased for June'21 payment.
2	BEDFORD BOROUGH COUNCIL	£111K	9	Sept'18 - Feb'21	£111K	Sexual Health recharge currently under query and being actively reviewed by Senior Business Partner - Medicine.
3	OXFORD HEALTH NHS FT	£93K	4	Apr'19 - Nov'21	£93K	Non Domestic rates recharges. Invoice being actively chased for June'22 payment.
4	NORTHAMPTONSHIRE COUNTY COUNCIL	£91K	10	Feb'18 -May'20	£91K	Sexual Health recharge currently under query and being actively reviewed by Senior Business Partner - Medicine.
5	UNIVERSITY OF BUCKINGHAM	£80K	1	Nov'20	£80K	Medical placement recharges currently under query re pending £20K CMR and under review with the Deputy Director of Finance. All actively being chased for June'22 payment.
6	OXFORD UNIVERSITY	£36K	2	Jan'22 - Mar'22		Salary Recharge. Actively being chased for June'22 payment.
7	PP OVERSEAS PATIENT (COVERING 4 INVOICES)	£28K	4	Dec'18 - Oct'21	£28K	Invoice currently under dispute with Patients. All details have been logged with the Home Office/UK Borders.
8	MILTON KEYNES CORONER	£26K	3	Jul'21 - Dec'21	£26K	Mortuary Fee recharges. Actively being chased for June'22 payment.
9	MEDICAL PROPERTY MANAGEMENT LTD	£25K	2	Jan'22		Utilities recharges. Invoice being actively chased for June'22 payment.
10	WHADDON MEDICAL CENTRE	£24K	1	Mar'22		Salary Recharge. Actively being chased for June'22 payment.
11	UNIVERSITY HOSPITAL SOUTHAMPTON NHS FT	£22K	1	Dec'21	£22K	Salary Recharge. Actively being chased for June'22 payment.
12	SALARY OVERPAYMENTS (COVERING 1 INVOICES)	£15K	1	Oct'17	£15K	Invoices under review/investigation with pending propossed legal action and actively chased.
13	CENTRAL BEDFORDSHIRE COUNCIL	£8K	1	Jul'17	£8K	Sexual Health recharge currently under query and being actively reviewed by Senior Business Partner - Medicine.
14	WEST NORTHAMPTONSHIRE COUNCIL	£5K	1	Feb'22		Psathology Recharge. Actively being chased for June'22 payment.
Total		**£700K**	**40**		**£474K**	
	Invoices cleared from Apr'22					
1	MEDICAL PROPERTY MANAGEMENT LTD	£22K	2	Oct'21	£22K	CMR created May'22
2	MILTON KEYNES CORONER	£9K	1	Oct'21	£9K	Paid in full May'22
Total		**£31K**	**3**		**£31K**	
	All other debt over 60 days less than £5K	**£414K**	**402**		**£394K**	**All debt actively reviewed and chased.**

Creditors Analysis
as of 31st May 2022

Approved (£'000)	Total	0 - 30	31 - 60	61 - 90	90+
NHS Organisations	529	368	128	7	26
Non NHS Orgs	4,891	1,311	2,703	479	398
Total	**5,420**	**1,679**	**2,831**	**486**	**424**

Unapproved (£'000)	Total	0 - 30	31 - 60	61 - 90	90+
NHS Organisations	649	138	206	283	22
Non NHS Orgs	1,077	614	388	31	44
Total	**1,726**	**752**	**594**	**314**	**66**

Total Creditors (£'000)	Total	0 - 30	31 - 60	61 - 90	90+
Total	**7,146**	**2,431**	**3,425**	**800**	**490**



Approved NHS (£'000)	Total	0 - 30	31 - 60	61 - 90	90+
ST HELENS & KNOWSLEY HOSPITALS NHS TRUST	190	105	97	(12)	0
NHS TRUST DEVELOPMENT AUTHORITY	93	72	0	0	21
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	90	90	0	0	0
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	60	59	0	0	1
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	37	1	18	18	0
NHS BLOOD & TRANSPLANT	22	21	1	0	0
FRIMLEY PARK HOSPITAL NHS FOUNDATION TRUST	7	7	0	0	0
NHS PROPERTY SERVICES LTD	6	0	6	0	0
OXFORD HEALTH NHS FOUNDATION TRUST	4	4	0	0	0
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRU ST	3	0	0	0	3
Others	17	9	6	1	1
Total	**529**	**368**	**128**	**7**	**26**

Approved Non NHS (£'000)	Total	0 - 30	31 - 60	61 - 90	90+
GE MEDICAL SYSTEMS LTD	961	0	956	0	5
WORKMAN LLP	353	0	181	0	172
PI GROUP	338	(16)	354	0	0
BCM CONSTRUCTION LTD	281	0	77	204	0
INTEGRATED DERMATOLOGY LTD	250	250	0	0	0
OLYMPUS KEYMED	247	0	247	0	0
RAMSAY HEALTH CARE UK	244	80	100	0	64
ULTIMA BUSINESS SOLUTIONS LTD	132	0	132	0	0
CHANNEL 6 (EUROPE) LTD	112	0	41	68	3
SIEMENS FINANCIAL SERVICES LTD	89	0	89	0	0
Others	1,884	997	526	207	154
Total	**4,891**	**1,311**	**2,703**	**479**	**398**

- Approved creditors are awaiting payment, whereas unapproved creditors have not been validated or approved by the organisation.

Appendix 13

Finance Risk Register
For the period ending 31st May 2022

Reference	Created on	Description	Impact of risk	Risk response	Scope	Last review	Next review	Status	Original score	Current score	Target score	Controls implemented	Risk appetite	Risk response	Change from previous Mth
RSK-134	04-Nov-2021	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability THEN there may be an increase in operational expenditure in order to manage COVID-19	LEADING TO potential for material increase in efficiency requirement from NHS funding regime to support DHSC budget affordability.	Treat	Organisation	20-Jun-22	13-Jul-22	Planned	20	16	8	Budgets have been reset for 22/23 based on current financial regime; financial controls and oversight have been reintroduced to manage financial performance, Cost efficiency programme has been reset to target focus on areas of greatest opportunity to delivery. The trust will work with BLMK system partners during the year to review overall BLMK performance	High	Tolerate	No change
RSK-202	23-Nov-2021	IF Transformation delivery is not adequately resourced and prioritised and/or schemes are unrealistic and not well planned THEN There is a risk that the Trust is unable to achieve the required efficiency improvements through the transformation programme leading to an overspend against plan	LEADING TO the Trust potentially not delivering its financial targets leading to potential cash shortfall and non-delivery of its key targets	Treat	Organisation	20-Jun-22	13-Jul-22	Planned	20	16	9	Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partners, Cross-cutting transformation schemes are being worked up, Savings plan for 22/23 financial year not yet fully identified.	Medium	Tolerate	No change
RSK-305	06-Dec-2021	If there is insufficient 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	Treat	Organisation	20-Jun-22	13-Jul-22	Planned	16	12	9	Trust is discussing this with the regional Capital Team	Medium	Treat	No change
RSK-355	***21-Jun-22***	***IF Sensyme Health's financial and management ownership changes Then there is a risk that Sensyne Health ceases to be a going concern***	***LEADING TO financial loss and reputational damage***	***Tolerate***	***Organisation***	***21-Jun-22***	***13-Jul-22***	***Planned***	***16***	***12***	***4***	***The Trust is collaborating with other NHS shareholders (with the support of expert advisors/Sensyne Health Board observer) to leverage influence with Sensyne Health and protect NHS shareholder interests. The Trust is taking legal advise on the implications***	***Low***	***Treat***	***New Risk***

Finance Risk Register
For the period ending 31st May 2022

Reference	Created on	Description	Impact of risk	Risk response	Scope	Last review	Next review	Status	Original score	Current score	Target score	Controls implemented	Risk appetite	Risk response	Change from previous Mth
RSK-206	23-Nov-2021	IF the Trust is unable to recruit staff of the appropriate skills and experience; there continues to be unplanned escalation facilities; There are higher than expected levels of enhanced observation nursing; and there is poor planning for peak periods / inadequate rostering for annual/other leave. THEN the Trust may be unable to keep to affordable levels of agency and locum staffing	LEADING TO Adverse financial effect of using more expensive agency staff and potential quality impact of using temporary staff	Tolerate	Organisation	20-Jun-22	13-Jul-22	Planned	16	9	9	Weekly vacancy control panel review agency requests(23-Nov-2021),Control of staffing costs identified as a key transformation work stream(23-Nov-2021),Capacity planning(23-Nov-2021),Robust rostering and leave planning(23-Nov-2021),Escalation policy in place to sign-off breach of agency rates(23-Nov-2021),Fort-nightly executive led agency reduction group meeting with aim of delivering reduction in both quantity and cost of agency used(23-Nov-2021),Agency cap breaches are reported to Divisions and the FIC(23-Nov-2021),Divisional understanding of how to reduce spend on temporary staffing to be developed(23-Nov-2021)	Medium	Tolerate	No change
RSK-200	23-Nov-2021	IF the Trust is unable to successfully tender for external audit services in 2022 THEN financial audits and other required annual assurance exercises will not take place	LEADING TO the Trust failing in its statutory obligations.	Treat	Organisation	20-Jun-22	13-Jul-22	Planned	20	9	8	There are on-going discussions with another providers following the lack of tenders received during March 2022	Medium	Tolerate	No change
RSK-203	23-Nov-2021	IF the are negative impacts following new legislation following Brexit, COVID-19 pandemic and supplier bankruptcy THEN there is a risk that the supply of key clinical products may be disrupted	LEADING TO some deliveries and services may be delayed, disrupted or reduce resulting in impact on patient care	Tolerate	Organisation	20-Jun-22	13-Jul-22	Planned	16	6	6	Trust's top suppliers have been reviewed and issues with supply under constant review(23-Nov-2021),Procurement business partners use the NHS Spend Comparison Site and local knowledge supported by the clinical procurement nurse to source alternative products(23-Nov-2021)	Medium	Tolerate	No change
RSK-204	23-Nov-2021	IF data sent to external agencies (such as NHS Digital, Advise Inc and tenders) from the Procurement ordering system contain patient details THEN there is a risk that a data breach may occur with reference to GDPR and Data Protection Act as the procurement department deals with large volumes of data.	LEADING TO a data breach and potential significant fine	Tolerate	Organisation	20-Jun-22	13-Jul-22	Planned	16	6	6	All staff attend an annual mandatory training course on Information Governance(23-Nov-2021),Staff are encouraged to use catalogues which reduces the requirements for free text(23-Nov-2021),Data sent out to external agencies is checked for any patient details before submitting(23-Nov-2021)	Medium	Tolerate	No change

Finance Risk Register
For the period ending 31st May 2022

Reference	Created on	Description	Impact of risk	Risk response	Scope	Last review	Next review	Status	Original score	Current score	Target score	Controls implemented	Risk appetite	Risk response	Change from previous Mth
RSK-205	23-Nov-2021	IF there is Incorrect processing through human error or system errors on the Procurement systems THEN there is risk that there may be issues with data quality within the procurement systems	LEADING TO Incorrect ordering resulting in a lack of stock and impacting on patient safety	Tolerate	Organisation	20-Jun-22	13-Jul-22	Planned	12	6	6	Monthly reviews on data quality and corrections(23-Nov-2021),Mechanisms are in place to learn and change processes(23-Nov-2021),Data validation activities occur on monthly basis(23-Nov-2021),A desire to put qualifying suppliers in catalogue(23-Nov-2021)	Medium	Tolerate	No change
RSK-207	23-Nov-2021	IF there is major IT failure internally or from external providers THEN there is a risk that key Finance and Procurement systems are unavailable	LEADING TO 1. No Purchase to pay functions available ie no electronic requisitions, ordering, receipting or payment of invoices creating delays for delivery of goods. 2. No electronic tenders being issued. 3. No electronic raising of orders or receipting of income	Tolerate	Organisation	20-Jun-22	13-Jul-22	Planned	12	6	6	If its an external issue, SBS the service provider of the purchase to pay and order and invoicing has a business continuity plan in place(23-Nov-2021),If its an internal issue. The Trust has arrangements with the CCG who also use SBS to use their SBS platform(23-Nov-2021)	Medium	Tolerate	No change
RSK-209	23-Nov-2021	IF staff members falsely represent themselves, abuse their position, or fail to disclosure information for personal gain THEN the Trust/Service Users/Stakeholders may be defrauded	LEADING TO financial loss and reputational damage	Tolerate	Organisation	20-Jun-22	13-Jul-22	Planned	12	6	6	Anti-Fraud and Anti-Bribery Policy(23-Nov-2021),Standards of Business Conduct Policy including Q&A section(23-Nov-2021),Standing Orders(23-Nov-2021),Local Counter Fraud Specialist in place and delivery of an annual plan(23-Nov-2021),Proactive reviews also undertaken by Internal Audit(23-Nov-2021),Register of Gifts and Hospitality(23-Nov-2021),Register of Declarations(23-Nov-2021)	Medium	Tolerate	No change
In month closed risks															
RSK-201	23-Nov-2021	IF there is lack of control over the expenditure position due to COVID and uncertainty about the future financial funding regime, THEN the Trust may have insufficient cash to meet its financial obligations	LEADING TO Low / negative cash balances and interruptions to supplier payments	Tolerate	Organisation	20-Jun-22	13-Jul-22	Planned	20	9	9	Monthly cash flow forecasting is undertaken to establish at which point the Trust balances become close to £1m (historically the value advised by NHSEI to be held)(23-Nov-2021)	Medium	Tolerate	No change

GLOSSARY OF TERMS

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

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Trust Board**	**Date: 7th July 2022**
Report title:	**Financial Plan 2022/23**	**Agenda item: 18**
Lead director **Report author** **Sponsor(s)**	**Name: Terry Whittle** **Name: Terry Whittle**	**Title: Director of Finance** **Title: Director of Finance**
FoI status:	**Public**	

Report summary	The Trust submitted a revised financial plan for FY23 following the release of additional funding from NHS England. This paper outlines the key components of the income and expenditure plan (break-even performance) and capital expenditure plan (£18.3m).			
Purpose *(tick one box only)*	**Information** ☐	**Approval** [x]	**To note** ☐	**Decision** ☐
Recommendation	To formally approve the FY23 financial plan			

Strategic objectives links	5. Developing a Sustainable Future 7. Become Well Governed and Financially Viable 9. Make Best Use of the Estate
Board Assurance Framework links	N/A
CQC outcome/ regulation links	Outcome 26 Financial Position
Identified risks and risk management actions	No risks and issues identified
Resource implications	No resource implications.
Legal implications including equality and diversity assessment	The paper has been assessed to ensure it meets the general equality duty as laid down by the Equality Act 2010.

Report history	Earlier financial plan drafts have been discussed with Finance and Investment Committee and Trust Board (private session).
Next steps	None
Appendices	None

TheMKWay
CARE. COMMUNICATE.
COLLABORATE. CONTRIBUTE.

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Financial Plan
2022/23

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

1. Background

- On 28th April 2022 MKUH submitted a £8.8m deficit finance plan for FY23. This position was consolidated with other local system partners as part of a £40.5m BLMK ICS deficit. The deficit components for MKUH were:
  - Higher prevalence of COVID during April and May (£2.2m); and
  - Increased level of inflationary pressures (£6.6m)

- The overall BLMK ICS position was:

Organisation	£m	Deficit % OpEx
Bedfordshire Hospitals FT	(15.2)	2.2%
Milton Keynes Hospital FT	(8.8)	2.7%
BLMK ICB (from 1 July)	(16.5)	-
BLMK ICS	(40.5)	-

- The BLMK ICS position was in-line with most other system submissions within the East of England region. A regional summary is shown in appendix 1.

- The 28th April submission was intended to be the final NHS plan and conform with the breakeven requirement set-out by national guidance. It was understood the consolidated NHS plan was a significant deficit. NHSE convened a webinar on 18th May for the finance leadership community where next steps were announced.

2. NHSE next steps (1/2)

Milton Keynes University Hospital NHS Foundation Trust

- The CFO of NHSE announced the release of an additional £1.5 billion funding to support NHS cost pressures. The funding provided was apportioned to the following categories:

Elements	1. General inflation	2. Ambulances	3. Other pressures	4. Specific pressures
Purpose	Fund equivalent of 0.7% increase in tariff CUF, based on changing GDP deflator element from 2.7% to 5.3%	Fund additional inflation and service pressures. Including call handlers (was SDF)	Fund other pressures especially those falling to commissioner side	Target specific issues not otherwise resolved
Other detail	Consider flow to all providers using tariff or where CUF is taken into account including acute, community, mental health, ambulance. Including inter-system flows and non-NHS providers.	Allocation to all ICBs, with schedule of expected flow, regional assurance to allow for differential approaches in current plans	Including care market / CHC price increases, 22/23 Funded Nursing Care rate, Better Care Fund, Ukraine resettlement	
Allocation basis	Fair share based on ICB 22/23 allocation Proportionate funding for SC and DC commissioners	Fair share based on ICB 22/23 allocation	Fair share based on ICB 22/23 allocation	Regional recommendations
Total	**£680m**	**£150m**	**£345m**	**£400m**
Of which ICBs	*£549m*	*£150m*	*£345m*	*£400m*
Of which DC	*£131m*	*N/A*	*N/A*	*N/A*
Recurrence	Recurrent			Non-recurrent
MHIS	ICB Mental Health Investment Standard requirements will be increased by 0.91%			No MHIS increase
Expectations	Residual financial gap will need to be closed by further action by system Funding will be released in full where this can be demonstrated			

2. NHSE next steps (2/2)

Milton Keynes University Hospital NHS Foundation Trust

- A letter was issued to ICB Accountable Officers on 20th May setting out conditions associated with receipt of additional funding. These are shown below:

To help keep the NHS within its spending limits for the year we are asking all systems to:

- Reflect new IPC recommendations in plans
- Evidence the key lines of enquiry we have produced for plans
- Make sure that efficiency schemes deliver recurrently from quarter 3 to compensate for any non-recurrent measures this year
- Engage in national pay and non-pay savings initiatives which we plan to launch in the coming months
- Re-establish agency controls – capped rates, use of framework providers only and a ceiling on agency costs.
- Follow a similar set of conditions in relation to premium bank staffing costs
- Seek approval from NHSE/I for consultancy above £50,000 and non-clinical agency

In addition by 31 August 2022:

- Internal audit to review processes and procedures for financial control
- Systematically review excess Inflation figures in plans

There will also be further measures for systems still not able to balance with additional funding, including around capital approvals

3. BLMK ICS additional funding

Milton Keynes University Hospital NHS Foundation Trust

- The BLMK ICS share of the additional £1.5 billion national funding is £20.4m *(note - £40.5m consolidated system deficit)*.

	1	2	3			
	General inflation	Ambulance	Other pressures	Total new recurrent funding (rounded)	Additional non recurrent funding	Total per system
System Name	£m	£m	£m	£m	£m	£m
NHS Bedfordshire, Luton and Milton Keynes ICB	8.6	2.4	5.4	16.41	4.02	20.43

- The distribution of funding is largely nationally prescribed. MKUH (providers) will receive a share of the general inflation (pot 1) and non-recurrent funding. Final values have been agreed and **£3.1m of additional funding has been allocated to MKUH overall is as follows** *(note - £8.8m deficit plan).*

	£m	
Uplift to tariff (0.7%)		
- BLMK	1.5	Main block contract with ICB
- other contracts	0.3	Spec Comm, Bucks and Nene
Non-recurrent funding	1.3	MKUH share of £4m (split with BHFT)
Total new funding	**3.1**	

4 . Financial plan summary (1/3)

Milton Keynes University Hospital NHS Foundation Trust

Statement of Comprehensive Income	£'000
Operating income from patient care activities	309,808
Other operating income	22,359
Employee expenses	(208,207)
Operating expenses excluding employee expenses	(113,585)
OPERATING SURPLUS/(DEFICIT)	10,375
FINANCE COSTS	
Finance income	0
Finance expense	(336)
PDC dividends payable/refundable	(5,431)
NET FINANCE COSTS	(5,767)
Other gains/(losses) including disposal of assets	0
Share of profit/(loss) of associates/joint ventures	0
Gains/(losses) from transfers by absorption	0
Movements in fair value of investments, investment property and financial liabilities	0
Corporation tax expense	0
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	4,608

Adjusted financial performance (Control Total basis)	
Surplus/(deficit) for the period/year	4,608
Add back all I&E impairments/(reversals)	0
Adjust (gains)/losses on transfers by absorption	0
Surplus/(deficit) before impairments and transfers	4,608
Retain impact of DEL I&E (impairments)/reversals	0
Remove capital donations/grants/peppercorn lease I&E impact	(4,608)
Prior period adjustments to correct errors and other performance adjustments	0
IAS19 - removal of Non cash Pensions on SOFP	0
Remove impact of prior year PSF post accounts reallocation	0
System envelope planning adjustment	0
Adjusted financial performance surplus/(deficit)	0

4. Financial plan summary (2/3)

Milton Keynes University Hospital NHS Foundation Trust

Key assumptions for the revised Statement of Comprehensive Income include:

- £3.1m of additional funding provided by NHS England
- £2.0m improvement due to a reduction in costs associated with Covid and inflationary pressures during the financial year
- £3.7m of non-recurrent mitigation

The Trust has identified the following items as key risks to plan achievement, some of which are beyond our direct control:

- Stabilisation of non-elective service demand to enable recovery of elective care services and qualification of associated Elective Recovery Funding (£7.4m included within the baseline plan), or;

- Provision of relief on unearned (planned) ERF due to operational pressures (e.g., ↑ Covid prevalence);

- Management of inflationary cost pressures (e.g., energy costs) to levels identified during the planning process.

- Continued workforce availability (at levels planned) to enable recovery of elective service backlogs

The Trust notes the value of non-recurrent funding and mitigations included and the impact of these items on the delivery of a balanced financial plan beyond the current year.

4. Financial plan summary (3/3)

Milton Keynes University Hospital NHS Foundation Trust

Capital expenditure programme FY23

	ICS Approved CDEL Allocation 2022/23	National CDEL Allocation 2022/23		
Scheme Subcategory	Internally Funded	Planned	Approved	Awaiting Approval
	£m	£m	£m	£m
Depreciation	15.04			
Self Funded	0.86			
PDC Funded				
New Hospital Programme		1.94	1.06	0.88
Endoscopy		0.14	0.14	
New Lease impact (IFRS16)		0.31		0.31
Sub Total CDEL	**15.90**	**2.38**	**1.20**	**1.19**
CDEL Allocation Approved	**17.10**			**1.19**
Total Planned CDEL	**18.28**			

Other funding - Still to be determined and held at ICB level

IT	Total for ICB £m
Levelling up digital Maturity	1.71
Critical Cybersecurity infrastructure	0.11
Total	**1.82**

The Trust has submitted a capital expenditure plan of £18.3m. This includes schemes with approved funding sources of £17.1m (>90%). A total of £15.9m qualifies under Integrated Care System capital expenditure limits, with the remaining £2.4m forming part of a national allocation.

In addition to planned capital expenditure, a further £1.8m of funding has been provided to BLMK ICS. The Trust will liaise with system partners to determine an allocation of funds for digital maturity and cyber security investments.

Meeting title	Trust Board	Date 7 July 2022
Report title:	Trust wide Report – Annual Claims Report	Agenda item: 19
Lead directors **Report author Sponsor(s)**	Ian Reckless Kate Jarman Tina Worth	Medical Director Director of Corporate Affairs Head of Risk and Clinical Governance
FoI status:	Public document	

Report summary	This report provides a quarterly overview of Risk Management processes/systems in relation to serious incidents. It also discusses Preventing Future Death (PFD) reports from HM Coroner to the Trust.			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** [x]	**Decision** ☐
Recommendation	The Committee is asked to note the contents of the report			

Strategic objectives links	Refer to main objective and link to others 1. Improve Patient Safety 3. Improve Clinical Effectiveness 4. Deliver Key Targets 7. Become Well-Governed and Financially Viable
Board Assurance Framework links	Lack of learning from incidents is a key risk identified on the BAF
CQC outcome/ regulation links	This report relates to CQC: Regulation 12 – Safe care & treatment Regulation 17 – Good governance Regulation 20 – Duty of Candour
Identified risks and risk management actions	Lack of learning from incidents is a key risk identified on the BAF
Resource implications	Litigation costs in relation to defence and claimant and damages paid
Legal implications including equality and diversity assessment	Contractual and regulatory reporting requirements.

Report history	1. Monthly reports to SIRG (Thursdays) 2. Quality and Clinical Risk Committee (June 2022)
Next steps	Benchmarking review from data from NHS Resolution
Appendices	Appendix 1 – NHSR claims abbreviated dashboard Appendix 2 – all opened claims 2021 – 2022 Appendix 3 – all closed claims 2021 – 2022 **NB: All embedded and can be provided on request**

Executive summary

The Trust works in collaboration with NNS resolution (NHSR) and Capsticks in the management of its clinical negligence claims. The majority of claims nationally received by NHSR are resolved without formal court proceedings and, in these early stages, more claims are resolved without payment of damages than with payment of damages. The overall cost of clinical negligence in England rose from £582 million in 2006 to 2007 to £2.2 billion in 2020 to 2021, representing a significant burden on the NHS. For all claims, legal costs have increased more than fourfold to £433 million since 2006 to 2007. Therefore, the Getting It Right First Time (GIRFT) programme and NHS Resolution have worked together to produce Learning from Litigation Claims, offering trust clinicians, managers and legal teams a practical and structured approach to claims learning, and sharing examples of best practice from across England. The aim is to maximise what can be learned from litigation, for the benefit of patients and to curb escalating costs. Claims for clinical negligence are a valuable source of learning and an opportunity for improvement which should not be lost.

The new guidance provides a framework to deliver this, suggesting measures such as:

- Appointing dedicated clinical staff to assist trust legal teams, with sessions incorporated into job plans;

- Enabling regular discussion of claims with clinicians in forums such as clinical governance or multidisciplinary meetings;

- Making clinicians more aware of the claims process and ensuring legal teams are more visible to clinical staff at all times;

- Ensuring clinical staff are aware when a claim has been initiated and are fully supported through the process;

- Working in partnership with patients, families and carers, and involving them in investigations, to ensure openness.

This report will detail claims information taken from the NHSR dashboard and the Trust's Radar system and will include:

- Number of clinical negligence claims opened
- Number of clinical negligence claims closed
- Brief analysis

Opened Clinical negligence claims

There were 103 opened claims 2021 – 2022 broken down as follows:

- Medicine – 14
- Emergency Medicine – 12
- Surgery (including anaesthetics) - 25
- Women's Health – 36
- Paediatrics - 1
- Therapies – 1
- Musculoskeletal - 14

This is a significant increase from the previous year when only 77 were reported which may be linked on Covid-19, as we come out of the pandemic.

Women's Health was the highest received specialty which is replicable to the national picture with 5 of these linked to the Early Notification Scheme. This relates to all babies born at term (≥37 completed weeks of gestation), following labour, that had a potentially severe brain injury diagnosed in the first seven days of life, and are any babies that fall into the categories:

- Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) or
- Was therapeutically cooled (active cooling only) or
- Had decreased central tone AND was comatose AND had seizures of any kind

Early notification occurs immediately after such births and allows NHSR to provide support to trusts and families and begin their own investigations at a much earlier stage. The scheme is already reducing the time between incident and resolution, with an associated reduction in costs and by being open about incidents, and candid with families it is hoped that this will help to break down any perception of defensiveness on the part of the NHS and ultimately that litigation should not be seen as a barrier to safety. By investigating these incidents early, it enables timely identification of those babies who have suffered injury as a result of care that does not meet the expected standard, and in appropriate cases the provision of a written apology, financial support and practical advice on how to access support in caring for their child in addition to providing support for the staff involved.

A detailed report is presented at the Trust's Serious Incident Review Group (SIRG) each month based on opened/closed claims from the preceding month and cross references any related complaints, incidents, inquests or serious incidents. The Divisions/specialties are also notified by the Litigation office of all new claims (once letter of claim/details of claim received) to facilitate the collation of supporting information and any learning previously noted at governance or Mortality and Morbidity (M&M) meetings which may help in supporting the Trust's liability, enable ongoing learning and identify and trends.

Clinical negligence claims closed

There were 159 claims closed 2021- 20202 broken down as follows:

- Medicine – 18
- Emergency Medicine -25
- Surgery (including anaesthesia/Intensive Care) – 36
- Women's Health – 49
- Musculoskeletal – 23
- Paediatrics – 2
- Other unknown - 6

This is comparable with the preceding year. Of these, 21 were abandoned due to inactivity or at claimant's request.

The closed claims sit across two system (Datix and Radar) with the ability to pull detailed reports to include the finances paid out inaccurate for the former. Going forward this will not longer be an issue for next year's annual report, since all of the data will be on Radar.

Of the 32 on Radar, 18 had no incurred costs, with the most paid out in damages for a claim in Medicine (Neurology) relating to an alleged negligent failure to diagnose hydrocephalus on a computerised tomography (CT) scan. It was alleged that had the correct diagnosis been

reached, the patient would have undergone urgent brain surgery and avoided permanent neurological injury. Following his neurological injury, the patient was in a low awareness state and was dependent on others for all aspects of daily living. Breach of duty has been admitted for the failure to report hydrocephalus on the CT scan on 26 June 2016.

Liability is always very much contested however this would be dependent on the available evidence to support a claim hence the importance of clarity in documentation in the medical notes and explicit risk/benefit communications at the time of consent.

A closed claims spreadsheet is shared with the Clinical Service Units (CSUs) each month to support learning and improve proactive if/where appropriate.

Common issues identified in respect of claims and pay outs, for wider learning relate to:

- Failure to inform/consent
- Unnecessary pain
- Treatment delay/failure
- Infection
- Medication errors (Medicine)
- Pressure ulcers (Medicine)

NHSR

NHSR provides trusts with dashboards noting our Trust's position against other similar sized trusts and allocating claims by value/risk:

- High Value = £1m and over, High Volume 3 or more (red)
- High Value= £1m and over, Low Volume< 3 claims (amber)
- Low Value < £1m, High Volume = 3 or more (blue)
- Low Value < £1m, Low Volume < 3 (green)

The latest Trust scorecard published 30/6/21 covers claims received between 1/4/11 – 31/3/2021, with total number of clinical negligence claims received totalling 350 and a total value of £148,711 340. There is however, no supporting narrative to explain and/or triangulate the data.

Appendix 1 provides detailed analysis per specialty including costs, causes, outcomes and trends.

Key points to note include:

- The average time for Gynaecology claims is 0.32 years longer than the average notification window for all claims received by the Trust
- The average time for Surgical claims is 0.78 years shorter than the average notification window for all claims received by the Trust
- 21% of claims volume relate to Obstetrics
- 17% of claims volume relate to Emergency Medicine
- 10% of claims volume relate to Musculoskeletal
- 73% of the value for claims relate to Obstetrics

The red claims as detailed below all relate to maternity care, and all remain ongoing. Obstetrics by nature of the associated risks and potential high costs for brain damaged babies, who may require ongoing high levels of care for life has a tendency to always flag as red both locally & nationally in other trusts.

Cause	Value	Claims
Fail / Delay Treatment	£ 38,686,500	3
Not Specified	£ 50,838,000	4
Application Of Excess Force	£ 2,452,000	2
Fail To Supervise	£ 12,975,000	1
Grand Total	£104,951,500	10

- Brain injury of baby due to hypoxic ischaemia sustained around time of birth - 1
- Delays in acting on abnormal CTG - 1
- Early notification scheme – 5
- Shoulder dystocia at birth - 1
- Delay in delivery causing cerebral palsy – 1
- Level of care given to claimant leading to a fit and also alleged that premature birth of son could have been avoided - 1

Since 2016/2017 the Trust has seen a decrease in the overall number of claims across most clinical specialties, although Musculoskeletal and Emergency Medicine peaked in 2018/2019 before decreasing.

There are 315 blue claims with the top 5 specialties:

- Obstetrics - 65
- Emergency Medicine - 59
- Trauma & Orthopaedics - 34
- Surgery – 76 (including anaesthesia)
- General Medicine – 39

The green claims tend to relate so smaller specialties like Dermatology, Palliative Care and Renal.

Appendix 1 – NHSR dashboard

scorecard%202021%20for%20QCRC.xlsx

Appendix 2 – New clinical negligence claims opened on Datix 2021– 2022

Claims%20opened%202021%20-%202022.x

Appendix 3 – Closed clinical negligence claims 2021 – 2022

Copy%20of%20Clinical%20Negligence%20

Datix%20claims%20closed.xlsx

Meeting title	**Trust Board**	**Date: 07 July 2022**
Report title:	**Medical Revalidation Annual Report**	**Agenda item: 20**
Lead director **Report author** **Sponsor(s)**	**Name: Dr Ian Reckless** **Name: Elisa Cox**	**Title: Medical Director** **Title: Business Manager**
FoI status:	**PUBLIC**	

Report summary	**Overview of Appraisal and Revalidation systems and outcomes for 2021/2022**						
Purpose *(tick one box only)*	**Information**		**Approval**	x	**To note**		**Decision**	
Recommendation	That the approval of the 'statement of compliance' confirming that the organisation, as a designated body, is in compliance with the regulations is endorsed.						

Strategic objectives links	1. Improve Patient Safety 2. Improve Patient Experience 7. Become Well-Governed and Financially Viable 8. Improve Workforce Effectiveness
Board Assurance Framework links	None
CQC regulations	This report relates to: CQC outcome – 12 (Suitability of staffing) CQC outcome – 14 (Supporting workers) NHLSA standard – 1.9 (Governance) NHSLA standard – 5.1 (Supervision of medical staff in training)
Identified risks and risk management actions	None as a result of this report
Resource implications	None as a result of this report
Legal implications including equality and diversity assessment	None as a result of this report

Report history	Annual Report
Next steps	Completion and submission to NHS England of the 'Statement of Compliance' by the Chief Executive on behalf of MKUH as a designated body

Executive summary

In the appraisal year from 01 April 2021 to 31 March 2022 (21/22 appraisal year), Milton Keynes University Hospital has a prescribed connection with 337 Doctors as a Designated Body for the purpose of Medical Revalidation. This number includes: Consultants; Specialty and Associate Specialist (SAS) doctors; Trust Grade doctors; and NHS locums. It excludes leavers during this period, General Dentist Council (GDC) registered dentists, trainee doctors and agency locums.[1]

In the 21/22 appraisal year, the following medical appraisals were completed:

- 315 doctors completed an enhanced appraisal between 01 April 2021 – 31 March 2022.
- 3 doctors had approved reasons for not completing an appraisal (2x maternity leave and 1x appraisal taking place elsewhere)
- 19 doctors completed their appraisal, but the appraisal was completed after 01 April 2022

This represents a 100% completion of appraisals in 21/22.

Purpose of the Paper

The purpose of this paper is to assure the Trust Board that we are discharging our statutory responsibilities in respect of Medical Appraisal and Revalidation for doctors who have a prescribed relationship with Milton Keynes University Hospital as designated body.

Background

Medical Revalidation was launched in 2012 to strengthen the way in which doctors are regulated, with the aims of: improving the quality of care provided to patients; improving patient safety; and, increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations **[References 1&2]** and it is expected that Trust Boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and,
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

[1] GDC registrants (dentists) do not revalidate but are appraised under the same Trust policy and process as their medically registered and licensed colleagues at MKUH. Trainee doctors are appraised by, and connected to, HETV (the Deanery). Agency locums are appraised by, and connected to, their agencies.
To ensure that their appraisal is completed on time for 22/23, their appraisal date has been moved back to their original appraisal due date or as close to this as possible.

We will continue to do this until everyone's appraisal is in line with their original anniversary month. The Medical Director's Office is also ensuring that all appraisals are scheduled between April – January to also ensure all appraisals are completed within the appraisal year.

The purpose of revalidation is to provide assurance to patients and the public, employers and other healthcare professionals that licensed doctors are up-to-date and fit to practise.

In respect to appraisals, doctors are required to maintain a portfolio of supporting information to demonstrate that they continue to meet the attributes set out in the GMC Domains of Good Medical Practice **[Reference 3]** and this portfolio should include clear evidence of:

- Continuing professional development;
- Quality improvement activity;
- Reflection and learning from significant events;
- Feedback from colleagues;
- Feedback from patients; and,
- Review of complaints and compliments.

Governance Arrangements

a. Organisational structure and responsibilities:

Responsible Officer (RO) – Dr Ian Reckless, Medical Director and Consultant Physician (as of 18 April 2016).

The Responsible Officer has executive responsibility for overseeing the appraisal process for all Doctors with a prescribed connection and making revalidation recommendations to the General Medical Council (GMC). Recommendations are based on assessment of annual enhanced appraisal portfolios and any other governance information available to the RO.

Revalidation Support Committee – Chaired by Mr Graham Anderson (Lay Person)

The Revalidation Support Committee is responsible for reviewing all appraisal portfolios due for revalidation, carrying out triangulation checks on GMC and local concerns, complaints and serious incidents. This occurs prior to the RO making a revalidation recommendation.

The committee also supplies feedback to both appraisers and individual doctors on issues relating to quality of appraisal portfolios at revalidation and can request that additional evidence is supplied in the portfolio.

The revalidation support group is formed of 2 lay representatives, appraisers (Consultants) and a representative from the Medical Director's Office. The committee reports to the Responsible Officer and provides an update to Workforce Board.

Trust Appraisal Leads – Dr Clare Woodward, Consultant in HIV/Genitourinary Medicine and Dr Suresh Menon, Consultant Anaesthetist

The Trust Appraisal leads are responsible for the quality improvement of appraisals in respect to inputs and outputs. The leads deliver this through training, recruitment, and review and performance management of Trust appointed appraisers.

Medical Appraisers – Various Consultants and Specialty Doctors

Medical appraisers are responsible for reviewing and advising individual doctors on their appraisal portfolios and assessing whether they have met the GMC Domains of Good Medical Practice **[Reference 2]**, giving their final recommendation to the Responsible Officer and agreeing a personal development plan with the individual.

Appraisers are trained by an externally recognised training provider. Appraisers are expected to do a minimum of 6 appraisals per year to maintain proficiency.

Our current appraisers are all qualified doctors or dentists of varying grades in the employment of Milton Keynes University Hospital, and have attended certified enhanced appraiser training. They also have access to yearly top-up training and quarterly peer support groups.

Risk Management & Patient Experience Departments

Both the Risk and Patient Experience departments supply information to individual doctors on their named involvement in complaints and Serious Incidents Requiring Investigation (SIRIs). This then provides them with a specific source of evidence to reflect upon in their appraisal portfolio.

The Risk and Patient Experience department then provide the Revalidation Support Committee / Medical Director's Office with reports on named involvement in complaints and serious incidents, for triangulation checks at the point of revalidation portfolio review.

Clinical Line Managers

Clinical line managers (CSU Leads, Divisional Directors) are required to provide a reference at appraisal for each of their direct reports. Clinical Managers are also expected to resolve issues that might arise out of appraisal or non-engagement with the appraisal process.

Medical Directors Office (MDO)

The Medical Director's office is responsible for administering:

- The appraisal system;
- The revalidation reschedule and process;
- Tri-angulation checks on concerns, complaints and serious incidents for doctors for revalidation;
- Communications around revalidation deferrals;
- Administering the non-engagement process;
- All reporting functions and progress monitoring; and,
- Communications with staff around appraisal on behalf of the Responsible Officer.

b. Maintaining accurate lists of prescribed relationships

The list of doctors with a prescribed relationship is maintained from:

- A monthly comparison to the ESR payroll list of currently employed doctors and leavers reports.
- All newly employed doctors receive a letter from the RO in their welcome pack and are encouraged to contact the Medical Director's Office to receive 1-2-1 training to get up and running with their appraisals.

c. Progress Monitoring

Monitoring of appraisal and revalidations is carried out through the following:

1. Quarterly Appraisal Rates

Appraisal rates are reported to the Responsible Officer and then through him to the Regional Responsible Officer and is in the format of a Quarterly Appraisal Return as required by the Framework of Quality Assurance for Responsible Officers and Revalidation. This has been paused since 2020 due to the pandemic.

2. Annual Organisational Audit (AOA)

The AOA is a tool to help ROs and Boards assure themselves that the system underpinning the recommendations they make to the GMC on doctors fitness to practice, the arrangements for medical appraisal and responding to concerns are in place. Since 2020, the AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

3. Annual Board Report

An annual report (this document) is reviewed by the Trust Board to assure members of the progress made and asks them to confirm to the Regional RO that we are fulfilling our statutory requirements.

4. Monthly Engagement Checks & Escalation process

The MDO checks the progress of every due appraisal and escalates overdue appraisals to the Responsible Officer.

d. Policy and Guidance

The current policy was reviewed and amended in January 2021.

a. Appraisers

Currently there are 54 Trust appraisers with an average of 6 doctors per appraiser currently assigned. The agreement is that each appraiser must do up to 6 appraisals per annum.

Each appraisal year, we re-recruit appraisers allowing people to continue, drop-out or take up the role. Every year, the Lead Appraisers and MDO write out to all Consultants and SAS doctors for expressions of interest to being an appraiser. The MDO collate the list and go through this with the Lead Appraisers. Training is then organised for those that have expressed an interest and then the list is reassessed to remove those that will no longer be carrying out appraisals and add those joining. The appraisers are managed by the Lead Appraisers who offers internal training for current appraisers.

Training entails a full day with a certified trainer and each appraiser will receive a certificate demonstrating that they have completed this training.

Further update training is given on a yearly basis for all appraisers and appraisers also have quarterly peer support groups to help them further develop best practice.

b. Quality Assurance

For Appraisers - *Appraiser Quality Assurance Programme*

To ensure ongoing improvement in appraisal:

- Appraisers are recruited and managed by the Trust Appraisal Lead(s);
- Trust Appraisal Lead(s) are required to review performance of appraisers including doctor's feedback, timeliness of completion of appraisal, quality of inputs (evidence), quality of outputs (appraisal summaries and personal development plans) and compliance to policy. Additional requirements have been detailed in the new draft policy;
- The appraisal lead(s) are required to review appraisals, monitor quality and take appropriate remediation steps if necessary;
- The Medical Appraiser role is recognised within the job plan and attracts a tariff;
- Appraisal feedback from the appraisee is collected after appraisal;
- Appraisers must carry out a minimum of 6 appraisals annually;
- Appraisers must attend quarterly appraiser support groups (private group meetings where appraisal issues can be discussed amongst appraisers and knowledge shared);
- New appraisers must attend facilitated training prior to carrying out an appraisal (1 day).

For the appraisal portfolio

To ensure ongoing improvement in appraisal:

- Appraisal portfolios are reviewed by the Revalidation Support Committee with written feedback given to both appraiser and individual where necessary. Specific areas of focus include Complaints, SIRIs, CPD and an agreed PDP.

For the organisation

- Feedback on the doctor's experience of both the appraisal and the systems around it is sought from all individuals after successful completion of appraisal.
- Yearly review of policy and guidance documentation is carried out by the Medical Director's Office.

6. Access, Security and Confidentiality

Appraisal portfolios, revalidation notes and feedback surveys are managed through the electronic database system (Allocate e-Appraisal and e-360). This system is available on any computer with internet access but only registered users with logins and passwords have access. Individuals only have access to their own information and there are a limited number of administration roles (controlled by the RO) that have access to other people's information.

When a doctor leaves the Trust, their account is closed, and they no longer have access to system. However Individual users are able to download all their appraisal portfolios to transfer to a new system if they should desire, but this needs to be done before leaving the Trust.

Any request for appraisal and revalidation information for a doctor must come from the new Responsible Officer or his/her office. This request must be received on a MPIT or similar

form and will be handled by the Medical Director's Office and approved for sending by the Responsible Officer. No requests for appraisal data will be supplied to individual doctors who have left the Trust or other agents, other than a new Responsible Officer.

7. Clinical governance

Individual Doctors are required to provide, discuss and reflect on involvement in complaints, compliments or serious incidents. Individuals are required to provide:

- Written evidence from the Patient Experience department and Risk Management detailing all events listed on the Datix system where the individual is named in the past 12 months
- A reference from their clinical line manager indicating involvement in complaints, compliments and Serious Incidents
- A letter from any other external body where the individual practices detailing involvement in any complaints, compliments or SIs.

As part of the role of the Revalidation Support Committee, these reports are also sought independently of appraisal and compared to those discussed in the appraisal.

8. Revalidation Recommendations

Between 01 April 2021 to 31 March 2022, we have made a total of 72 recommendations to the GMC about our doctor's revalidations.

There are 3 possible recommendations that can be made by the Responsible Officer through the GMC Connect website:

Revalidate

The requirements of a positive revalidation recommendation from the Responsible officer are:

"Based on the outcomes of such appraisal or assessment, and any other information available to me from relevant clinical and corporate governance systems, I am satisfied that:

- *Where relevant, each of the named medical practitioners is practising in compliance with any conditions imposed by, or undertakings agreed with, the General Medical Council.*

- *Where relevant, each of the named medical practitioners is practising in compliance with any conditions agreed locally".*

There are no unaddressed concerns identified by the above systems and processes about the fitness to practise of any of the named medical practitioners"

- The GMC protocol for making revalidation recommendations **[Reference 3]**

Defer

Deferral is a request to delay the revalidation decision pending either a local management process or for further information. This is a neutral act and does not reflect that there is an issue with an individual doctor. The minimum period of deferral is 4 months and the maximum (for one request) is 12 months. Repeat deferrals are challenged by the GMC revalidation team.

Deferral requests are typically made because mandatory information is not included in the appraisal, but also (on rare occasions) because an individual is going through a management process that has not been resolved.

Non-engagement

This is the final confirmation to the GMC that a doctor is not engaging with the process. At this point the GMC enact their own non-engagement process which can ultimately end of with a removal of the licence to practice for the individual involved.

Late Recommendations made by the RO to the GMC

We have not made any late recommendations to the GMC

Higher level Responsible Officer

Each RO has a prescribed connection to NHS England or Department of Health. The Responsible Officer's higher level RO is based at NHS England Midlands and East. The higher level RO will submit revalidation recommendations to the GMC for all ROs connected to them. The recommendation will be based, as it is for all doctors, on information from appraisal and from routine monitoring of performance and fitness to practise.

9. Recruitment and engagement background checks

The recommended employment checks are already carried out by the Human Resources recruitment team and where specific information is required in respect to appraisal information this is collected by the Medical Director's Office.

Where the checks are carried out by a third party, i.e. Locum Agency reliance is placed on the framework agreements/contracts that these checks are done by the agency.

10. Monitoring Performance

Performance of all doctors is monitored through the clinical line management structure of clinical leads for specialties and CSU leads for service units and divisional directors.

11. Responding to Concerns and Remediation

A responding to concerns policy has been created and is now on the Trust intranet.

12. Risks and Issues

There are no specific risks or issues that need to be brought to the Board's attention.

13. Board / Executive Team Reflections

Not applicable

14. Recommendations

The Board to receive the report (noting that it will be shared, along with the annual audit, with the Higher Level Responsible Officer) and to consider any needs/resources highlighted.

The Board is asked to approve the 'statement of compliance' confirming that the organisation, as a designated body, is in compliance with the regulations.

15. References

[1] *The Medical Profession (Responsible Officers) Regulations 2010*, Found at URL: http://www.legislation.gov.uk/uksi/2010/2841/pdfs/uksi_20102841_en.pdf

[2] *Good medical Practice*, General Medical Council (2013), Found at URL: http://www.gmc-uk.org/static/documents/content/Good_medical_practice_-_English_0914.pdf

[3] *The GMC protocol for making revalidation recommendations,* Third Edition, General Medical Council (2014), Found at URL: *http://www.gmc-uk.org/Responsible_Officer_Protocol.pdf_56096180.pdf*

Meeting Title	Trust Board Meeting	**Date:** 7th July 2022
Report Title	Risk Report	**Agenda Item**: 21
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 June 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 June 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, 2 are overdue their review dates. The overdue risks have been escalated for corporate review.

- There were 2 new significant risks added since the last paper:

  a. ***RSK-341*** *- IF there is a delay with imaging reporting for CT and MRI for patients on cancer pathways. THEN there could be a delay with diagnosis and the commencement of treatment.*
  b. ***RSK-343*** *- If there is insufficient dietetic staff in post. THEN the service may be unable to meet referrals demand.*

- There are no risks showing on Radar as controlled. This is where current risk scores for the risks are the same as their target risk scores. The controlled risks are listed below:

- There are 7 risks that have been identified as uncontrolled. These are therefore recorded as significant risks with no controls in place to reduce the risk. All of the uncontrolled risks have plans being put in place (outstanding controls) to mitigate the risk. These uncontrolled risks are listed below:

  a. ***RSK-025*** *- 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.*

  b. ***RSK-101*** *- IF the maternity service at MKUH 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*

c. ***RSK-158*** *- If the escalation beds are opened the additional patients that will need to be seen will put additional demand on the Inpatient Therapy Services to manage and support patient flow during periods of significant pressure.*

d. ***RSK-248*** *- IF the core IT network fails (due to its age). THEN at least half of the IT network (if not all of it) will fail and IT will stop working for all devices.*

e. ***RSK-250*** *- IF staff across MKUH continue to use eCARE in the same way, that the volumes of requests made to the IT Department remain at their current rate, and the volume of change and project work continues at the current volume. THEN the IT Department will become less responsive and a range of functions within eCARE will continue to be left without action*

f. ***RSK-324*** *- 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.*

g. ***RSK-331*** *- If current demands on the Therapy's admin service continues without the capacity to meet the volume of work. THEN clinician's diary slots will be left unfilled, and patients won't be contacted in a timely manner.*

3. CONCLUSION

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

4. RECOMMENDATION

The Group is asked to review and discuss this paper.

5. APPENDICES

Appendix 1 - Significant Risk Register as of 28th June 2022.

6. DEFINITIONS:

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

Significant Risk Register

Report Date: **28-Jun-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-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		12-May-2022	30-Jun-2022	Pending	25	25	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	Regraded at paediatrics quadrumvirate as risk as not changed in the last 5 years.
RSK-019	22-Sep-2021	Sushant Tiwari	IF there is an increased number of incidents of violence and aggression in Emergency Department THEN there will be an impact on patient safety, staff mental and physical health	LEADING TO an increased risk of physical or verbal damage to staff or other patients, risk of delay in care whilst incidents resolved; potential for litigation or claims dependent on harm; Increased staff sickness rate, poor retention and recruitment of staff; negative impact on Trust reputation; poor patient experience	Region	Emergency Department	22-Jun-2022	27-Jul-2022	Planned	12	20	6	Police panic button in reception and majors,unacceptable behaviour posters + national abuse posters,Security forum for Trust (22-Sep-2021),Review of Reception	CCTV cameras in place (dead spot remains in "Streaming")(22-Sep-2021),Conflict Resolution training(22-Sep-2021),Incidents reviewed on Datix incident reporting system(22-Sep-2021)	Low	Tolerate	Meeting requested by Mr Ajuwon (16/06/22) with CGL, Matron, Ops manager and Senior Sister/ V&A Lead for ED to review risk as overdue. Agreed to increase risk from moderate to high due to increase in incidents reported and frequency. CGL requested to update risk on Radar and risk assessment would formally be reviewed at next Governance meeting to update controls/ mitigation. Trust H&S advisor also invited to attend clinical governance meeting as CGL advised group of Trust V&A steering group which staff were unaware of.
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		09-Jun-2022	14-Jul-2022	Planned	20	20	6	Actively recruiting staff,Prioritisation of wards	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. THEN we will be unable to meet patient needs or network requirements (without the increase in cot numbers and corresponding cot spacing).	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.	Region	Paediatric Services	12-May-2022	30-Jun-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	PHE measures around covid19 are now not relevant, still insufficient space.
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	11-May-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.
RSK-248	26-Nov-2021	Craig York	IF the core IT network fails (due to its age) THEN at least half of the IT network (if not all of it) will fail and IT will stop working for all devices,	LEADING TO an inability to access key systems such as eCARE, imaging, pathology, HSDU, plus many more	Organisation		24-May-2022	30-Aug-2022	Planned	20	20	5	Replacement procured, implementation planned (16-Feb-2022)		Low	Treat	Risk likelihood increased due to recent WiFi issues believed to be linked to lack of CORE replacement.
RSK-341	17-May-2022	Paula Robinson	IF there is a delay with imaging reporting for CT and MRI for patients on cancer pathways THEN there could be a delay with diagnosis and the commencement of treatment	LEADING TO potential increase in the required treatment, potential poorer prognosis for patient, poor patient experience, increase in complaints and litigation cases.	Organisation		20-Jun-2022	30-Aug-2022	Planned	20	20	8	2x Specialist Doctors appointed on a fixed-term basis to uplift internal reporting capacity (14-Jun-2022),Specialist Radiology to be recruited to uplift reporting capacity,Explore alternative outsourcing for some specialist areas (e.g. lung),Imaging Business Case for substantive Radiologists and Radiographers	PTL tracking to escalate to imaging leads(18-May-2022),Agency Locum Consultant appointed 2 days a week to uplift internal reporting capacity(14-Jun-2022),Temporary reduction in double reporting for Quality Assurance to increase real-time scan reporting(14-Jun-2022),Current Radiologists doing 30% over standard reporting levels(14-Jun-2022)	Low	Treat	Risk escalated to Risk & Compliance Board for addition to the Corporate Risk Register. Approved 21/06/2022

Source: Radar

Significant Risk Register

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-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		19-Jun-2022	30-Aug-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	Ongoing work with Radar & across Trust to improve functionality of system for staff to best enable reporting & timely investigation of incidents
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		09-Jun-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
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	05-Jun-2022	14-Jul-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 on 16th May: Risk remains unchanged
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	16-May-2022	13-Jun-2022	Overdue	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 (03-May-2022),Set slots kept for very urgent cases but does not meet needs. (03-May-2022),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 (16-May-2022),Plans to re-instate small group sessions allowing approx. 40 patients to be seen per week (16-May-2022)	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

Significant Risk Register

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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	Musculoskeletal	09-Jun-2022	30-May-2022	Overdue	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		31-May-2022	29-Jun-2022	Pending	16	16	12	Paediatric Dietetic Assistant Practitioner appointed - to start on 9.5.22, after induction will help to reduce risk (01-Jun-2022)	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),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(19-Apr-2022)	Low	Treat	Staffing have improved slightly - new staff being trained, inducted etc - to review OP lists etc in 1 month
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 increase in efficiency requirement from NHS funding regime to support DHSC budget affordability.	Organisation		20-Jun-2022	12-Jul-2022	Planned	20	16	8	The current funding has now been clarified .The trust will work with BLMK system partners during the year to review overall BLMK performance	Cost and volume contracts replaced with block contracts (set nationally) for clinical income(04-Nov-2021),Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until end of March 2022)(04-Nov-2021),Budgets to be reset for FY22 based on financial regime; financial controls and oversight to be reintroduced to manage financial performance(04-Nov-2021),Cost efficiency programme to be reset to target focus on areas of greatest opportunity to deliver(04-Nov-2021)	High	Treat	Risk transferred from Datix
RSK-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	30-May-2022	30-Jul-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	No change - continue to progress through LLD. Quality Managers and HODs are now reviewing quality assurance associated risks for LLD build. Harmonization across departments continues to be the biggest challenge, delays to Micro go live with new LIMS still anticipated. To review in two months for progress update.
RSK-202	23-Nov-2021	Karan Hotchkin	IF Transformation delivery is not adequately resourced and prioritised and/or schemes are unrealistic and not well planned THEN There is a risk that the Trust is unable to achieve the required efficiency improvements through the transformation programme leading to an overspend against plan	LEADING TO the Trust potentially not delivering its financial targets leading to TO potential cash shortfall and non-delivery of its key targets	Organisation		20-Jun-2022	12-Jul-2022	Planned	20	16	9		Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partners(23-Nov-2021),Cross-cutting transformation schemes are being worked up(23-Nov-2021),Savings plan for 21/22 financial year not yet fully identified(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix
RSK-258	29-Nov-2021	Anthony Marsh	IF the Switchboard resources cannot manage the service activity THEN this may result in poor performance	LEADING TO failure To meet KPI's and Emergency Response Units will put Patients, Staff and Visitors at risk and Communication with Users will give poor perception of the We Care action initiative	Organisation		26-Jun-2022	26-Sep-2022	Planned	20	16	4	Review of staff rota profile (24-Jun-2022)	Re-profiled staff rotas(29-Nov-2021),Bank staff employed where possible(29-Nov-2021),IT Department implemented IVR to assist in reducing the volume of calls through the switchboard(29-Nov-2021),Contingency trained staff available to assist(29-Nov-2021),Two additional workstations/consoles created in Estates Information office and Security office to allow for remote working(29-Nov-2021)	Low	Treat	Risk increased to likely due to significant number of vacancies and difficulty with existing resource to cover shifts.

Source: Radar

Significant Risk Register

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RSK-015	21-Sep-2021	Mariama Bah	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		07-Jun-2022	29-Aug-2022	Planned	15	15	10	Education and training regarding Mental Health and suicide risk. Mental Health Practice Development nurse has been recruited by the Trust and will be working alongside the ward when in post.	All patients are assessed on admission as to all obvious removable risk factors(21-Sep-2021),Review done with Corporate nursing team involving the environment. All obvious removable risk factors removed.(25-May-2022),Safer bed spaces in Bay 1 and bay 3. Hospicom brackets removed in siderooms(25-May-2022),Senior nurses on the ward made aware of safe bed spaces. If bed space not available and patient high risk will work to move other patients to make space or request one to one.(25-May-2022),Dissemination of Ligature risk policy and the appropriate pathway to the unit, via staff communications , "Message of the week" and word of mouth.(25-May-2022),Staff made aware to remove unnecessary ligature risks if clinically not required. Eg. Suction/oxygen/equipment/call bell.(25-May-2022),Tuff cut scissors in resus trolley(25-May-2022),Request for one to one enhanced observation nurses based on Mental Health Risk Assessment. Ranging from Health Care Assistant, Registered Mental Health Nurse or security. If not available manage in numbers as best as possible, however is a risk to patient and also the ward.(25-May-2022),Patient own drug (POD) cupboards by bedside and all drugs	Low	Treat	Risk Reviewed at Acute SPEG: CH advised this has not changed.
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	11-May-2022	30-Jun-2022	Pending	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	12-Jun-2022	31-Dec-2022	Planned	12	15	6	Approval of Business Case for 10x additional members of staff,10x additional members of staff to be recruited,Recruitment programme is underway (13-Jun-2022)	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	Recruitment programme is underway. Regular meetings with Finance and HR are held.
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	Musculoskeletal	26-Jun-2022	29-Jun-2022	Pending	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),There are occasional surges in trauma cases especially at the weekend which impacts on trauma/ elective lists on Mondays.(15-Oct-2021)	Low	Treat	No change to all.
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	15-May-2022	30-Jul-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	No change to risk

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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		31-May-2022	29-Jun-2022	Pending	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	Ongoing discussion between Deputy Director of Finance and CCG regarding paediatric community HEF service
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 Inpatient Therapy Services 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		12-Jun-2022	12-Jul-2022	Planned	16	15	6	Therapy staff attend board rounds and work with the MDT to determine priority patients. The skills mix and workforce is reviewed twice weekly 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 Locum cover for vacant posts. Daily attendance at 10.30 system wide discharge call. Inpatient Therapy Service participation in MADE events. Review of staffing model across inpatient medical and frailty wards. (13-Jun-2022),Closure or Reduction in Escalation Beds (24-Jun-2022)		Low	Treat	Risk reviewed with Divisional Triumvirate. Control added
RSK-159	12-Nov-2021	Adam Baddeley	If patients referred to the Occupational Therapy and Physiotherapy inpatient services covering medical wards are not being seen in timely manner, then there will be a delay in these patients being assessed, treated and discharged.	Leading to deconditioning of vulnerable/complex patients requiring a short period of therapy; increased length of stay; potential readmission, increased demand for packages of care requiring double handed provision.	Organisation		12-Jun-2022	30-Jul-2022	Planned	20	15	6	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
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	06-Jun-2022	30-Jul-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	Risk remains the same
RSK-250	26-Nov-2021	Craig York	IF staff across MKUH continue to use eCARE in the same way, that the volumes of requests made to the IT Department remain at their current rate, and the volume of change and project work continues at the current volume THEN the IT Department will become less responsive and a range of functions within eCARE will continue to be left without action	LEADING TO increased clinical risk, increased risk to performance of eCARE, potential disruption to staff, and delays in the deliver or projects and realising their benefits	Organisation		24-May-2022	30-Aug-2022	Planned	15	15	3	Prioritisation of workload is in place to cover the most impacting of issues or projects, however this only reduces the potential impact slightly		Low	Treat	Volume of work is increasing month on month without additional staff to support.

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RSK-271	30-Nov-2021	Ayca Ahmed	IF there is insufficient space within the Medical Equipment Library (MEL) THEN MEL staff will be unable to carry out the required cleaning process to comply with the appropriate guidelines set by CQC and MHRA	LEADING TO Lack of cleaning and processing space due to the growth of the MEL over the years means not keeping unprocessed and processed equipment separately, not complying with CQC Regulation 15: Premises and equipment and MHRA Documentation: Managing Medical Devices April 2015	Region	Estates	26-Jun-2022	30-Dec-2022	Planned	15	15	3	The MEL dept relocation is on the draft capital plan under estates, TBC	Staff members are taking processed equipment straight to the shelving areas as soon as it is cleaned to avoid cross contamination. This ensure equipment is kept separate, but this is not a productive method of working(30-Nov-2021),Issue has been raised at Space Committee (June 2021)(30-Nov-2021),2019-2020 Additional office has been provided, outside of the main department for the Service Manager and the Equipment training Auditor. This has created some additional space for the Library(30-Nov-2021),2019-2020 Additional storage provided outside of main department in the location of a storage facility within a staircase approved and provided for a number of services under an approved Business Case on the Capital Programme(30-Nov-2021)	Medium	Treat	Reviewed by Medical Devices Manager, no change to risk rating.
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	06-Jun-2022	30-Jul-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	Risk remains the same
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	12-May-2022	30-Jun-2022	Pending	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,Establishment Review to be completed		Low	Treat	Vacancy factor of 19.8WTE
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	05-Jun-2022	30-Jun-2022	Pending	15	15	9	Approval for two bank staff until 1.7.22		Medium	Treat	Risk Owner advised that review date should have been 1st July, not 6th June. Date amended.
RSK-343	23-May-2022	Elizabeth Pryke	If there is insufficient dietetic staff in post THEN the service may be unable to meet referrals demand	Leading to patients not receiving dietetic input as needed, which could result in: - Insufficient dietetic education for adults with complex nutritional issues, including adults with diabetes, gastrointestinal disease, those either malnourished or at risk of malnutrition needing nutritional support etc. - Reduction in patient experience and poorer outcomes - MDT will not work effectively as insufficient dietetic input, increasing workload of other members of MDT - Patients with long term conditions such as Diabetes, CHD etc will not have the support to develop the skills for independence and self-management to achieve good health outcomes	Region	Therapies	16-Jun-2022	29-Jun-2022	Pending	15	15	6		Triaging patient referrals based on clinical need Daily team huddle to try and manage this and ensure communication is good across the team Advised ward staff so they can start first line nutritional support(23-May-2022),Setting up weekend telephone clinic(23-May-2022),Patients triaged as more urgent will be seen - reduced service communicated to senior nurses, consultants etc(14-Jun-2022),Patients triaged as more urgent will be seen - reduced service communicated to senior nurses, consultants etc(14-Jun-2022)	Low	Treat	risk continuing

Meeting Title	**Trust Board of Directors**	**Date: July 2022**
Report Title	**Board Assurance Framework**	**Agenda Item: 22**
Lead Director	**Name: Kate Jarman**	**Title: Director of Corporate Affairs and Communication**
Report Author	**Name: Kwame Mensa-Bonsu**	**Title: Trust Secretary**

Current Key Highlights/ Summary	Board Assurance Framework containing the principal risks against the Trust's objectives. **A. Update –** The following risk entries have been updated: 1. **Risk Entry 2** (page 7), 2. **Risk Entry 16** (page 36) 3. **Risk Entry 17** (page 38) **B. Retirement** 4. **Risk Entry 4** (page 11) will be retired after the July 2022 Trust Board meeting. 5. **Risk Entry 10** (page 25) will be retired after the July 2022 Trust Board meeting. **C. Review** 6. **Risk Entry 18** (page 40) is being reviewed, and this would result in a change of risk articulation and Executive Lead. **D. Risk Score** 7. The risk score for **Risk Entry 20** (page 45) have been revised upwards **–** from **16 to 20 –** because of the increasing challenge associated with recruitment to vacancies in the short term (0-18 months).

Past Highlights/Summary To Note	**Highlights/Summary in June 2022:** 1. The risk score for the following risk entries have been revised downwards: a. **Risk Entry 3 – From 16 to 12** (page 9), because the challenge is no longer related to responding with agility to sudden changes in demand/circumstances, rather the challenge is with managing the backlog of demand within relatively fixed budgetary and human resource constraints. b. **Risk Entry 7 – From 16 to 12** (page 17), because some written assurances have now been received from the East of England NHS region that commissioners will cover the excess revenue costs driven by inefficiencies of a satellite model. A roadmap to the development of this service is now clearly visible.			
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	The Finance and Investment Committee, July 2022
Next Steps	Trust Executive Committee , July 2022
Appendices/Attachments	Board Assurance Framework

The Board Assurance Framework – Summary of Activity in June 2022

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

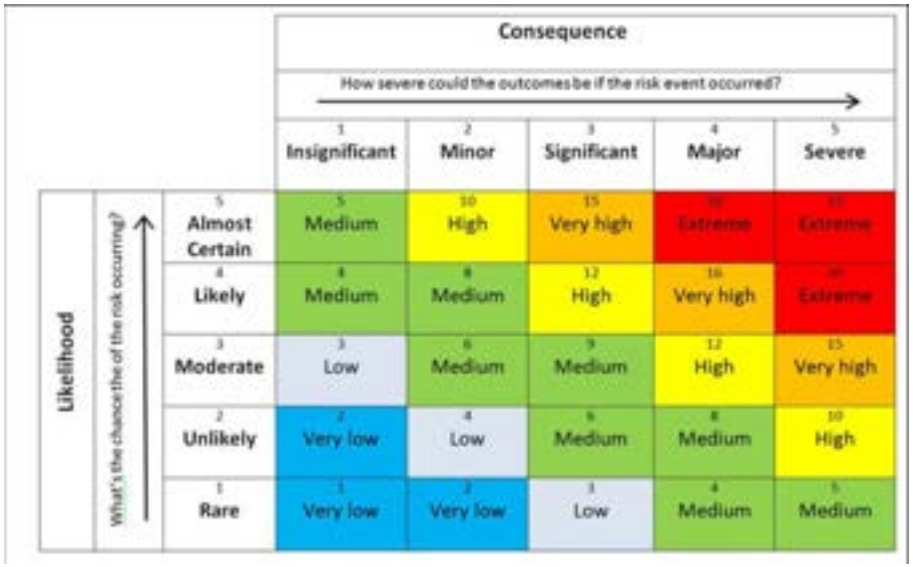
1. Keeping you safe in our hospital
2. Improving your experience of care
3. Ensuring you get the most effective treatment
4. Giving you access to timely care
5. Working with partners in MK to improve everyone's health and care
6. Increasing access to clinical research and trials
7. Spending money well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

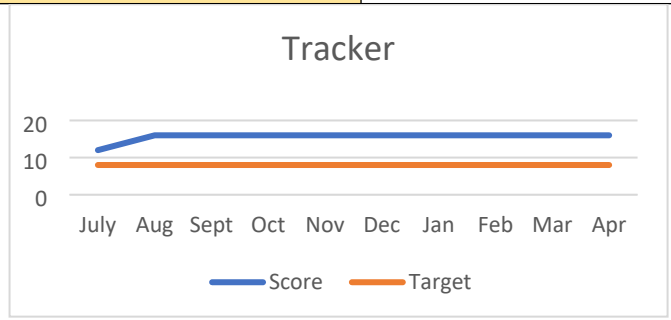
Green	**Positive assurance**: The Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat/ opportunity. There are no gaps in assurance or controls and the current exposure risk rating is at the target level; or gaps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

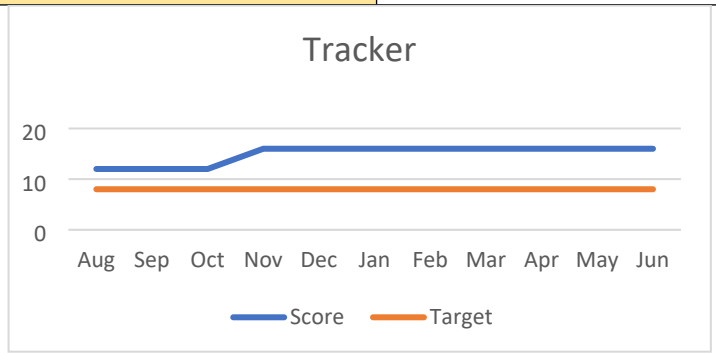
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Significant increase in activity and number of patients through the ED Significantly higher acuity of patients through the ED	Clinically and operationally agreed escalation plan Adherence to national 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	27/06/22	**Risk Rating**	16	8		



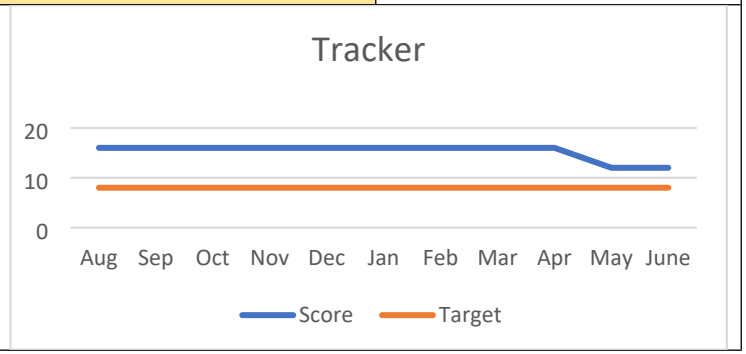
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Not appropriately reporting, investigating or learning from incidents. A lack of systematic sharing of learning from incidents.	Improvement in incident reporting rates SIRG reviews all evidence and action plans associated with Sis Actions are tracked	Establishing Learning and Improvement Board Establishing Divisional Quality Governance Boards	Established Under review summer 2022	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	Ongoing – Key roles established				

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

Strategic Objective 1: Improving Patient Safety

Strategic Risk	If the Trust is unable to accurately predict demand (for example, relating to the COVID-19 pandemic) and re-purpose its resources (physical, human and financial) with agility, the Trust will fail to manage clinical risk during periods of sustained or rapid change in the level or type of demand.				**Strategic Objective**	Improving Patient Safety
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Medical Director	**Consequence**	4	4	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	27/06/22	**Risk Rating**	12	8		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Rapid or sustained period of upheaval and change 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 evolved over the course of the pandemic 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						

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	23/06/22	**Risk Rating**	8	8				

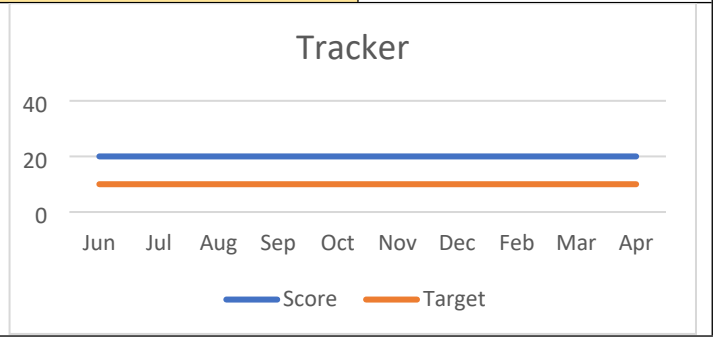
Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Inadequate assessment of clinical risk/ impact on clinical services or practices Inadequate resourcing Inadequate training	Robust governance structures in place with programme 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		



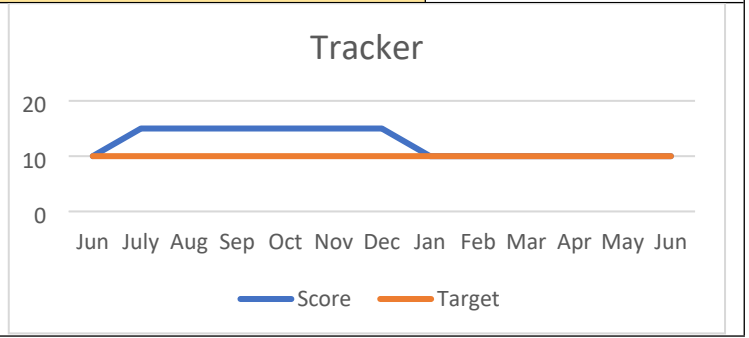
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Cessation of all routine elective care, including cancer screening and other pathways, during the peaks of the Covid-19 pandemic	Compliance with national guidance Granular understanding of demand and 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	27/06/22	**Risk Rating**	10	10		



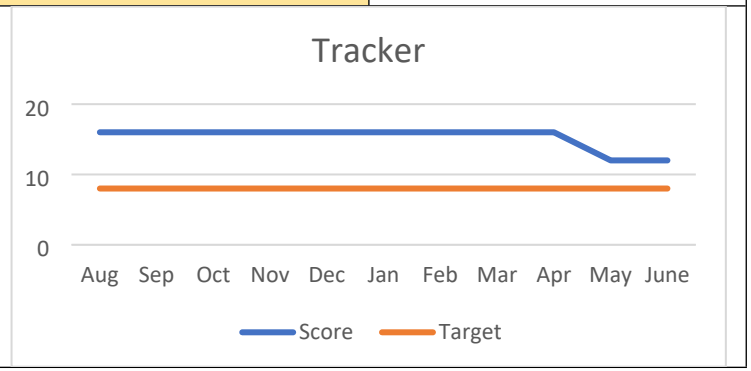
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Demand for ITU and inpatient beds exceeds capacity, including escalation capacity within the hospital and regionally. Risks have evolved over the	Increased capacity across the hospital Increased capacity 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	

course of the pandemic 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**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	27/06/22	**Risk Rating**	12	8		



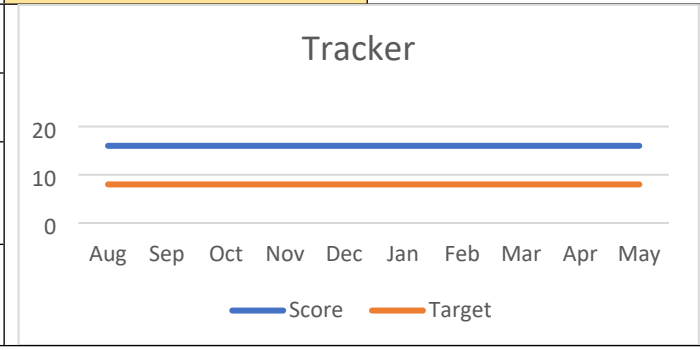
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Break down in the established relationship (subcontract) between Oxford University Hospitals and the private Genesis Care facility (Linford Wood, Milton Keynes)	Contingency for the provision of treatment 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	26/05/22	**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. (Delayed due to COVID restrictions)	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	Comprehensive analysis of patient ethnic groups to ensure meeting all requirements. Not all patients have ethnicity recorded. Link with EDI Leads.	EDI Team developing am outreach strategy to engage with the local community. Current Links: • MK council	

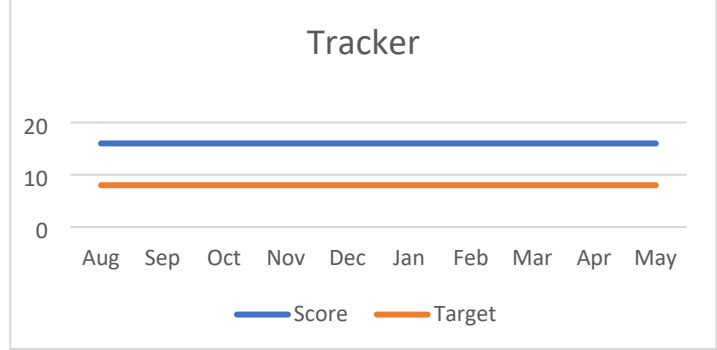
Adult Inpatient Survey Urgent and Emergency Care Survey Maternity Survey Cancer Patient Experience Survey	• Patent Experience Strategy • Learning Disabilities Strategy • Dementia Strategy • Nutrition steering group • Catering steering group • Domestic planning group • Discharge steering group • Induction 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:** Started 1st November 2021	themes and areas of for improvement. Patient experience strategy action plan progress. Tendable Audits 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		• Welcome MK • Open university • Milton Keynes Centre For Integrated Living • Islamic Centre MK • Sikh Gurdwara MK • Hindu Association MK • Muslim Nigerian Community MK • Milton Keynes Intercultural Forum, which is supported by MK Community Foundation and Community Action: MK	

	feedback and co-production **Timeframe**: Started October 2021		Dashboard Due July 2022	partnership (MVP) Cancer Patient Partnership **Website:** 'You said we did'			

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

Strategic Objective 2: Improving Patient Experience

Strategic Risk	If the Trust does not effectively work to use feedback from complaints and PALS contacts to inform learning and embed related changes patient experience will not be improved.				**Strategic Objective**	Improving Patient Experience
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Chief Nurse	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	26/05/22	**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:	Quality surveillance system to triangulate feedback from complaints with incidents and other quality measures across the organisation.	Current review underway for systems to link and triangulate data.	**Annual:** Complaints and PALS Report **Quarterly:** Quarterly reports with themes and areas of for improvement. Patient experience	Patient feedback. Cognitively impaired Learning Disabilities Sensory Deficit: vision, hearing, speech	Complaints/PALS feedback forms in easy read FFT are available in easy read FFT through text messaging. Engagement with local LD services and users to co-	

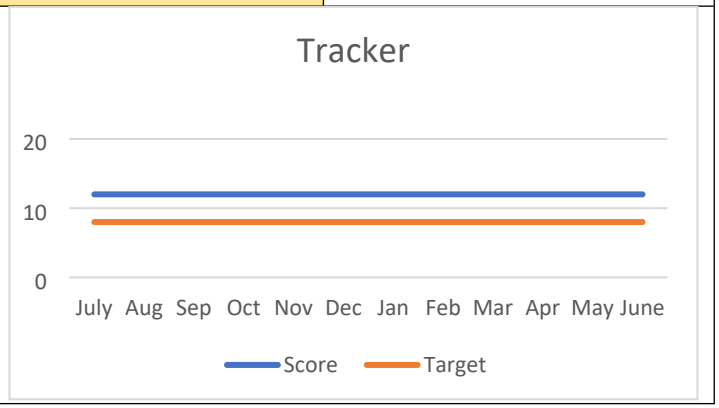
	• Patent Experience Strategy • Learning Disabilities Strategy • Dementia Strategy • Nutrition steering group • Catering steering group • Domestic planning group • Discharge steering group • Induction training Customer service training – NHS Elect program Leadership training includes how to receive feedback from patients. Appreciative inquire approach to support complaints handling and response letters.	Audit of identified learning in divisions to ensure learning embedded.	Divisions to audit learning from feedback and report to Patient Experience Board.	strategy action plan progress. Tendable Audits 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**: Started October 2021 Divisional review of learning from complaints in CIG.	Language difficulties Children and young people. Link with EDI leads and Trust Networks	produce information. Bi-Monthly Trust Board Patient Experience Report	

	Monthly divisional meetings with Head of Patient and Family Experience to review themes, complaints, associated changes, and learning.			Complaints questionnaire for complaints re process and experience. PALS KPIs responding to feedback in a timely manner to initiate change and learning. **Website:** 'You said we did			

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

Strategic Objective 3: Improving Clinical Effectiveness

Strategic Risk	If clinical audit requirements are not completed the Trust will fail to meet the requirements of clinical compliance regimes including NICE				**Strategic Objective**	Improving Clinical Effectiveness
Lead Committee	Quality	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Director of Corporate Affairs	**Consequence**	4	4	**Risk Appetite**	Minimal
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	21/06/22	**Risk Rating**	12	8		



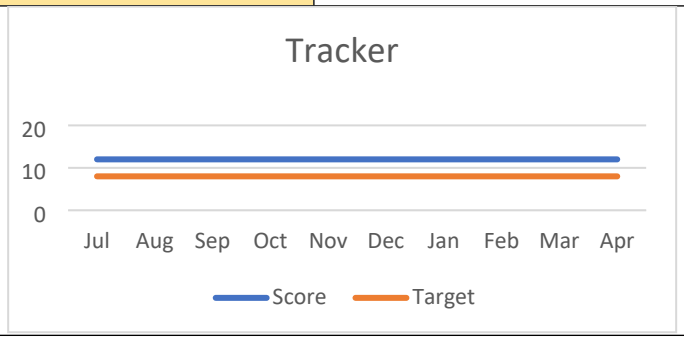
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
1. Lack of understanding/ awareness of audit requirements by clinical audit leads 2. Resources not adequate to support data collection/	1. Designated audit leads in CSUs/ divisions 2. Clinical governance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

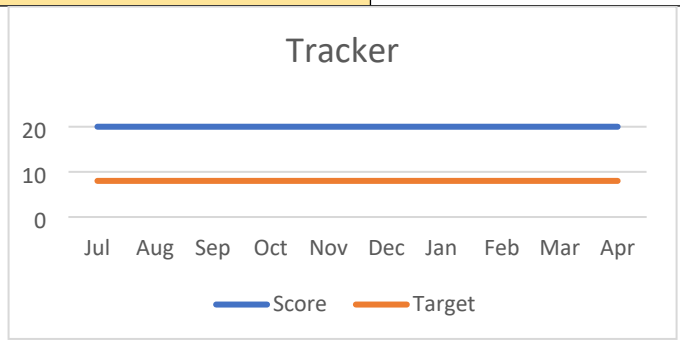
Strategic Risk	If the Trust is unable to establish robust governance around data quality processes, there is the risk that this could lead to patient harm, reputational damage and regulatory failure.				**Strategic Objective**	Improving Clinical Effectiveness
Lead Committee	Audit	**Risk Rating**	**Current**	**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: There is a risk that when the Trust introduces new digital solutions some colleagues may worry this will replace their role. This may impact negatively on morale and may cause some staff to seek employment elsewhere unnecessarily. The belief that jobs may be at risk may also impact on Staff Side relations.

Strategic Objective 8: Investing in Our People

Strategic Risk	If the Trust introduces new digital solutions some staff may be concerned that this will replace their role. This may impact negatively on morale and may cause some staff to seek employment elsewhere unnecessarily. The belief that jobs may be at risk may also impact on Staff Side relations.				**Strategic Objective**	Investing in Our People	
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff	At target level – no tracker
Executive Lead	Director of Workforce	**Consequence**	3	3	**Risk Appetite**	Cautious	
Date of Assessment	13/04/22	**Likelihood**	3	3	**Risk Treatment Strategy**	Treat	
Date of Review	30/06/22	**Risk Rating**	9	9			

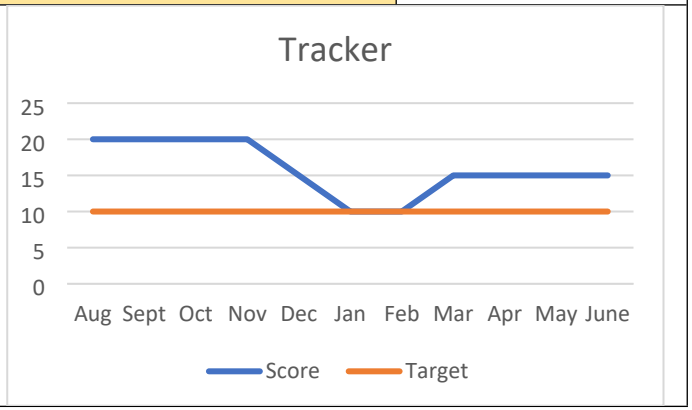
Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Lack of information and misunderstanding could cause this risk to materialise	Good communication with staff, Staff-side and wider Trust through consultation meetings, JCNC, TEC.	None Currently	Continued review	External review and reporting Vacancy and Retention Rates	None Currently	None Currently	

	Informal briefings on projects/programmes from the early stages to avoid uncertainty about job outcomes, or where jobs are removed, plans for redeployment/job description changes.						

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	23/06/22	**Risk Rating**	15	10		



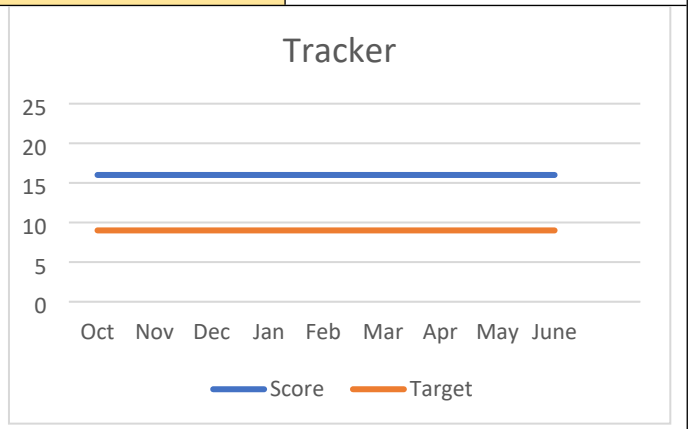
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Increasing Cyber-attacks across the world.	2 dedicated cyber security posts Good network protection from cyber security breaches such as Advanced Threat Protection (ATP) – A part of the national programmes	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	27/06/22	**Risk Rating**	16	9		



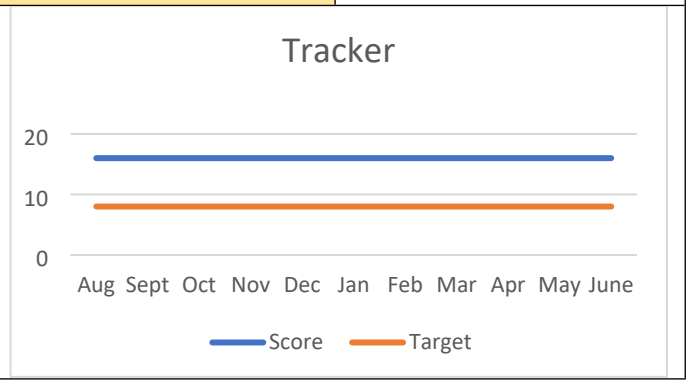
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
The current NHS capital regime does not provide adequate certainty over the availability of strategic capital finance. Consequently, it is difficult to progress development plans	The Trust has a process 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 (NHSE)	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	27/06/22	**Risk Rating**	16	8		



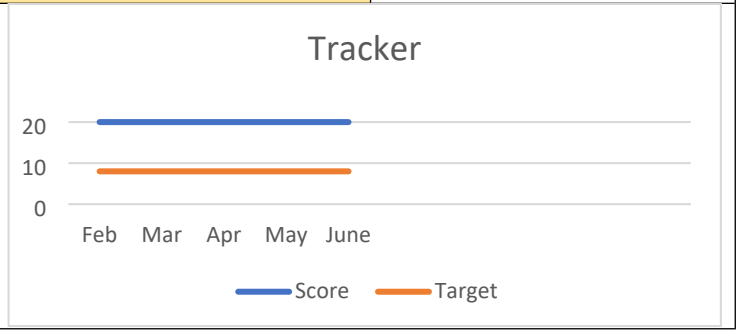
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Increase in operational expenditure in order to manage COVID-19 Reductions in non-NHS income streams as a direct result of COVID-19.	1. Cost and volume contracts replaced with block contracts (set nationally) for clinical income; 2. Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts;	No details known for 2023/24 funding and beyond. Ability to influence (negotiate) and mitigate inflationary price rises is modest at local level.	Await publication of multi-year revenue settlement from NHS England and work with ICS partners to	Monthly financial performance reports. Financial efficiency reporting. BLMK ICS finance performance reports.	Systematic monitoring of inflationary price rises impacting Trust	Develop process for monitoring inflationary price rises.	

Impaired operating productivity leading to additional costs for extended working days and/or outsourcing. Increase in efficiency required from NHS funding regime to support DHSC budget affordability and delivery of breakeven financial performance. Risk of unaffordable inflationary price increases on costs incurred for service delivery	3. Budgets updated to support known cost pressures and backlog recovery programmes 4. Financial efficiency programme established to identify efficiencies in cost base. 5. Close monitoring of inflationary price rises.		forward plan. Closely monitor inflationary price rises and liaise with ICS and NHS England.				

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	27/06/22	**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.	Stakeholder meeting in BLMK in June 2022. Ongoing discussions with OUH, specialist commissioners	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.		and Northampton suggest that a medium-term solution may be a H&N link 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	23/06/22	**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	30/06/22	**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	

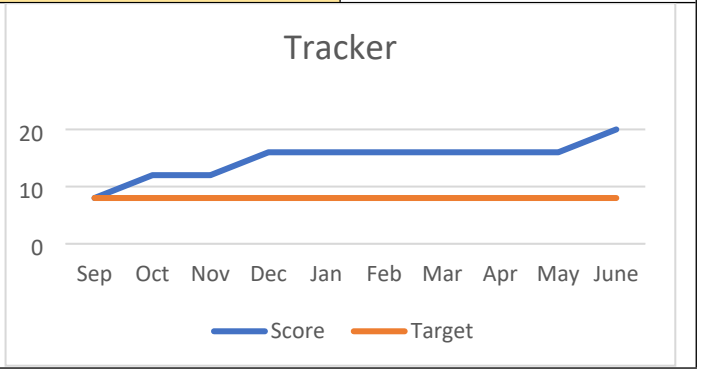
Culture within isolated departments	• Recruitment and retention premia policy • We Care programme • Onboarding and exit strategies/reporting • Annual Staff Survey • Learning and development programmes • Health and wellbeing initiatives, including P2P and Care First • Staff recognition - staff awards, 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**	5	2	**Risk Treatment Strategy**	Treat
Date of Review	30/06/22	**Risk Rating**	20	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	

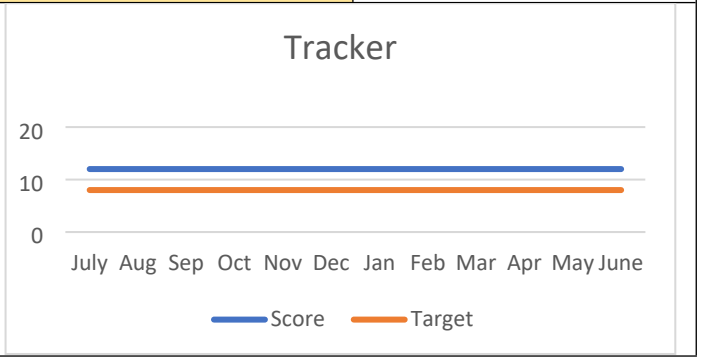
urology and trauma and orthopaedics Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply)	experience opportunities. • Exploration and use of new roles to help bridge particular gaps. • Use of recruitment 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	30/06/22	**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	

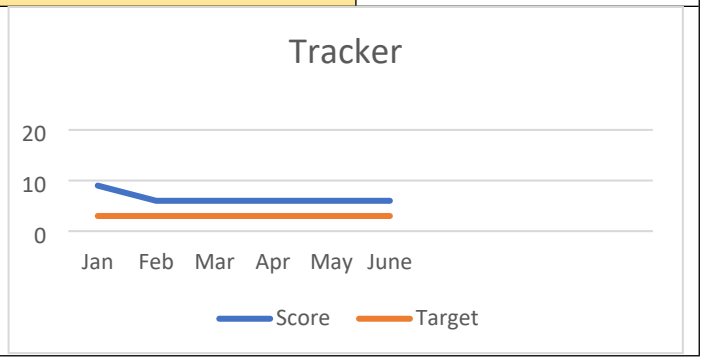
Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply) Large percentage of workforce predicted to retire over the next decade Large growth prediction for MK - outstripping supply Buoyant private 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	27/06/22	**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. Benchmark	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-quality services in	The result of the British Cardiovascular Intervention Society (BCIS) assurance process in January 2022 was positive in May 2022.	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	

length of stay for the admitted group is 2-3 days, whereas the experience for MK residents (super-spell) is 5-6 days.	Milton Keynes (Oxford's cardiology research profile is world-leading attracting and retaining the best clinicians).	Commissioners are provisionally supportive of the development, formal decision to be expected from ICB in July 2022.	recruitment and training needs). Internal business case at MKUH for consideration in July 2022.				

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 in relation to COVID-19 infections

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 in relation to COVID-19 infections						**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	30/06/22	**Risk Rating**	8	8				

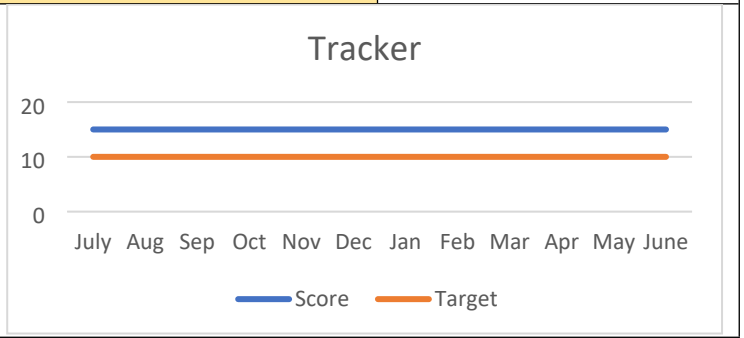
Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Ability to maintain a safe working environment during the Covid-19 pandemic due to a lack of equipment, including PPE, or inadequate staffing numbers	• Incident command structure in place • Oversight on all critical stock, including PPE • Immediate escalation of issues with immediate	None currently – noted that this risk may escalate very quickly	None Currently	Completed Risk Assessments PPE Stock Level Reports Staff Test Stock Levels Staff Vaccine Uptake Report	None Currently	None Currently	

	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						

RISK 24: If the Trust does not implement and progress staff health and wellbeing initiatives, there is the risk of staff burning out during the recovery from 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 the recovery from 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	30/06/22	**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.	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	

	• Remote working wellness centre in place. • 12 weeks of wellbeing focus from January to March.						

Agenda item 23.1
Public Board 07.07.22

Meeting of the Finance and Investment Committee held on 03 May 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- There no matters **approved** by the Committee.

Summary of matters considered at the meeting:

- Regarding the Trust's performance, the Committee requested a paper in 6 months on the financial impact of the overall increase of patients on the waiting list, to review the impact on the Trust's finances, equality of access and patient safety.

- Regarding the final financial position for 2021/22, the Committee noted the draft cumulative deficit of £0.7m, close to the Trust's year-end forecast position. The Committee further noted that Pay expenditure was above plan by £1.8m due to increased sickness levels which had subsequently returned to normal levels.

- The Committee was informed of the difficulties faced by the Trust's external provider for supplier payments and noted the steps being taken to mitigate the risks associated with those challenges.

- The Committee noted the draft financial plan for 2022/23.

- The Committee received a briefing on developments around the Trust's strategic research partnership with Sensyne Health PLC and the next steps required by the Trust.

Agenda item 23.2
Public Board 07.07.22

Meeting of the Finance and Investment Committee held on 07 June 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- There no matters **approved** by the Committee.

Summary of matters considered at the meeting:

- The Committee was informed that the Trust's financial performance for M01 (April 2022) was largely on plan.

- Regarding the final financial position for 2021/22, the Committee noted the draft cumulative deficit of £0.7m, close to the Trust's year-end forecast position. The Committee further noted that Pay expenditure was above plan by £1.8m due to increased sickness levels which had subsequently returned to normal levels.

- The Committee noted the Enhanced Bank Rates Pay Review.

- Regarding the draft financial plan for 2022-23, the Committee noted the next steps to complete the final plan.

- The Committee noted the update on the latest financial efficiency savings before submission in the middle of June.

- The Committee received a briefing on further developments around the Trust's strategic research partnership with Sensyne Health PLC and the next steps required by the Trust.

Agenda item 23.3
Public Board 07.07.22

Extraordinary Meeting of the Finance and Investment Committee held on 16 June 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- The Committee **approved** the final draft of the Trust's Financial Plan for 2022-23

Summary of matters considered at the meeting:

- There were no other matters considered at the meeting

Agenda item 23.4
Public Board 07.07.22

Extraordinary Meeting of the Audit Committee held on 18 May 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- The Committee **approved** the final Draft Going Concern Assessment

Summary of matters considered at the meeting:

- The Committee reviewed and noted the Draft Annual Report and the Draft Quality Report for 2021/22.

- The Committee noted the Annual Accounts for 2021/22 for ADMK Ltd, a subsidiary of Milton Keynes University Hospital, and the external audit arrangements for both businesses.

- The draft assessment compiled to inform the Value for Money opinion as part of the year-end audit process for FY2021/22, was noted by the Committee.

- Two internal audit reports were noted by the Committee:
    - Risk Management
    - Freedom to Speak Up (FTSU)

Agenda item 23.5
Public Board 07.07.22

Extraordinary Meeting of the Audit Committee held on 13 June 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- The Committee **approved** the Draft Annual Report and the Draft Quality Report for 2021/22.

Summary of matters considered at the meeting:

- There were no other matters considered at the meeting.

Agenda item 23.6
Public Board 07.07.22

Meeting of the Trust Executive Committee held on 11 May 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- The Committee approved the following documents:
    - Decontamination Policy
    - Food Allergen Management Policy
    - Correspondence Policy
    - Police Requests (Out of Hours) SOP

Summary of matters considered at the meeting:

- The Committee considered the continuing and significant operational pressures within the organisation.
- The Committee requested a review of the Board Assurance Framework (BAF)
- Progress with workforce planning and clinical pathways for the new Maple Centre was noted by the Committee
- The Committee noted that a third exit to the hospital would be opened in July 2022.
- The Freedom to Speak Up Annual Report was noted by the Committee

Agenda item 23.7
Public Board 07.07.22

Meeting of the Trust Executive Committee held on 8 June 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- The Committee approved the following business case subject to minor clarifications:
    - Reconfiguration of the Children's Physio Department at Stony Stratford Health Centre
    - MRI Head and Neck Coil
    - Anaesthetic Gas Savaging System
    - Cryotherapy machine

- The Committee approved the following documents
    - Asbestos Policy
    - Bereavement SOP
    - Emergency Blood Product Management Arrangement
    - Guideline for Supply of Discharge Medicines
    - Policy and Procedures for Pre and Post Insertion Management of Gastrostomy and Jejunostomy Tubes in Adults
    - Disciplinary Policy and Procedure
    - Career Break Policy and Procedure
    - Mobilisation of Reservists Policy and Procedure
    - Sickness Absence and Attendance Policy and Procedure
    - Right to Work Policy
    - Display Screen Equipment Policy

Summary of matters considered at the meeting:

- The Committee noted the update on the governance restructure of the Board and Sub-Committee agendas.

- The positive progress with regard to the international recruitment campaign was noted by the Committee.

- The Committee noted the ongoing thematic review in response to an increase in deep tissue injuries.

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Board of Directors**	**Date: 7 July 2022**
Report title:	**Use of Trust Seal**	**Agenda item: 24**
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. 29 March 2022

Lease relating to part of the 1st and 2nd floor of the Whitehouse Health Centre (MK8 1EQ)

b. 9 June 2022
Deed of Surrender relating the Academic Centre, Milton Keynes University Hospital

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	Annual Claims Report
	Falls Annual Report
	Pressure Ulcers Annual Report
	Safeguarding Annual Report
September	Annual Digital Review
	Research & Development Annual Report
	Results of the Messenger Review of Health and Social Care Leadership
	Objectives

November	Infection Prevention and Control Annual Report
	Annual Complaints Report
	Annual Patient Experience Report
	CNST Maternity Incentive Scheme and Board Assurance Framework Sign Off
	Guardian of Safe Working Hours Annual Report
	Medical Revalidation Annual Report

Response to a question from a member of the public about Functional Neurological Disorders (FND)

Background:

A member of the Public approached the Chair and CEO on 15 June to ask about our approach to the management of functional neurological disorders (FND), and our plans going forward. We were specifically asked whether we were aware of / planned to adopt the model developed in Exeter and published (April 2022) in the academic journal ACNR https://acnr.co.uk/articles/developing-a-multidisciplinary-pathway-for-functional-neurological-disorders-in-a-uk-national-health-service-the-exeter-model/. The correspondent was posing the question as the management of a relative at the Trust was felt to be suboptimal.

Response:

Functional Neurological Disorders (FND) encompass a very wide range of conditions with persistent physical symptoms - from unexplained sensory symptoms, fatigue or 'brain fog' through to more conditions with more established descriptive labels such as IBS (irritable bowel), CFS (chronic fatigue) and 'long' Covid. Patients with such symptoms are seen across all specialties, although they may concentrate in neurology as neurologists tend to see patients with arrays of symptoms.

The most challenged group with FND are those people with multiple symptoms impairing quality of life. Evidence of the effectiveness of any particular approach is quite limited and this inevitably hampers active decision making on investment in a dedicated service. The Exeter model advocates the formation of a multi-professional team approach with time and resource from a range of specialties including psychology and physiotherapy.

MKUH has been in discussion with commissioners for several years about developing a bespoke service for this patient group. To date - and perhaps hampered by the pandemic - progress has been limited. At MKUH we are keen to establish a clear pathway for assessment, appropriate investigation, and explanation of FND to patients: well-intentioned but incorrect speculation on the part of other clinicians (in the absence of such a pathway) can be very damaging to FND patients.

One of our local challenges is a perceived diminution of service as patients (and their families) transition from paediatric to adult services. We are keen to work with commissioners and other providers to develop a clearer structure across physical health, mental health, social care and clinical psychology in terms of expertise and leadership in this area.

We recognise that many patients with FND have severely impaired quality of life and they may use significant health resources. For both reasons, it is important to improve services in this area, both in general and in relation to the management of specific patients with more severe problems. Historically, there have been challenges in both

identifying and funding bespoke intervention and care for such patients.

The further development of integrated care (with the advent of the BLMK Integrated Care Board) offers a new opportunity for all system partners to re-engage with the FND agenda, as service development is likely to be attractive to care providers as well as patients. MKUH has raised the issue at the Milton Keynes Joint Leadership Team and will look to identify a partner organisation in Milton Keynes to take forward the discussion at BLMK on our behalf.

MKUH Trust Board, 07 July 2022

Response to a question from a member of the public about Parkinson's Disease

Background:

The Chief Executive was approached on 13 June 2022 by a group of Health Professionals with Parkinson's Disease (PD), in association with Parkinson's UK [Appendix 1]. The letter asked the CEO to commit MKUH to undertaking work to improve the timing and reliability of the administration of PD medicines when people with PD are admitted to hospital (particularly on an emergency / unplanned basis). Delays in accessing such time critical medicines can result in extended length of stay and real specific patient harms (for example, contributing to inpatient falls).

Response:

Following recognition by the Trust's Serious Incident Review Group (SIRG) in late 2019 of several incidents linked to delays in the administration of PD medicines, a multi-professional task and finish group was established to examine the issue and contributory factors. This group used the technique of appreciative inquiry and was made up of pharmacists, ward-based and ED doctors (prescribers), ward nurses, patient safety specialists and an expert neurologist.

The group identified a range of improvement measures including adjustments to the prescribing catalogue, automated alerts within the e-prescribing system and education / training materials.

This work led to a further audit against key quality standards which demonstrated improvement. This work was presented for learning at a national conference (Society for Acute Medicine) [Appendix 2]. The team is now looking at the material referenced by the correspondent for further improvement ideas. We are happy to pledge commitment on behalf of our Trust as described by the correspondent.

MKUH Trust Board, 07 July 2022

Appendix 1 – Letter received 13 June 2022
Appendix 2 – Poster presented at the Society for Acute Medicine

University Hospitals of Leicester NHS
NHS Trust

Dear Joe

I am writing to you as one of a group of NHS Professionals living with Parkinson's disease, to ask for your help and support with a very important care quality agenda.

As a group we have found ourselves in a situation where our healthcare experiences of living with Parkinson's as well as working within the NHS has left us in a unique position to fully appreciate the importance of getting Time Critical medication on time.

We know from our own clinical settings that we don't always get this right for patients and as healthcare professionals although we may know its importance to get medication on time, many of us didn't realise really how crucial this is, until we have found ourselves in the situation of needing these medications ourselves. Any delay can be significant for someone living with PD in terms of managing the symptoms with missed doses impacting for several days

On the 11th April this month, we marked World Parkinson's Day by releasing a short video on social media, raising awareness of this agenda. We were supported by two NHS Chief Executive's at Surrey and Sussex Healthcare NHS trust and The University Hospitals of Leicester NHS Trust, and since the launch 9 other NHS Trusts have come forward in our support.

The link to the video is below for your interest.

https://vimeo.com/696514057

In summary missing one dose will lead to an increased length of stay, which caused an extra 28,500 nights in hospital, in NHS Trusts in England and Wales in 2018-2019. Many do not return to their baseline as a result.

In order to really make a difference to all our patients in the NHS we are seeking pledged support from all NHS trusts. Parkinson's UK are keen to help by providing a tool kit for trusts to help crack the 'get it on time' agenda, sharing best practice where it already exists and supporting the formation of a working group in your trust. We have included a link to a paper from Leeds detailing how they successfully change managed this issue.

https://academic.oup.com/ageing/article/49/5/865/5869603?login=false

Will you join this time critical quality improvement project? Will you help drive this agenda in the Milton Keynes University hospitals NHS foundation trust?

We really hope that you will join other NHS Chief Executive colleagues in pledging your commitment to this work and on behalf of the Parkinson Community we thank you so much.

Please confirm your pledge by emailing jonathan.acheson@uhl-tr.nhs.uk and Rachel Williams Parkinson's UK (rwilliams@parkinsons.org.uk)

Kind Regards

J Acheson

Jonny Acheson

Emergency Medicine Consultant, Leicester Royal Infirmary

Accuracy and timeliness of levodopa prescribing and administration in adult inpatients with Parkinson's Disease: a live quality improvement initiative

Samuel Mackrill, Silvia Parajes Castro, Anna O'Neill, Onajite Kousin-Ezewu, Anna Costello and Zainab Alani
On behalf of the Parkinson's Disease Quality Improvement Group, Milton Keynes University Hospital NHS Foundation Trust

Introduction

Acute inpatients taking levodopa for Parkinson's Disease are at increased risk of adverse events due to inaccurate or delayed prescribing and administration of their usual regimen. The importance of this is reflected in national quality standards (NICE QS164) and campaigns such as "Get It On Time" from Parkinson's UK. Three-years into our live and ongoing quality improvement (QI) initiative we present current results and experience, and discuss ongoing challenges.

Methods

We set-up a multidisciplinary task-force of doctors, nurses, pharmacists, and patient safety specialists who review and discuss interventions regularly. Using appreciative inquiry techniques to engage with staff and patients, and the online platform "Life QI" to organise our ideas, we identified three areas for intervention: patient and carer involvement, prescribing, and administration. PDSA cycles ran over 12 months, and we have now completed our third cycle. Interventions have included: education campaigns, deeper information sharing between primary and secondary care, alerts integrated into the electronic patient record, making prescribing easier (such as adding common drug brand names), and changes to pharmacy workflows to prioritise levodopa-containing medications.

Data collection flowchart

Hospital inpatients prescribed a levodopa-containing product
Sampled from each successive January to allow for direct comparison

Exclusions
Admission for <48 hours
Prescribed levodopa for a non-PD indication
Patients made nil-by-mouth within 48 hours of admission
Levodopa was started for the first time during admission

Manual electronic case note review
To extract key data points reported opposite

PDSA Model

PLAN
Established objectives
Regular MDT group meetings
Appreciative enquiry
Review of previous cycle data

DO
Implementation of interventions

ACT
Iterative refinement of interventions
Ineffective interventions abandoned

STUDY
Annual review of key metrics
Compare data with previous cycles
Consider effects of each intervention

Interventions by cycle

Cycle 1: Jan 2019 - Jan 2020

- Grand round presentation to raise awareness among prescribers.
- Programme of education for doctors, nurses and pharmacists; including dissemination of standardised "get it on time" material from Parkinson's UK.

Cycle 2: Jan 2020 - Jan 2021

- Introduction of an automated alert embedded within the electronic patient record for patients with a coded diagnosis of Parkinson's disease, prompting early medicines reconciliation and the importance of accurate timings.
- Ongoing programme of prescriber education.

Cycle 3: Jan 2021 - Jan 2022

- Grand round presentation for doctors addressing learning from serious incidents involving time-critical medications.
- Video tutorial on how to reschedule administration times on our local electronic prescribing system.
- Changes to pharmacy workflows to highlight medicine reconciliation for patients with Parkinson's as a priority task.
- Community liaison to improve coding of Parkinson's patients to improve reach of existing electronic alerts and workflows.
- Levodopa preparations searchable by brand name.

Results

Changes in predefined outcomes between the start of the project and the most recent cycle are reported. These are: (1) delay from admission to prescribing (10:38 versus 4:35); (2) accuracy of recording individualised administration times (72% versus 92%); and (3) administration of levodopa within 60 minutes of the prescribed time during the first 48 hours of admission (52% versus 62%).

Table of population characteristics and results

Measures	Jan 19	Jan 20	Jan 21	Jan 22
Number of patients included in analysis	32	27	26	31
M:F (percentage female)	45%	50%	46%	42%
Mean age (years)	81 years	78 years	80 years	80 years
Mean length of stay (days)	13 days	15 days	9 days	10 days
Delay to prescribing Time difference between of admission (typically to the emergency department) and prescribing of levodopa (hh:mm).	10:58	9:37	4:52	4:35
Prescribing accuracy Percentage of times the patient's individualised levodopa administration times were accurately recorded at time of prescribing.	71%	77%	90%	92%
Administration timeliness Percentage of times the patient's levodopa was administered within 60 minutes of their individualised administration times (during the first 48 hours of admission).	52%	62%	59%	62%

Discussion

Our results suggest that pairing a multidisciplinary task-force with dynamic, iterative and durable system changes can improve acute care for patients with Parkinson's Disease. Identified future interventions include improved facilitation of patient self-administration, and engagement with emergency department colleagues to target the earliest phase of an acute admission.

References:
1. Quality Standard QS164, NICE, https://www.nice.org.uk/guidance/qs164
2. "Get It On Time" campaign, Parkinson's UK, https://www.parkinsons.org.uk/get-involved/get-it-time