Bundle Trust Board Meeting in Public 8 September 2022

1.1	10:00 - Agenda Agenda Board Meeting in Public - 08.09.22.docx
1.2	10:00 - Apologies
2	10:00 - Declarations of Interest
3	10:00 - Patient Story
4	10:15 - Previous Minutes of the Meeting Minutes Trust Board Meeting in Public 07.07.22 draft AD.docx
5	10:15 - Matters Arising Board Action Log 12.07.22.xlsx
6	10:15 - Chair's report MKUH Coversheet Chair's report.docx Chair's report sept.docx
7	10:20 - Chief Executive's Report
8	10:25 - Patient and Family Experience Annual Report Patient and Family Experience annual report 2021 to 22.docx
9	10:35 - Feedback from Maternity Assurance Group Trust Board_Maternity_Public_September.docx TOR MAG_LATEST_01092022.docx MAG upward report slides.pptx
10	10:45 - Serious Incident and Learning Report Front sheet Serious Incident and Learning Report.docx SI report September 2022.doc
11	10:55 - Mortality Update Board Mortality Sept 2022_IR.docx
12	11:05 - Workforce Report Trust Board Workforce Report M4 202223 .docx Self Assessment - MKUH Education and Placement 2022.pdf
13	11:15 - Violence and Aggression Programme Update MKUH Coversheet V and A update.docx V and A Update for Board September 22.docx
14	11:25 - Performance Report 2022-23 Executive Summary M04 Coversheet.docx 2022-23 Executive Summary M04.docx 2022-23 Board Scorecard M04.pdf
15	11:35 - Finance Report Public Finance Report M4.docx
16	11:40 - Research and Development Annual Report Trust Board_RandD_Public_September.docx Research and Development Annual Report 2021-22.pdf
17	11:45 - Emergency Preparedness, Resilience and Response Annual Report EPRR Core Standards Assurance 2022 Report.docx
18	11:50 - Significant Risk Register Risk Report August 2022.docx Significant Risk Register - as at 31st August 2022.xlsx
19	11:55 - Board Assurance Framework

Board Assurance Framework September 2022.docx

20 12:00 - Summary Reports

Audit Committee Summary Report 06 June 2022.docx

FIC Summary Report 05 July 2022.docx

FIC Summary Report 02 August 2022.docx

QCRC Summary Report 06 June 2022.docx

Charitable Funds Committee Summary Report 28 April 2022.docx

Trust Executive Committee 13 July 2022.docx

Trust Executive Committee 10 August 2022.docx

21 12:05 - Use of Trust Seal

Use of Trust Seal Sept 2022.docx

22 12:10 - Forward Agenda Planner

Trust Board Meeting In Public Forward Agenda Planner.docx

23 12:15 - Questions from Members of the Public

24 12:20 - Motion to Close the Meeting

25 12:20 - Resolution to Exclude the Press and Public

Agenda for the Board of Directors' Meeting in Public

Meeting to be held at 10:00 am on Thursday 08 September 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 • 2021/22 Register of Interests – Board of Directors - Board-Register-of-Interests-2021-22.docx (live.com)	Information	Chair	Verbal
3		Patient Story	Receive and Discuss	Director of Patient Care and Chief Nurse	Presentation
4		Minutes of the Trust Board meeting held in public on 07 July 2022	Approve	Chair	Attached
5		Matters Arising	Note	Chair	Attached
Chair and Chief Executive Updates					
6	10:15	Chair's Report	Information	Chair	Attached
7	10:20	Chief Executive's Report - Overview of Activity and Developments	Receive and Discuss	Chief Executive	Verbal
Patient Experience					
8	10:25	Patient and Family Experience Report Annual Report	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached
Patient Safety					
9	10:35	Feedback from Maternity Assurance Group	Receive and Discuss	Medical Director / Director of Patient Care and Chief	Attached

Item No.	Timing	Title	Purpose	Lead	Paper
				Nurse / Maternity Safety Champion	
10	10:45	Serious Incident and Learning Report	Receive and Discuss	Director of Corporate Affairs/ Medical Director	Attached
11	10:55	Mortality Update	Receive and Discuss	Medical Director	Attached
Workforce					
12	11:05	Workforce Report	Receive and Discuss	Director of Workforce	Attached
13	11:15	Violence and Aggression Programme update	Receive and Discuss	Director of Workforce / Director of Corporate Affairs	Attached
11:20 – Break (10 mins)					
Performance and Finance					
14	11:30	Performance Report Month 04	Receive and Discuss	Chief Operations Officer	Attached
15	11:35	Finance Report Month 04	Receive and Discuss	Director of Finance	Attached
Assurance and Statutory Items					
16	11:45	Research & Development Annual Report	For Noting	Medical Director	Attached
17	11:50	Emergency Preparedness, Resilience and Response Annual Report	For Noting	Director of Operations	Attached
18	12:00	Significant Risk Register	Receive and Discuss	Director of Corporate Affairs	Attached
19	12:05	Board Assurance Framework	Receive and Discuss	Director of Corporate Affairs	Attached
20	12:10	(Summary Reports) Board Committees • Audit Committee 06/06/2022 • Finance & Investment Committee 05/07/2022 and 02/08/2022 • Quality & Clinical Risk Committee 06/06/2022	Assurance and Information	Chairs of Board Committees	Attached

Item No.	Timing	Title	Purpose	Lead	Paper
		• Charitable Funds Committee 28/04/2022 • Trust Executive Committee 13/07/2022 and 10/08/2022			
21	12:15	Use of Trust Seal	Noting	Director of Corporate Affairs	Attached
Administration and Closing					
22	12.20	Forward Agenda Planner	Information	Chair	Attached
23		Questions from Members of the Public	Receive and Respond	Chair	Verbal
24		Motion To Close The Meeting	Receive	Chair	Verbal
25		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, 03 November 2022					

Milton Keynes University Hospital NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Minutes of the Trust Board of Directors Meeting in Public held on Thursday, 7 July 2022 at 10.00 hours via Teams

Present:		
Alison Davis	Chair	(AD)
Professor Joe Harrison	Chief Executive	(JH)
Heidi Travis	Non-Executive Director	(HT)
Haider Husain	Non-Executive Director	(HH)
Gary Marven	Non-Executive Director	(GM)
Professor James Tooley	Non-Executive Director	(JT)
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)
John Blakesley	Deputy Chief Executive	(JB)

In Attendance:		
Kate Jarman	Director of Corporate Affairs	(KJ)
Jackie Collier	Director of Transformation & Partnerships	(JC)
Sarah Crane (Item 7)	Lead Chaplain	(SC)
Mustafa Hussain	Graduate Management Training Scheme Trainee	(MH)
Julia Price	Senior Corporate Governance Office	(JP)
Kwame Mensa-Bonsu	Trust Secretary	(KMB)

1 Welcome and Apologies

1.1 AD welcomed all present to the meeting and introduced Mustafa Hussain. There were apologies from:

Dr Luke James, Non-Executive Director
Helen Smart, Non-Executive Director

2 Declarations of interest

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

3 Minutes of the Trust Board Meeting in Public held on 5 May 2022

3.1 The minutes of the Trust Board Meeting in Public held on 5 May 2022 were reviewed and **approved** by the Board with one amendment that BM was present at the meeting.

4 Matters Arising

4.1 Action 2
The survey results would be shared at November's Board. Closed

Action 5
AD and DP fed back from the recent Leadership Council where allyship and recruitment had been identified as particular aspects the Council would like the Board to focus on. This action was completed. Closed

Action 7
HH noted that this action had not been completed. NBM to review and resolve. Open

Action 8
This action was completed. Closed

Action 9
This action was completed. Closed

There were no other matters arising.

5 Chair's Report

5.1 AD presented the Chair's Report and informed the Board that she had met with Ben Hayworth, the new lead for the charity, MK Arts for Health. Plans for the charity included improvements to courtyard areas such as a sensory garden and a new shed which would incorporate a green roof system. JB advised that the shed would require liaison with the Trust's fire safety officer. JH added that a staff allotment was being planned for one of the courtyards that was not maintained by MK Arts for Health.

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

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

6.1 JH invited DP to update the Board on progress to address violence and unacceptable behaviour within the hospital. He advised that the Royal College of Nursing had provided very positive feedback on this work. DP reminded the Board that the staff survey had indicated no staff-on-staff violence this year and the focus had shifted to patient-on-staff violence. She reported that the working group established to address the issues had been well attended by a good cross-section of staff and progress to date included the following:

- Policy and strategy refresh;
- A trust wide poster campaign had taken place;
- Staff training around bullying and harassment and unconscious bias had been introduced and flags on the electronic patient record system, eCARE, were being used for people known to have behavioural issues;
- A review of incidents had not identified any particular themes;
- A series of listening events would be taking place to allow staff to share their stories to identify different means of preventing incidents occurring;
- All staff would now be required to undertake conflict resolution training whilst restraint and break away training was being provided to all patient facing staff;
- Information for staff advising of their rights and available support was due to launch;
- Security team members were being allocated specific areas where regular patients would often display unacceptable behaviour and extra training for staff within these areas would be offered;
- A buzzer system was being introduced in the Emergency Department to enable patients to wait elsewhere when waiting times were very long;
- A business case for a dedicated project manager and health and safety advisor was being drafted.

6.2 JH reported that, regionally, the Trust was the best performing hospital in terms of 4 hour waits in the Emergency Department, patients waiting more than two years and for attempting to increase activity levels to over 100% to tackle waiting list backlogs.

6.3 JH and IR had held a number of open sessions over the previous two weeks with all maternity staff where engagement had been fantastic. Feedback indicated that the staff had greatly appreciated this opportunity and the Executive Team were considering how these sessions could encompass other parts

of the organisation. BM suggested using social media to promote the engagement sessions to improve recruitment.

6.4 JH confirmed that the Integrated Care System (ICS) was legally constituted from 1 July 2022. The first meeting of the Integrated Care Board (ICB) had been held with another meeting scheduled for two weeks' time and JH advised that the health and care community were working well together. He was keen to see progress in the provision of support for the development of Places. He highlighted that the proposal to develop a PCI service at Milton Keynes under the umbrella of Oxford University Hospitals would be put forward for ICB approval at the end of the month.

6.5 JH advised that the Executive Team had been working with the four clinical divisional triumvirates to ensure there was adequate investment in the quality priorities of electives, diagnostics, emergency care and outpatients and an update on progress would be provided to Board in November.

6.5 IR reported that there had been a recent death of a mother who passed away 10 days after giving birth. This was obviously a very distressing event for the family and all involved in her care, which included a number of organisations and the Trust was working with partner agencies to understand exactly what had happened. On behalf of the Board, AD offered condolences to the family.

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

7 Patient Story

7.1 NBM introduced SC, Head of Chaplaincy, Bereavement and Willen Hospice Spiritual Care Lead. SC began by highlighting the impact illness had on individuals, their loved ones and care givers and she explained that the chaplaincy team's goal was to ensure the availability and delivery of high quality pastoral, spiritual and religious care to all patients, visitors and staff without prejudice or judgement.

7.2 During the pandemic, funding had been secured to enable the team to provide more tangible spiritual care particularly for non-religious people. These included journals to write in, essential oils, ear defenders and eye masks. Ward 7 was chosen as the pilot site in November 2021 and SC reported that 80% of patients had found the activities meaningful regardless of their religious faith. The resources were helpful in starting conversations and many people acknowledged the isolation and loneliness of being a patient and the value of having someone to chat to. To date, 25 resource boxes had been delivered to wards including the paediatric ward (5), and the initiative had been extended to Willen Hospice and the Campbell Centre (on site mental health centre). Plans were being developed to recruit 20 volunteers to help deliver the service across all wards. NBM reported that there were 227 potential volunteers awaiting processing and induction. She added that in the past, people had been asked which areas they wished to support but going forward they would be deployed to areas requiring cover.

7.3 HH congratulated SC on this fantastic initiative and asked about the size of the chaplaincy. SC advised that the team consisted of 3.3 whole time equivalents covering the hospital, Willen Hospice and a limited service to the Campbell Centre. Around 400 patients a month were seen. HH asked whether there was capacity to support patients from all faiths and how the team interacted with non-Christian faiths. SC recognised that counter measures were needed to address the bias towards Christianity nationally and she hoped to recruit non-Christian faith leaders in the future.

7.4 NBM commented on the huge impact the chaplaincy had on patient experience and by raising their concerns over individual patients. The team also encouraged collaboration with religious groups and NBM advised that there were Christian and non-Christian leaders on the Bank who could be called upon when necessary.

7.5 AD congratulated SC on this inspiring approach and thanked her for sharing the initiative with the Board.

The Board **noted** the Patient Story.

8 Patient and Family Experience Report

8.1 NBM explained that the focus this year was on people with learning disabilities and autism. External visits were taking place, led by the Patient Experience Matron, Sharon Robertson, to establish focus groups to obtain feedback on experiences and provide a source of advice on how to support people with learning disabilities when introducing new care pathways or different ways of working. NBM described a patient's negative experience in the Emergency Department which had led to some collaborative working with the individual's home to improve the experience for others with learning disabilities. NBM advised that subsequently, when another patient from the same home visited the Department they had a much more positive experience.

8.2 NBM highlighted the launch of the patient experience trolley containing activities for patients to improve their experience. She also referenced the launch of a QR code for patients, giving them access to up to date information on the hospital's website.

8.3 JH reported that in response to the national rise in complaints and the local complaints backlog, within the last ten days, additional support to assist with the complaints team had been approved. Recognising the desire nationally by patients for more information on waiting times, JB and IR had arranged for the publication of waiting times for a range of specialties on the hospital's website.

The Board **noted** the Patient and Family Experience Report

9 Maternity Update

9.1 IR reminded the Board of the huge weight of expectation for boards across the NHS to have sight at a granular level of maternity-related data such as CNST (Clinical Negligence Scheme for Trusts), the Perinatal Quality Surveillance Model (PQSM) and outputs from the Ockenden reports. To date, the Board had been looking at this data but going forward, a Maternity Assurance Group, chaired by LJ (Maternity Safety Champion) was being established with the inaugural meeting scheduled in July.

9.2 IR highlighted the five principles of PQSM around increasing oversight for perinatal and maternity care particularly for the ICS; the minimum dataset for the quarterly CNST dashboard; and for Ockenden, the monthly review of maternity and neonatal safety and quality by the Board.

9.3 Over the last quarter there had been 16 deaths reported to MBRRACE (a national audit programme) of which 13 were stillbirths and 3 were terminations for medical reasons. Themes identified were not found to be causative in any of the cases but provided learning points for the wider pathway.

9.4 There were four unavoidable admissions to the Neonatal Unit in March, slightly higher than the previous month. A business case was under development to improve the model through which transitional care was delivered. The main causes around transitional care which affected between 30 and 40 babies per month were phototherapy (light treatment for jaundice) and intravenous antibiotics.

9.5 There were five actions following the Ockenden Report that the Trust was not fully compliant with and these were being addressed.

9.6 IR reminded the Board that in April as a result of the Ockenden review the Trust was invited to decide whether to continue with the roll out of the Continuity of Carer model, where teams of eight midwives looked after women throughout their pregnancy and postnatally, to stop the roll out or to wind it back to the more traditional model of care. It was decided to not expand the roll out and to leave things as they were, given the number of vacancies at the time. Over the last 4-8 weeks there had been a number of developments within Maternity, the key one being the loss of more staff. IR did not believe this was specific to Milton Keynes. Ideally, there would be 145 midwives in post and over the last year there had typically been 125 midwives and the gap was being managed successfully. However, this number had reduced further and there were currently 110 midwives in post. IR explained that despite 18 midwives

coming on stream over the next few weeks, this left a significant gap against the establishment but the Board was assured that bank and agency were used to ensure that 90% of all midwifery shifts were filled. IR explained that there were currently two models in operation: the Continuity of the Carer model and the traditional model. This was the worst scenario in trying to deliver the service. The staff engagement sessions with Maternity discussed under Item 6 were brought about as a result of the increased vacancy rate. The general view amongst the midwives was that a change was needed. IR advised that a definitive decision would be made within the next few weeks and the Board would be kept informed.

9.7 GM queried whether rolling back the model completely would alleviate the problems if the staffing gap remained and IR responded that going to back to a single system would bring its own problems. Running the Continuity of Carer system successfully required around 145-150 midwives.

9.8 BM queried whether international recruitment was having an impact and NBM explained that induction processes and training were more complicated for overseas midwives due to their different practices and the support required was significant.

9.9 IR commented that although the focus was on staffing numbers, skill mix and experience were also very important. He reported that many leavers had opted to join Frimley Park's newly established telephone triage service for pregnant women which was sited in Bicester.

9.10 JH reported that despite a small dip over the last five years, the number of births at the trust was generally consistent at around 3800 a year and DP would be reviewing establishment figures over that period. BM proposed a deep dive into maternity staffing for the last five years at Workforce and Development Assurance Committee.

Action: Deep dive into midwifery establishment over the last five years for Workforce & Development Assurance Committee

The Board **noted** the Maternity Update.

10 Serious Incident and Learning Report

10.1 KJ highlighted the following from the report:

- The number of serious incidents relating to deep tissue injuries particularly on patients' heels and reported that this, and drug errors, were both areas of focus.
- The Trust received a Regulation 28 report from HM Coroner in relation to the disengagement of alarms for monitored patients. A response would be provided by 12 July 2022 and KJ would be meeting with the Coroner later in the month regarding disclosures and the management of electronic records.

10.2 IR reminded the Board of the national issue of patients acquiring Covid in hospital during the early part of the pandemic. To December 2021, at this hospital, 88 patients had died having acquired COVID in hospital, 60 of whom died 'of COVID' and 28 dying 'with COVID'. From December 2021, 20 patients had died having acquired COVID in hospital, 5 'of COVID' and 15 'with COVID'. All families involved had been written to and engaged with.

10.3 KJ advised that from the end of June, appreciative inquiry practice was being rolled out across wards and departments

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

11 Focus on Falls (2021/22 Annual Report)

11.1 NBM advised that the number of falls had increased but the number of falls resulting in moderate harm had reduced, adding that the majority of patients suffering moderate harm did have capacity. Work was ongoing with therapies teams and the Meaningful Activities Coordinator to address the issues.

11.2 In response to a question from HH, it was explained that the average indicator in the first slide related to the average number of falls per month in the quarter.

11.3 The Board **noted** the 2021/22 Falls Annual Report

12 Focus on Pressure Damage (2021/22 Annual Report)

12.1 NBM highlighted some of the themes around pressure damage and advised that a huge amount of work was being undertaken by the Harms Prevention Group, focusing on deep tissue injuries. Patients coming into the Emergency Department were at greater risk from harm when malnourished or after having spent a significant period lying down at home or on trolleys. NBM explained the importance of early intervention and added that the new bed stock roll out would make a significant difference. However, there had been an increase in incidence over the last few months and a report would be presented at the next Board meeting in September.

The Board **noted** the 2021/22 Pressure Damage Annual Report

13 Safeguarding Annual Report

13.1 NBM explained that the Hospital was a statutory partner in safeguarding represented at the Safeguarding Board with the Council and Police. Safeguarding training compliance at the Trust was consistently around 95% and NBM explained that it had been challenging during the pandemic to maintain this level for those requiring safeguarding children training at Level 3, highlighting the increase in activity for the team during this time. A maternity safeguarding lead had recently been appointed.

13.2 HH reported that when he last spoke to the safeguarding nurse, she had stated that there was no tool to communicate with partner agencies other than by phone and he asked if this situation had improved. NBM advised that sharing information had become easier since the introduction of the Multi-Agency Safeguarding Tracker (MAST).

13.3 AD requested a glossary for acronyms for this report. She also highlighted the use of the term ‘learning disability deaths’ which should have read ‘deaths of people with a learning disability’.

The Board **noted** the Safeguarding Annual Report.

14 Nursing Workforce Report

14.1 NBM advised that additional capacity for OSCE (objective structured clinical examinations) was now in place but meant that newly recruited international nurses were having to travel to Northumbria for them. However, they were settling into their base wards and more nurses were in the pipeline. NBM reported that recruiting health care assistants was proving challenging as private companies, such as Tesco’s, were able to offer more lucrative packages. She emphasised the importance of recruiting the most suitable candidates to reduce turnover.

14.2 DP reported that international nurses were proving keen to work for the hospital, resulting in other organisations getting in touch to find out why this was the case.

The Board **noted** the Nursing Workforce Report

15 Workforce Report Month 2

15.1 DP highlighted the following from the report:

- An increase in turnover reflected nationally. Pre-pandemic turnover had been around 10%, decreasing to 5% at some points during the pandemic. This was thought to be because people were waiting for the end of the pandemic before moving on.
- The quality and number of candidates had increased.
- Apprenticeships and development courses continued to be publicised broadly for all staff with a view to spending the maximum amount of the Apprenticeship Levy.
- Listening events with staff following the staff survey results were taking place.
- A review of all recruitment practices was underway to ensure these were as inclusive as possible.

15.2 GM commented that nationally people were beginning to leave the workforce earlier and he expected this situation to worsen.

15.3 HH asked about the results from the recent night workers survey and DP responded that as a result of the survey, various offers and services were being put in place such as access to hot meals. She explained that the reasons people elected to work nights were largely as expected such as caring commitments, work/life balance and increased pay.

15.5 AD commented on the time to hire indicator and DP explained that the vaccination status checks that had been required in the last quarter of 2021-22 continued to play out but additional people had been recruited to the HR team to assist with the increasing number of applications and subsequent interviews. DP highlighted that turnover within the recruitment team was high as people found other jobs within the Trust and she was looking at means to encourage them to stay within the HR team for at least 18 months whereupon they would then be assisted to move on if they wished.

The Board **noted** the Workforce Report

16 Performance Report Month 2

16.1 EL advised that bed occupancy had reduced slightly in May with some escalation areas contracting. However, the number of patients not meeting the Criteria to Reside was 77 and EL reported that on some days this figure could be as high as 90, reflecting the challenges experienced by external partners. The number of Stranded Patients in month was 184 and Super Stranded was 50, reflecting the gridlock within the system.

16.2 From an emergency care perspective, handover care processes continued to be developed and a positive regional visit had taken place at the end of June where the different approach adopted here was noted and in particular, the engagement of staff and integration of the ambulance service. However, the Emergency Department (ED) performance dipped in month to 54.8% against a target of 100% for a total time in ED of no more than 8 hours for admitted patients. The total open pathways decreased in month reflecting the validation work undertaken with external agencies reviewing the organisation's data quality and also reflected the elective position which improved in May. There were 1500 patients waiting more than 52 weeks, mostly in non-admitted pathways. Diagnostic capacity continued to be challenging due to the availability of sufficient staff to operate the additional equipment procured.

16.3 In response to a question from GM, EL explained that where patients stay in hospital for more than 7 days, they become Stranded patients and longer than 21 days they are considered Super Stranded. Generally, there were complex and justifiable reasons why patients remained in hospital for long periods but often it was because they were waiting for space to become available in the community. EL reminded the Board that discharge processes had been agreed as a priority area for MK Place in terms of transformation. AD added that allocation of resources to help community partners maintain flow was high on the agenda of the ICS.

16.4 The Board noted the blank graphs within the Patient Experience section of the report and although it was acknowledged that there had been no Duty of Candour breaches, the Executive Team agreed to consider how best to make the information more accessible.

Action: Executive Directors to review the content of the report to provide more accessible data

The Board **approved** the Performance Report

17 Finance Report Month 2

17.1 TW advised the Board that the report reflected the Trust's financial position for the first two months of the fiscal year. The 2022-23 financial plan was resubmitted at the end of June but the figures reported reflected the original plan. This would be amended in the next report.

17.2 The Trust reported a £4.8m deficit for the first two months of the year, associated with costs against inflationary charges, the increase in the prevalence of COVID and a £1m shortfall for monies assumed from the Elective Recovery Fund (ERF). JH advised that the Trust was in the top regional performers for increasing activity levels but was still unable to qualify for funds of up to £600k per month, despite committing to costs for qualification for that income. JH stated that the Board would be kept informed of any changes to the funding regime or if the Trust was no longer able to sustain the increased levels of activity.

17.3 TW advised that since the report was produced, savings of around £5m were agreed and work was ongoing to bridge the gap to £12m, however, turbulence from inflationary pressures and rising energy prices was a cause for concern that the Finance & Investment Committee would continue to monitor. TW highlighted the healthy cash position, the greater proportion of which was committed to capital expenditure. He added that there were no concerns over the capital programme despite being slightly behind plan, and he was looking to ensure an even spread of payments across the year.

The Board **noted** the Finance Report.

18 2022/23 Financial Plan

18.1 TW advised that the Trust had originally submitted a deficit plan of £8m aggregated against the Bedford, Luton and Milton Keynes (BLMK) ICS deficit position of £41m, following which, NHS England (NHSE) released around £1.5bn additional funding at the end of April. This equated to £20m additional funding for BLMK of which £3m was made available to the Trust. ICSs were required to break even. In order to achieve this, the organisation must achieve £7.5m of ERF which was by no means guaranteed and conversations were ongoing over how this would be managed. TW reminded the Board of expected energy price rises in the autumn and he advised that a judgement on bank and agency staffing levels had been made in the resubmitted plan but there was no contingency for high levels of sickness, a subject for discussion at the extraordinary Finance & Investment Committee prior to submission. TW added that not all of the schemes on the £18.3m capital expenditure programme had been approved and the final balances would be worked through as the year progressed.

The Board **approved** the 2022/23 Financial Plan.

19 Annual Claims Report

19.1 KJ advised that the report had been shared with the Quality and Clinical Risk Committee and advised that the profile was fairly typical, focused around Emergency Medicine and Maternity services. There was a new legal toolkit around efficient claims management and savings. Work was ongoing to link claims with learning but this often involved a significant time-lag.

19.2 IR reported that the Trust, encouraged by the Getting It Right First Time (GIRFT) programme, was working hard to involve senior clinicians in learning from claims and litigation. He advised that the Trust admitted liability early on where appropriate to avoid lengthy and expensive court cases.

The Board **noted** the Annual Claims Report

20 Medical Revalidation Annual Report 2021/22

20.1 IR explained that under regulations, the Trust was required to ensure that its doctors were fit to practise and IR made recommendations to the General Medical Council (GMC) every five years. He highlighted that the 337 doctors did not include post graduate trainees and pointed out that the number of doctors on the bank had increased. The Trust's Revalidation Committee, chaired by a lay person, had been praised by the GMC who were assured by the Trust's processes.

The Board **approved** the Medical Revalidation Annual Report 2021/22

21 Significant Risk Register

21.1 KJ highlighted the changes to the risk register described in the report advising that risks identified as uncontrolled did not indicate that there were no controls, just that they had not been documented. Work was continuing with divisions and service leads to ensure that the register was as up to date as possible.

21.2 AD requested that the wording for Risk 101 (dedicated theatres for maternity services) was amended for clarity.

Action: KJ to arrange for the amendment of Risk 101

The Board **noted** the Significant Risk Register

22 Board Assurance Framework

KJ highlighted the changes detailed in the report and advised that work on maternity risks was ongoing.

The Board **noted** the Board Assurance Framework

23.1 Summary Report for the Finance and Investment Committee Meeting – 3 May 2022

The Board **noted** the report.

23.2 Summary Report for the Finance and Investment Committee Meeting – 7 June 2022

The Board **noted** the report.

23.3 Summary Report for the Finance and Investment Committee Meeting – 16 June 2022

The Board **noted** the report.

23.4 Summary Report for the Audit Committee Meeting – 18 May 2022

The Board **noted** the report.

23.5 Summary Report for the Audit Committee Meeting – 13 June 2022

The Board **noted** the report.

23.6 Summary Report Trust Executive Committee Meeting – 11 May 2022

The Board **noted** the report.

23.7 Summary Report Trust Executive Committee Meeting – 8 June 2022

The Board **noted** the report.

24 Use of Trust Seal

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

25 Forward Agenda Planner

25.1 KJ advised that the meeting agenda structure was under review and she reported that a new Executive and Non-Executive Director buddying arrangement for visits was being established.

25.2 It was agreed that Freedom To Speak Up reports would be shared more frequently with the Board, given the positive engagement sessions IR and JH had held with Maternity. IR queried whether a risk should be included on the BAF around speaking up.

Action: DP to review and consider replicating the maternity engagement exercise in other areas of the hospital.

25.3 AD agreed that there was huge ambition to develop Freedom To Speak Up and the Leadership Council were liaising more with the staff network leads. The Freedom to Speak Up Guardian was keen to develop relationships with the networks.

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

26 Questions from Members of the Public

26.1 IR presented the paper on functional neurological orders in response to a question from a member of the public following the management of a relative at the Trust which was felt to be suboptimal. He thanked the individual who had raised the question and invited others to come forward with any other queries.

26.2 In response to another question posed by a member of the public regarding the timing and reliability of administration of Parkinson's Disease medication, IR acknowledged that the organisation recognised that medication was not always administered in a timely way and a lot of quality improvement work had been undertaken with the patient safety champions and the Pharmacy Department to address the issue. On behalf of the Trust, IR was happy to pledge commitment to this care quality agenda.

26.3 AD advised that Governor Lucinda Mobaraki had requested information on hip and knee operation waiting times and the Trust's response had been shared with her. In addition, with a view to openness and transparency, the Trust had published waiting times for the five most frequent operations for all specialties on the website (referenced under Item 8.3). The Board expressed their appreciation of the Governors' engagement with their constituents.

26.4 There were no further questions from the public.

27 Any Other Business

27.1 There was no other business.

26 The meeting closed at 12:30

Updated : 23/08/22

NHS
Milton Keynes University Hospital
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Trust Board Action Log

Action No.	Date added to log	Agenda Item No.	Subject	Action	Owner	Completion Date	Update	Status Open/ Closed
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
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	08-Sep-22	The page has been refreshed. The Patient Experience Team have established a schedule of monthly reviews.	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
12	07-Jul-22	16.4	Performance Report	Executive Directors to review the content of the report to provide more accessible data	Executive Directors	08-Sep-22		Open
13	07-Jul-22		Significant Risk Register	Risk 101 to be amended to provide greater clarity	KJ	08-Sep-22	Amendment completed.	Completed
14	07-Jul-22	25.2	Forward Agenda Planner	DP to consider ways to replicate the maternity engagement exercise in other areas of the hospital	DP	08-Sep-22		Open

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: 07.09.2022**
Report Title	**Chair's Report**	**Agenda Item: 6**
Lead Director	**Name: Alison Davis**	**Title: Chair**
Report Author	**Name: Alison Davis**	**Title: Chair**

Key Highlights/ Summary	Appointment of new Chief Nurse Changes in Non-Executive Group			
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Noting** x	**For Review** ☐

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

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

Chair's report 07.09.2022

To provide details of activities, other than routine committee attendance, and matters to note to the Trust Board.

It has been a quieter period than my previous reports as we entered the holiday season:

1. I took part in the appointment panel for our new Chief Nurse and we welcome Yvonne Christley to the Board meeting today.
   Our thanks again to our former Chief Nurse, Nicky Burns-Muir who retired from the post.

2. I have been receiving updates about the exciting plans proposed by MK Arts for Health, for the refurbishment of some of the courtyards and look forward to an update to the Board later in the year.

3. I met with Hayley Edwards of Carers Support MKUH, to find out about the support available for unpaid carers supporting patients at the hospital and the challenges in meeting the need.

4. Work has progressed on the Governance and planning for future Board meetings and seminars

5. The membership database has been refreshed and several Governors have been busy attending events in their constituencies, listening to public feedback and encouraging them to join as members of the Trust.

6. Several changes are taking place in the Non-Executive Director (NED)group due to personal or work circumstances and steps are being taken to address gaps in the team.
   We are looking forward to welcoming our new Associate NEDs this month.

7. The BLMK Chairs and Leaders Group met in August and discussion focused primarily on the Integrated Care Partnership strategy development session planned for the 6th September

Meeting title	Board of Directors Meeting In Public	Date: 08 September 2022
Report title:	Trust wide report – Annual 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 an annual overview of patient experience, engagement and feedback across the Trust and improvements to patient and family experience as a result of feedback received and the gaining of feedback.				
Purpose *(tick one box only)*	**Information**	**Approval**	**To note**	x	**Decision**
Recommendation	The Board is asked to note the contents of the report				

Strategic objectives links	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	None
Next steps	Annual report detailing analysis, improvements, and trends from patient experience feedback.

1. Introduction and purpose

This report details the Trust's overall position regarding patient and family experience feedback, engagement activity and the achievements of the Patient and Family Experience team for 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 in 2021/22

Feedback pages on the Trust's website

The team have improved the information available to patients and families through the Trust's website regarding how they can provide feedback. The link inviting patients and families to leave feedback is on the front page of the Trust Website. The webpages are illustrated below:

Each tab provides the user with details on how they can feedback on their experience or make a suggestion for improvement. The 'You Said We Did' tab is updated with information as to what changes have made as a result of feedback, and this is demonstrated below.

Compliment Project

All compliments received are acknowledged shared and recorded on the Trust's event reporting database. Each month a 'compliment of the month' regarding an individual and a team are chosen. The individual receives a personal card from the Chief Nurse thanking them for their contribution and the team receive a certificate. The theme of the compliment of the month is stars and consequently the card and certificate are star based. The card/certificate is presented to the winners by a

member of staff from the Patient and Family Experience team who dresses as a gold star, pictures are then shared in the CEO newsletter. The members of staff and teams receiving ‘compliment of the month’ are detailed in the Patient and Family Experience quarterly reports.

Alongside the card/certificate a golden raffle ticket is given for a draw that takes place every quarter with the winner receiving a £25 Amazon gift voucher, the winning ticket is picked at random.

The £25 Amazon vouchers were won by the following staff:

Q1 - IBD Nursing

Q2 - Jeff Ward (Pharmacy)

Q3 - Domestics Team

Q4 - Lea Beaili – ED Student Nurse

Increasing the amount of Friends and Family Test (FFT) feedback

During 2021/22, the Patient and Family Experience team worked with the providers of the ‘My Care’ application Zesty to increase the amount of feedback received through the FFT route. This involved Zesty sending the FFT questionnaire to patients via a SMS message.

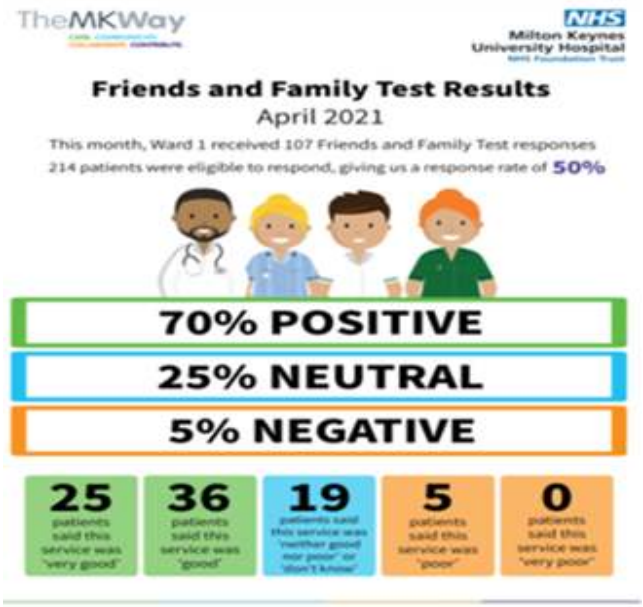
This project underwent a trial during September 2021 with all patients attending the Trauma and Orthopaedics (T&O) outpatients department. During Q1 2021/22, only 3 T & O patients had replied to the FFT questionnaire in paper form. During the trial, held for 3 weeks in September 2021, 105 patients responded to the FFT via the SMS method. Following this success, from October 2022 onwards, all patients attending any outpatient area received their FFT via SMS. In February 2022, patients attending the Emergency Department (ED) were also included. Work will continue with Zesty during 2022/23 to enable FFT SMS messages to be sent to all patients that have been admitted and subsequently discharged. The success of this collaborative work is detailed below and is evidenced by the significant increase in the amount of FFT feedback received.

Communication of FFT results

In addition to staff having access to all feedback received via the Patient Experience Platform (PEP), as detailed below, posters are created by the Patient and Family Engagement team, on a monthly basis, detailing how each area has been rated by their patients regarding the FFT categories of:

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

Posters are displayed on all ward areas.



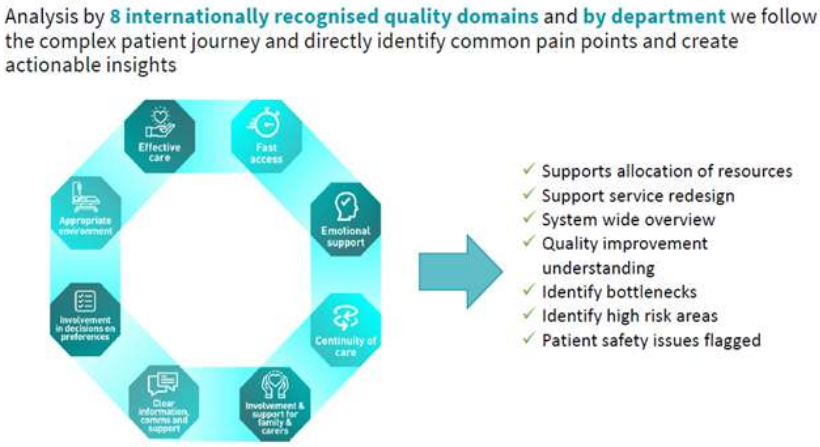
Patient Experience Platform (PEP) Health

With the increase in the amount of free text comments received through the FFT route it was recognised that theming the feedback inhouse was complex. Analysis that could be shared with the divisions and individual areas to assist them in understanding what the patients thought about their experience, and what mattered most to them was required.

On 1st December 2021 collaborative work commenced with PEP Health and the PEP platform (dashboard) was introduced into the organisation.

PEP Health collect all free text comments from patient feedback received through the FFT route, and online review 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. The platform therefore offers the Trust a unique insight into patient experience and what matters to our patients and families. PEP Health were able to record historical data from our inhouse FFT database to allow for comparative analysis.

As above, the feedback is themed into 8 quality domains as illustrated below.



All staff can have access to the dashboard following a request for log in details. Users can select collated feedback from specific areas and timeframes and search for themes using the dashboard via an icon on their desktop. This gives users a more comprehensive range of data than has previously been available.
The presentation of the dashboard is illustrated below:

A User guide and recording demonstrating the dashboard is available for all staff on the following link: 20211215_150338000_iOS.mov.

The feedback from the divisions in respect of the actions taken as a result of feedback will be discussed at the Patient and Family Experience Board Focus Group C- Shared Learning (meeting in June 2022).

Patient Experience Network National Awards (PENNA)

Early in the year the Patient and Family Experience team submitted an entry to PENNA to showcase the work undertaken in the organisation during the Covid-19 pandemic, to support patients and their families. The entry was entitled ‘Keeping Patients Connected in a Pandemic’ and included initiatives such as: Letters to Loved ones; the Relatives Line; and the Patient Bag Drop off service.

The team was shortlisted as a finalist. The awards took place on 10th September 2021.

Following the successful presentation, the team were approached to present again in a workshop arranged by the PEN, NHS England, and NHS Improvement. NHS staff from across the country were invited to attend the workshop which was entitled: 'Using Insight for Improvement'. The presentation was very positively received.

Using Appreciative Inquiry (AI) in patient and family experience

The Patient and Family Experience team have worked closely with the AI team to achieve the following:

- Co-created a booklet with patient representatives from the Trust's Patient Engagement Group to use when recruiting patient and volunteers to become patient representatives to support the Trust with advice and feedback, from their perspective, on initiatives and service changes or redesign. The booklet is designed to be completed by the patient or volunteer to enable them to focus on why they wish to engage and contribute to the Trust and what they can bring to the role. Consideration is also given to what would be required from the Trust to ensure a positive and worthwhile experience for all. This booklet will be invaluable during 2022/23 to assist the Patient and Family Experience team's objective to increase the number of patients and families that we engage with on all improvements and service redesign/design.
- The co-creation with the AI team of a Patient Experience toolkit. An online toolkit which includes selection of tools and resources to support Trust staff to gather and learn from patient experience stories. It includes a range of tools and resources that can be used to gather stories and feedback, ideas for using the Friends and Family Test (FFT) and compliments to grow and develop as a team, and a framework for personal and group reflection for responding to patient and family concerns.
- AI tools were used by Trust staff to obtain high quality patient feedback. The tools challenge staff to think about the language they use during patient interactions to consider what really matters to our patients and their families and therefore what changes can be made to improve experience.

Collaborative working

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

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

availability of medication out of hours was reviewed and resulted in an improvement in patient experience.

Other improvements include:

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

Ongoing improvements

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

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

Communication Training – provided to staff in the Emergency Department, Health Care Assistant group, Preceptorship Nurses, and Band 6 junior sisters.

3. Patient Experience data

Friends and Family Test (FFT)

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

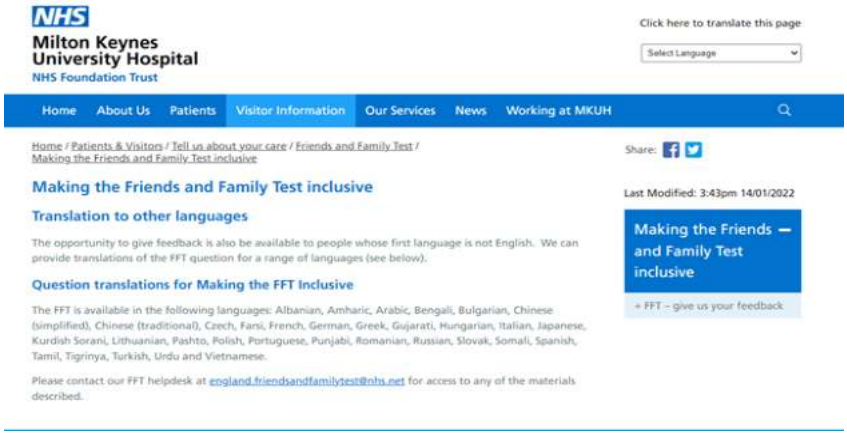
Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22	TOTAL NUMBER RESPONSES FOR 2021/22
3137	3600	16499	16059	**39295**

During 2021/22, 93.93% of patients on average rated the Trust's services as very good or good.

FFT- Ethnicity

From the 39295 respondees to the FFT,and where an ethnic origin was stated, 73% of respondees described themselves as being White British.

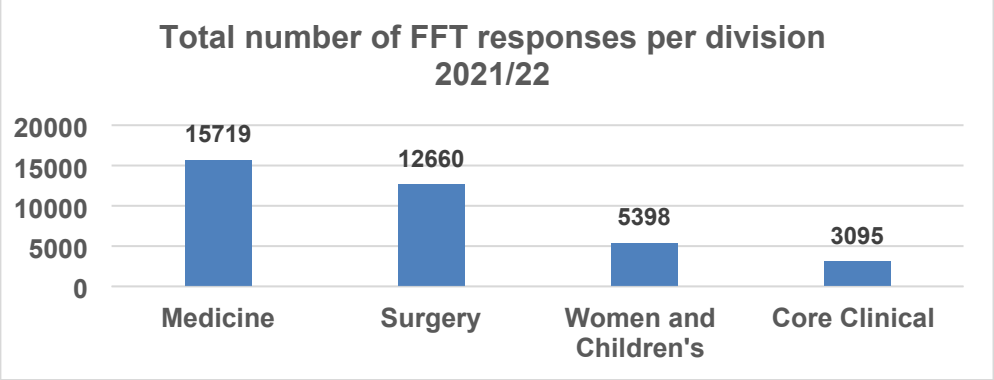
The ‘Tell Us About Your Care’ website pages have been improved with regard to providing information on how to get the FFT form in a different language, if required.



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 minority groups to obtain their valuable feedback in a way that suits them.

Divisonal FFT responses

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



FFT care principles

During 2021/22 the overall rating for the Trust in relation to positive comments from FFT feedback was 4.6* out of 5*.

The Trust are performing **well** in the following care principles according to FFT feedback:

- **Effective treatment delivered by trusted professionals**

Definition: Positive therapeutic relationships between patients and staff are at the heart of person centred care. People should receive the most appropriate and effective care for their needs and be treated in a way that recognises and respects the outcomes that matter most to them. Interactions with care professionals should inspire a sense of confidence and trust.

- **Emotional support, empathy and respect**

Definition: To deliver person centred care, a caring holistic approach that includes the provision of support and empathy is needed. For care to be compassionate it must be delivered with respect, dignity, sensitivity and with an understanding about the person.

The care principles in which the Trust are **need improvement** are:

- **Continuity of care and smooth transitions**

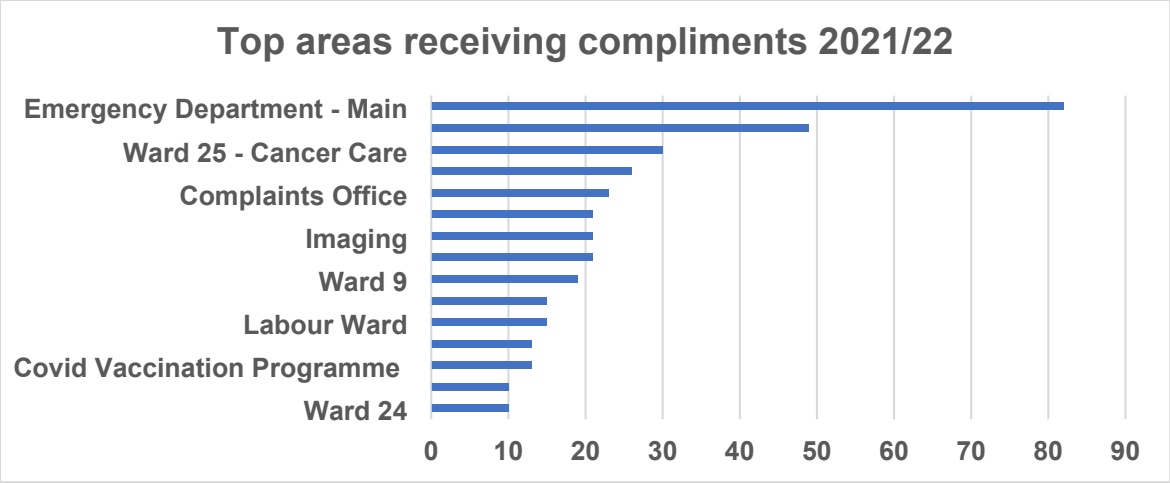
Definition: Often, people's care journeys will bring them into contact with a range of care providers and health and social care staff. Providing a sense of continuity across these is vital to ensuring that people have good overall experiences. Continuity of care is not just influenced by the relationships people have with staff, but by how well information is shared between staff and services and by how organisations interact with one another.

- **Involvement in decisions and respect for preferences**

Definition: People have the right to be involved in their health and care. Involvement in care supports people to play an active role and to
feel more confident in considering treatment options, associated benefits and risks, and in making informed decisions.
Care should be delivered in a way that is sensitive to the needs and preferences of the person. Focusing on the patient as an individual includes treating the person with respect and with sensitivity to their background, social and cultural values. Active listening and enquiry can be important to elicit people's preferences, which should not be assumed.

Compliments

During 2021/22 the Trust received 666 compliments, the top areas receiving compliments are detailed in the graph below.



Surveys

National

The 2021 Adult Inpatient patient included patients who were admitted and discharged during November 2021. The survey field work took place between January to May 2022 and embargoed results will be received in June 2022. The official publication of results by the CQC will take place in October 2022.

The 2021 Maternity Survey included women who gave birth during February 2022. The survey field work will take place during April to August 2022 with embargoed results expected September 2022 and the final CQC report expected in January 2023.

4. Patient Experience and Engagement Activity

Volunteers

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

A volunteer software package has been commissioned and currently the Volunteer team are receiving the training required to ensure the system is able to go live. The software will ensure that the recruitment of volunteers into bespoke roles will be much easier and will improve communication with the volunteers and manage their individual training needs. Currently there are 250 potential volunteers waiting to fill volunteering opportunities as they become available.

5. Governance and learning

Patient Experience Board

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

Focus Area A - Governance
Focus Area B - Engagement
Focus Area C - Shared Learning

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

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

Focus Area C meeting was cancelled due to the Trust being in Opel 4 escalation as was Focus Area A meeting in January 2021.

Focus Area B meeting took place in February 2022 with updates from complaints and PALS and patient experience feedback. Updates were given regarding the Matrons Group work to improve communication with families and carers. Further updates were received from Chaplaincy services regarding multifaith engagement, volunteer's team, Carers MK and the national survey programme. Patient stories were shared regarding time critical medication for patients living with Parkinson's disease.

6. Conclusion

There is much to celebrate during this year with the improvements that have been made regarding the amount of valuable feedback gained from our patients and their families and the different pathways our patients can use to provide their feedback. 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 continue to enhance learning and outcome from feedback across the Trust. 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.

The 'Tell Us About Your Care' pages on the Trust's website has been improved to ensure people can easily access the information they need and it also includes a section which details what the Trust have done in relation to feedback received- 'You said, We Did'.

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Trust Board**	**Date: 08 September 2022**
Report title:	**Maternity Update**	**Agenda item: 9**
Lead director Report author Sponsor(s)	**Dr Ian Reckless**	**Medical Director / Maternity Safety Champion**
FoI status:	**Publicly disclosable**	

Report summary				
Purpose *(tick one box only)*	**Information** ☐	**Approval** X	**To note** X	**Decision** ☐
Recommendation	Receive and discuss and approve terms of reference			

Strategic objectives links	Improving patient safety
Board Assurance Framework links	
CQC outcome/ regulation links	Trust objective – patient safety **This report relates to CQC:** **Regulation 12 – Safe care & treatment** **Regulation 17 – Good governance**
Identified risks and risk management actions	NHS maternity services are under significant pressure with many risks identified and requiring mitigation (Ockenden and other seminal reviews)
Resource implications	None
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	Regular update
Next steps	Receive and discuss
Appendices	1. Draft Terms of Reference for Maternity Assurance Group (MAG) – for approval. 2. Presentation on key issues discussed at inaugural meeting of MAG including two items for escalation for Board discussion.

Executive Summary

1. We have previously had in-depth discussions at Trust Board on maternity services and we have considered how best we can be collectively assured on the key issues going forward.

2. There are growing expectations of Provider Trust Boards on the part of NHSE and NHSR (CNST) in the light of Ockenden and other seminal work on maternity services in the NHS.

3. We previously agreed to set up a 'Maternity Assurance Group' (MAG), composed chiefly of the Maternity Safety Champions (Executive and Non-Executive) but open to other Board members.

4. MAG will scrutinise pertinent issues in detail and report to Trust Board allowing the unitary Board to have informed discussion and gain assurance and / or address gaps and issues.

5. **Draft ToR are presented here for modification / adoption by Trust Board.**

6. A presentation will be given at Trust Board describing the key issues explored at MAG's inaugural meeting on 25 August.

7. **Two specific issues are escalated for discussion** –

    a. [A] Our approach to the Ockenden recommendation of a *specific / dedicated* patient safety specialist for maternity services

    b. [B] Trust Board's view as to the appropriate point at which to engage in planning for potential future adoption of the maternity continuity of carer (MCoC) model (in the context of the need to suspend the model in recent weeks).

8. Board will be reviewing the *draft* minutes of the inaugural meeting of MAG in private session today. Once approved by MAG, these minutes will be presented to Board in public session at a future meeting.

Milton Keynes Hospital NHS
NHS Foundation Trust

Maternity Assurance Group (MAG)
Terms of Reference

1. Background and Purpose

Public reporting to the Board on issues pertaining to maternity services is both required and important to enable transparency and public accountability. However, given the volume and the technical nature of some of the information, a sub-group of Board can make a valuable contribution as the wider unitary Board fulfils its assurance function.

The Maternity Assurance Group (MAG) has been formed by Trust Board to ensure that members of the Trust Board (including Executive and Non-Executive Maternity Safety Champions) have an appropriate forum in which to discuss, explore and challenge issues pertaining to Maternity Services: this includes through exploration of detailed and complex information (quantitative and/or qualitative) where appropriate.

MAG has been set up in the context of the developing expectations of the Clinical Negligence Scheme for Trusts (CNST) and of NHS England (national, regional, system) for NHS Provider Board oversight and scrutiny of Maternity Services in the light of Ockenden and other seminal reviews.

It is anticipated that MAG will advise Trust Board on issues related to Maternity Services to facilitate self-declarations and formal external submissions. It will also highlight gaps and deficiencies as they emerge. Importantly, MAG is not a forum for the *operational management* of maternity services at MKUH: this function takes place through Divisional structures (Women's and Children's) reporting through to Trust Executive Committee (TEC).

2. Cycle of Business / Outline Agenda

In relation to CNST –

- MAG will review evidence such that Trust Board can be assured of the Trust's performance in respect of the 10 safety actions described by CNST, and be made aware of gaps in performance against expectations / plans to close those gaps.
- Specifically, MAG will review evidence such that Trust Board can be assured that the Trust is using the Perinatal Quality Surveillance Model (PQSM) through its operational management and departmental governance structures (reference: CNST Safety Action 9).
- Specifically, MAG will review evidence such that Trust Board can be assured in relation to maternity staffing at least every six months (reference: CNST Safety Actions 4 and 5).

- Specifically, MAG will review evidence such that Trust Board can be assured in relation to performance with the Saving Babies' Lives Care Bundle.

In relation to The Final Ockenden Report –

- MAG will review Trust performance against the recommendations ('safety actions') and develop a detailed understanding of areas in which actions are not being met.
- MAG will advise Trust Board on any gaps and make detailed recommendations if / when it is proposed that the Trust actively supports ongoing non-compliance.

In relation to other maternity issues –

- MAG will be engaged / sighted as appropriate when there are national / regional / LMNS requests of the Trust in relation to Maternity Services.
- Through its work, MAG will ensure and evidence that the Trust Board can have confidence in local multi-professional leadership.
- MAG will be sighted and have input into a Maternity Service Quality Improvement Plan.
- MAG will be briefed on other important issues pertaining to Maternity Services by exception.

3. **Membership**

Core Members:

- Non-Executive Director – Maternity Safety Champion (Chair)
- Medical Director – Maternity Safety Champion
- Director of Patient Care and Chief Nurse – Maternity Safety Champion
- Director of Corporate Affairs
- Director of Operations

In Attendance:

- Any other member of the Trust Board is welcome to attend
- Divisional Director – Women's and Children's
- Associate Director of Operations – Women's and Children's
- Head of Midwifery
- Clinical Director, Women's
- Representative of Corporate Services / Trust Secretary (minutes)

By Invitation:

- Maternity Governance and Quality Lead Midwife
- Consultant Neonatologist
- Consultant Anaesthetist with Obstetric interest

4. **Frequency of meetings**

MAG will meet on the fourth Thursday or the month, with an expectation of at least ten meetings per year.

5. Quorum

A quorum is achieved through the presence of a minimum of:

- a non-Executive Director
- an Executive Board Maternity Safety Champion
- a clinical representative of the Women's and Children's Divisional Triumvirate.

6. Reporting

MAG reports to Trust Board. Reporting will be through minutes (which may be submitted as *draft* in Part 2 but will have been reviewed by MAG Chair), and a small number of slides to highlight areas of discussion. Full packs of MAG papers will be available to Members of Trust Board on request.

Developed following inaugural meeting of MAG, 25 August 2022

For consideration (for approval) by Trust Board, 09 September 2022

Maternity Issues September 2022

Upward report to Trust Board from Maternity Assurance Group (MAG)

Maternity Assurance Group

- We have previously had in-depth discussions at Trust Board on maternity services and we have considered how best we can be collectively assured on the key issues going forward.
- There are growing expectations of Provider Trust Boards on the part of NHSE and NHSR (CNST) in the light of Ockenden and other seminal work on maternity services in the NHS.
- Public reporting to the Board is both required and important to enable transparency and public accountability – however the volume and the technical nature of some of the information mean that a sub-group of Board can make a valuable contribution.
- We previously agreed to set up a 'Maternity Assurance Group' (MAG), composed chiefly of the Maternity Safety Champions (Executive and Non-Executive) but open to other Board members.
- MAG will scrutinise pertinent issues in detail and report to Trust Board allowing the unitary Board to gain assurance and / or address gaps and issues.

Maternity Assurance Group (MAG)

- MAG met for the first time on 25 August and was chaired by Dr Luke James, Non-Executive Director.
- Proposed Terms of Reference for MAG are shared within the pack for Trust Board in *public* for modification / agreement.
- Draft minutes of the inaugural meeting are shared within today's pack for Trust Board in *private session* for noting (they will be approved at the next MAG, and will then return to Board in *public*).
- The full papers of MAG are available to Board members via the Trust Secretary.
- The following slides highlight the key issues discussed on 25 August and which are brought to the attention of Trust Board.

Maternity Assurance Group (MAG)

In relation to CNST (Clinical Negligence Scheme for Trusts):

- MAG reviewed evidence that we are complying with the ten CNST safety actions with the exceptions of safety action 5 (supernumerary status of LWC) and safety action 6 (sub-element, preterm steroids). We are now more confident about compliance with the MSDS (maternity services data set). Options for actions to close the gaps identified were discussed. Board will be required to undertake a self-declaration in December.
- MAG reviewed a detailed staffing report (in relation to safety actions 4 and 5), as required every 6 months. Key issues / gaps identified include those in relation to midwifery workforce (vacancies against establishment, and the impact of the *birthrate**plus*** 2022 modelling) and neonatal (medical) staff where the impact of new guidance is being assessed.
- MAG gained assurance that the Trust has adopted the Perinatal Quality Surveillance Model in monitoring the safety of maternity and neonatal services (safety action 9a).
- MAG reviewed information pertaining to compliance with the Saving Babies' Lives Care Bundle.

Maternity Assurance Group (MAG)

In relation to Ockenden Final Report:

- MAG received an update on compliance and discussed the 4 areas where we currently self-assess as 'red' in terms of compliance (there are 84 recommendations / safety actions in total):
  - Nationally recognised training for labour ward co-ordinators - discussed
  - A dedicated patient safety specialist for maternity – discussed and **escalated to Trust Board**
  - 24/7 presence of one or more midwife who has undertaken high dependency training - discussed
  - Formal audit programme in respect of intrauterine transfers out of the unit - discussed
- MAG asked to review the 21 areas where we currently self-assess as 'amber' at its September meeting.

Maternity Assurance Group (MAG)

In relation to other matters pertaining to maternity services:

- MAG reviewed the Maternity Improvement Plan developed by the service.
- MAG received and discussed the *birthrate**plus*** midwifery workforce report following work undertaken in May 2022. The report recommends a modest uplift in establishment (approximately 5%, registered midwives) – largely on account of a substantial increase in the acuity of women birthing at MKUH since the 2018 report – and prompts us to review our historical ratio of registered staff to support staff. The report will be reviewed through Trust Executive Committee. Of note, there is active / ongoing recruitment in view of current vacancies against existing establishment.

Maternity Assurance Group (MAG)

In relation to other matters pertaining to maternity services:

- MAG had an in depth discussion around the Continuity of Carer (MCoC) model and the changes that had taken place since discussions at Trust Board in May 2022:
  - An increased number of vacancies had required three of the six MCoC teams to be suspended in July 2022 following a significant engagement exercise led by the Chief Executive and Medical Director to understand the experience of staff across the service. Regional and national colleagues provided support as we appraised options. The transition of care (MCoC to traditional) in these three teams seemed to have gone well.
  - A formal consultation period followed on the medium term position in respect of MCoC at the Trust. A decision has subsequently been made to revert to the traditional model of maternity care across our whole service. Staff were overwhelmingly supportive of this.
  - Colleagues in the wider NHS remain focused upon the rollout of MCoC, seeking information on proposed trajectory to full implementation by March 2024. It is recommended that MKUH should only consider / plan the reintroduction of MCoC as and when our staff numbers have improved to within a small margin of our staff establishment – **escalated to Trust Board**

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Board of Directors Meeting in Public**	**Date: 08/09/22**
Report Title	**Serious Incident and Quality Improvement Report**	**Agenda Item: 10**
Lead Director	**Kate Jarman** **Dr Ian Reckless**	**Director of Corporate Affairs** **Medical Director**
Report Author		

Key Highlights/ Summary	*A monthly summary of serious incidents and quality improvement work/*			
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Noting** [ ]	**For Review** [ ]

Strategic Objectives Links	*Safety, experience, effectiveness*
Board Assurance Framework (BAF)/ Risk Register Links	*Timely reporting and learning*

Report History	*SIRG* *Quality and Clinical Risk Committee*
Next Steps	*Routine report*
Appendices/Attachments	*List of Attached Reports*

Monthly review August 2022

This report summarises the Serious Incidents reported during August 2022. There were 16 new SIs reported on STEIS in August 2022. These are summarised below:

STEIS number	Category	Location	Details
2022/16309	Unexpected adult death	Emergency Department (ED)	The patient was contacted at approximately 19.30 by GP to attend ED due to deranged blood test results. No pre-alert to ED. Arrived in ED at 20.15. When called for triage found to be grey and clammy and cardiac arrest very shortly afterwards. Advanced life support (ALS) attempts sadly unsuccessful
2022/16310	Intrauterine death (IUD)	Labour Ward	Placental abruption IUD 34+2
2022/16728	Suboptimal care deteriorating patient	ED	Patient attended ED, appropriately discharged home with after care. Felt unwell the following day and went to the Urgent Care Centre (UCC), waited for approximately six hours before being referred to ED and had further wait. Patient admitted to stroke unit on palliative care pathway
2022/16729	Hospital acquired infection	Ward 21	MSSA bacteraemia
2022/17516	Hospital acquired infection	Ward 8	MRSA in blood cultures
2022/17927	New pressure ulcer	Ward 20	Deep tissue injury (DTI)
2022/17929	New pressure ulcer	Ward 23	Deep tissue injury (DTI)
2022/17931	Unexpected adult death	Ambulatory Emergency Care Unit (AECU)	Patient referred from ED with chest pain, suddenly became unresponsive. Resuscitation sadly unsuccessful
2022/17932	Violence and abuse	Ward 15	Patient suffering with confusion stabbed a staff member with a multitool that he appeared to have concealed on his person
2022/18469	Delayed diagnosis	ED & Gynaecology	Ruptured ectopic pregnancy in theatre requiring emergency laparotomy + salpingectomy
2022/18470	Medical device complication	Ward 5	Extravasation from cannula
2022/18471	Medical device complication	Intensive Care Unit (ICU)	Mattress deflation for patient with tracheostomy caused hyperextension of the neck with tracheostomy dislodgement
2022/18472	New pressure ulcer	Ward 23	Deep tissue injury (DTI)
2022/18473	New pressure ulcer	Ward 1	Deep tissue injury (DTI)
2022/18474	New pressure ulcer	Ward 23	Deep tissue injury (DTI)
2022/18475	New pressure ulcer	Ward 23	Deep tissue injury (DTI)

Noted trends/concerns from SIRG

- Continued DTIs. Thematic review to be undertaken for those on Ward 23
    - Need for further education on the use of mattress pumps to ensure they are plugged back in and switched off after patient transfers
    - Importance of assessing non-compliance with re-positioning in pressure ulcer management (pain control, mental capacity etc) with escalation to the senior team for support
    - Compliance with completion of visual phlebitis (VIP) scores to observe for signs of infection

Duty of Candour (DOC)

The Trust is required to report compliance to the Integrated Care Board for each quarter in relation to both elements of the DOC requirement (initial discussion and formal written follow up) for all incidents with moderate harm. Compliance requires all stages of the regulations to be completed. The Risk Management dashboard tracks breached DOC, which is formally reviewed on a monthly basis. There is an escalation process in place up to the executive team if Divisions risk non-compliance.

100% compliance was reported at the end of quarter one.

Quality Improvement and Learning

The Trust held an appreciative inquiry festival during the summer to spread and share positive practice. Further training for teams and leaders (across professions) in appreciative inquiry and improvement is taking place during the autumn.

Quality improvement posts have been recruited to by the Head of QI, and a draft quality improvement strategy will be brought to the Trust Executive Group and Quality and Clinical Risk Committee in September and October. The Head of QI has established a revised QI Board and is introducing a QI Academy to standardize and spread training and good practice in QI across the organization.

There is a programme of quality visits underway across wards and departments to provide peer support and review, particularly looking at the Care Quality Commission's new quality statements (part of the updated inspection framework).

Meeting title	**Trust Board**	**Date: 08 September 2022**
Report title:	**Mortality Update**	**Agenda item: 11**
Lead director **Report author** **Sponsor(s)**	**Dr Ian Reckless** **Dr Nikolaos Makris**	**Medical Director** **Associate Medical Director**
FoI status:	**Publicly disclosable**	

Report summary	The Trust regards mortality as an important metric of the quality of the services provided. Hospital mortality may reflect the performance of the wider health and social care system in Milton Keynes. There is *quantitative* evidence to demonstrate that risk adjusted mortality at MKUH is 'as expected' when compared to peers. There are no major outlying areas of concern. Deaths are also analysed *qualitatively* with 100% coverage through the Medical Examiner system, and the use of 'Structured Judgement Reviews' to ensure that there is learning in cases where it is felt that the outcome could have been improved. The statutory Coronial system is also involved in the review of selected hospital deaths and provides an additional layer of assurance. The Trust's system of mortality review is operated through the Mortality Review Group, reporting through to Patient Safety Board and on to Trust Executive Committee.			
Purpose *(tick one box only)*	**Information** **X**	**Approval**	**To note**	**Decision**
Recommendation	Receive and discuss			

Report history	Periodic updates

Executive Summary

High-level *quantitative* metrics for the most recent 12-month rolling period available are as follows:

- The Trust's **crude mortality rate is 'mid-range'** when examined alongside its peers (1.27% compared to a national rate of 1.32%).

- The Trust's **HSMR is statistically 'mid-range'** when examined alongside its peers (rolling 12 months, June 2021 to May 2022) (106.5).

- The Trust's **SHMI is in the 'as expected' category** (rolling 12 months to Feb 2022) (1.10), having moved down from the 'higher than expected' category (rolling 12 months to Sep 2021) (1.13).

A variety of data definitions are included as **appendix 1**. The Trust has previously undertaken detailed work to better understand its position in relation to the risk-adjusted mortality indices (HSMR and SHMI), as the figures are numerically above the national average (although importantly within the expected range) and have increased over time. Two key factors from the review were:

- The way in which various unplanned day case attendances have been categorised at MKUH over time compared to peers ('planned day case or outpatient attendance', as opposed to a 'non-elective zero-day admission'). This potentially reduces the denominator for the calculation of the risk-adjusted mortality indices. This categorisation is now being corrected (to better reflect national practice) and a gradual correction might be expected for a period of up to 15 months as the data feed through.

- The frequency with which 'signs or symptoms' are coded as the primary diagnosis at MKUH has increased since the introduction of our Electronic Health Record (EHR). An inpatient admission is divided into a larger number of slides known as 'finished consultant episodes' (FCE). An FCE is the time spent under the care of a named consultant in a named specialty. Only information recorded in the initial two FCEs is considered in determining mortality statistics. A patient admitted with and dying from bilateral bronchopneumonia (a condition known to have a high mortality rate) may have their admission coded as the symptoms / signs of 'cough and dyspnoea' if the second FCE concludes before the necessary information is available to enable 'bilateral bronchopneumonia' to be recorded in the notes (and subsequently coded).

In relation to the *qualitative* review of deaths, MKUH has established a Medical Examiners' Office (MEO) which:

- reviews all hospital deaths;
- issues Medical Certificates of Cause of Death (MCCD) in conjunction with the primary doctor;
- liaises with / refers to the Coroner's Office; and,
- requests Structured Judgement Reviews (SJRs) from medical teams where deaths are considered to have been potentially avoidable.

Following a successful trial in December 2021, the MKUH MEO has commenced reviewing all deaths from Willen Hospice. The system is being expanded nationally to include review of all community deaths. A trial involving several Primary Care Practices in Milton Keynes is expected to start in November 2022, with completion of the roll-out early in 2023.

Main Report:

Quantitative data relating to mortality

Crude mortality data are shown in **Appendix 2a**.

HSMR data (supplied by CHKS) covering the period June 2021 – May 2022 are shown in **Appendices 2a and 2b**.

SHMI data (supplied by NHS Digital / CHKS) covering the period Mar 2021 – Feb 2022 are shown in **Appendices 2a and 2c**.

Relevant contextual points in understanding the underlying data include:

- Palliative care coding is high compared to the national peer position (50.8% of all deaths coded as palliative care compared to the national average of 38.1%). Work has previously been undertaken to demonstrate that the palliative care team only becomes involved in appropriate cases.
- Coding depth is in line with the peer position, with an average of 6.9 diagnoses per Finished Consultant Episode (FCE).
- 'Sign or symptom' coding (where signs or symptoms rather than an actual diagnosis are associated with the patient's episode of care) is high compared to the peer position, with 14% of admissions having a sign or symptom as a primary diagnosis compared to the national average of 9.5%.
- Percentage of 'zero-day length of stay admissions via the Emergency Department' was previously low compared to peer but is now 'mid-range'. This is a result of changes to the recording of attendances at the Ambulatory Emergency Care Unit (AECU), which previously gave artificially low values for MKUH. This correction will take some time to work through to the rolling 12-month figures.

Subset analysis of HSMR or SHMI (based on the '56 diagnostic baskets' making up HSMR, or 142 diagnostic groups making up SHMI) does intermittently flag outlier status. Any outlier flags are reviewed and discussed at the Mortality Review Group. There are currently no flags that – following screening and analysis – lead the MRG to have cause of concern in respect of care quality.

Perinatal Mortality

The recording and review of stillbirths, late fetal losses and perinatal deaths in the Trust is carried out through the Perinatal Mortality Review Group (PMRG). This is a multi-disciplinary meeting consisting of Midwives, Obstetricians, Neonatologists and members of the Governance Team. It includes external reviewers alongside those from MKUH. Deaths are reported to the MBRRACE-UK perinatal mortality surveillance group in a standardised format (using the Perinatal Mortality Review Tool, PMRT).

Across Q1 (April to June 2022), there were two stillbirths (2.4 per 1000 births) and one neonatal death (1.2 per 1000 births). One of the two stillbirths awaits review using the PMRT at the time of writing. In the case of the other stillbirth and the neonatal death, the PMRT did not identify any specific measures that could / should have been undertaken and that might have altered the outcome.

COVID-19 Mortality

The number of admissions with, and deaths from, COVID-19 have been below the national average for the last year, with COVID-19 coded admission and death rates broadly following the national monthly profile.

Mortality rates have fallen over the last year, from 20.8% (12 months to May 2021) to 8.4% (12-months to May 22) and have closely tracked national peer values (see time series in **appendix 2d**).

Qualitative data relating to mortality

Data for the last 15 months are illustrated in the table below. All deaths undergo review through the Medical Examiner system. The system offers a point of contact for bereaved families or clinical teams to raise concerns about care prior to the death. Concerns can also be raised by the Medical Examiner following review of the medical record. Deaths with concerns regarding avoidability then undergo a formal Structured Judgement Review (SJR).

SJRs are carried out by trained reviewers who look at the medical records in a critical manner and comment on specified phases of care. The output of the SJR is presented at Mortality and Morbidity (M&M) Meetings. If a death is deemed avoidable, then a second SJR is carried out at which point the case will be graded with an 'avoidability' score. The second SJR form concludes with key learning messages from the case and actions to be taken.

	Q1 Apr-Jun 2021	**Q2 Jul-Sep 2021**	**Q3 Oct-Dec 2021**	**Q4 Jan-Mar 2022**	**Q1 Apr-Jun 2022**
Number of deaths	205	241	319	278	274
Number of deaths reviewed by Medical Examiner	100%	100%	100%	100%	100%
Number of SJRs Requested by Medical Examiner	21	16	21	16	29
% deaths in which SJR requested	10.1%	6.6%	6.6%	5.7%	10.5%
Cases taken for investigation by the Coroner following referral (% of total deaths)	13.7%	9.5%	14.1%	10.4%	10.6%
Cases in which MCCD (Form A) completed after discussion with Coroner (% of total deaths)	10.7%	7.0%	9.7%	12.5%	11.9%
% (Number) of Urgent Release completed paperwork within 24hours †	100% (6/6)	100% (5/5)	80% (4/5)	75% (3/4)	100% (3/3)
MCCD completion within 3 days	89.3%	90.1%	90.3%	93.5%	92.1%
Number of Relatives directed to PALS	19	7	7	4	11
Number of MCCDs rejected after Medical Examiner scrutiny	7	10	5	4	8
Deaths of people with Mental Health or Learning Disability diagnoses	0	2	3	0	0

We are conscious that a key area for development in the Trust's mortality review framework is to gather and collate evidence from this quantitative review work – both within the Medical Examiner's Office and in each clinical department which hosts M&M meetings and undertakes SJRs – to ensure that key themes are identified, and learning is shared and acted upon. This is a key area for work across the remainder of 2022/23 to provide more valuable information for assurance and quality improvement.

Appendix 1

Definitions

Crude Mortality – A hospital's crude mortality rate looks at the number of deaths that occur in a hospital in any given year and expresses this as a proportion of the number of people admitted for care in that hospital over the same period. The crude mortality rate can then be articulated as the number of deaths for every 100 patients admitted.

Finished Consultant Episode (FCE) – A continuous period of admitted patient care under one consultant within one healthcare provider**.**

HSMR – Hospital Standardised Mortality Rate (HSMR). This measure only includes deaths within hospital for a restricted group of 56 diagnostic categories with high numbers of admissions nationally. It takes no account of the death of patients discharged to hospice care or to die at home. The HSMR algorithm involves adjustments being made to crude mortality rates to recognise different levels of comorbidity and ill-health for patients cared by similar hospitals. HSMR was created by Dr Foster (now Telstra Health).

MBRRACE – Mothers and Babies, Reducing Risk through Audits and Confidential Enquiries. A national confidential enquiry collecting data on deaths in pregnant women (up to one year post-partum) and perinatal deaths from 22 weeks gestation up to 28 days post delivery.

Relative Risk – Measures the actual (observed) number of deaths against the expected number deaths. Both the SHMI and the HSMR use the ratio of actual deaths to an expected number of deaths as their statistic. HSMR multiplies the Relative Risk by 100. SHMI is typically presented around a mean expressed as 1.00.

- HSMR above 100 / SHMI above 1.00 = There are numerically more deaths than expected
- HSMR below 100 / SHMI below 1.00 = There are numerically less deaths than expected

Confidence intervals are then described suggesting the likelihood that any variation between observed and expected has occurred through chance alone or represents a 'statistically significant' variation (real, not due to chance).

Structured Judgement Review (SJR) – A report created according to a standard template, reviewing the care given to a deceased patient which generates a score for the quality of care given.

SHMI – Summary Hospital-level Mortality Indicator (SHMI). SHMI indicates the ratio between the actual number of patients who die following treatment at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge.

CHKS. Third-party tools are used to report the relative position of Milton Keynes University Hospital NHS Foundation Trust (MKUH) on nationally published mortality statistics. CHKS produces monthly mortality reports for MKUH based on its Hospital Episode Statistics (HES) data submissions.

Appendix 2a

Summary Mortality Data

Metric	Period	Previous	Latest	National Peer	Variance	*Status*
HSMR	R12M to May-22	102.7	106.5	98.2	8.3	*'Mid range'*
SHMI	R12M to Feb-22	107.9	110.3	100.0	10.3	*'As expected'*
SHMI - In Hospital	R12M to May-22	77.1	77.2	72.6	4.6	*'Mid range'*
Mortality Rate %	R12M to May-22	1.26	1.27	1.32	-0.05	*'Mid range'*
FCEs with palliative care code Z515	R12M to May-22	1.80%	1.78%	1.38%	0.40%	*'Fourth Quartile'*
Deaths with palliative care code Z515	R12M to May-22	50.8%	50.8%	38.1%	12.74%	*'Fourth Quartile'*
Average Diagnoses per FCE	R12M to May-22	6.8	6.9	6.9	0.0	*'Mid range'*
Sign or symptom as a primary diagnosis	R12M to May-22	14.30%	14.06%	9.54%	4.53%	*'Fourth Quartile'*
% 0 Length of Stay Admissions via A&E	R12M to May-22	28.43%	28.32%	30.66%	-2.34%	*'Mid range'*

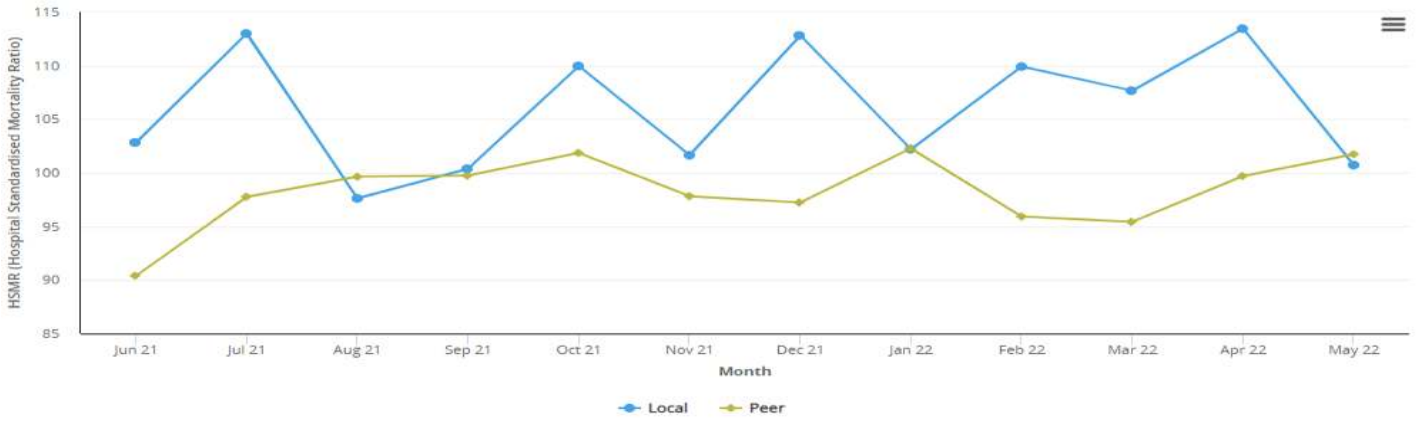
Month	HSMR - Monthly	HSMR - Rolling Month	SHMI - IH Monthly	SHMI - IH Rolling Month	SHMI - Monthly	SHMI - Rolling Month	Mortality Rate - Monthly	Mortality Rate - Rolling Month
Jun-21	102.8	95.7	83.3	74.3	117.9	105.3	1.02	1.62
Jul-21	113.0	98.5	97.7	77.0	129.6	107.4	1.41	1.63
Aug-21	97.6	99.5	87.9	78.7	111.8	108.0	1.25	1.63
Sep-21	100.4	100.0	69.0	77.2	104.1	108.1	1.10	1.61
Oct-21	110.0	101.8	79.4	77.3	100.2	106.8	1.29	1.61
Nov-21	101.7	101.0	82.4	77.8	125.4	109.0	1.46	1.57
Dec-21	112.8	102.5	74.7	78.5	103.7	109.5	1.57	1.51
Jan-22	102.2	99.4	77.5	78.5	112.1	110.3	1.42	1.29
Feb-22	109.9	99.7	69.4	78.1	92.5	110.3	1.31	1.24
Mar-22	107.7	102.9	61.9	77.3			1.30	1.26
Apr-22	113.4	105.1	76.0	77.1			0.94	1.26
May-22	100.7	106.5	74.9	77.2			1.12	1.27

Appendix 2b

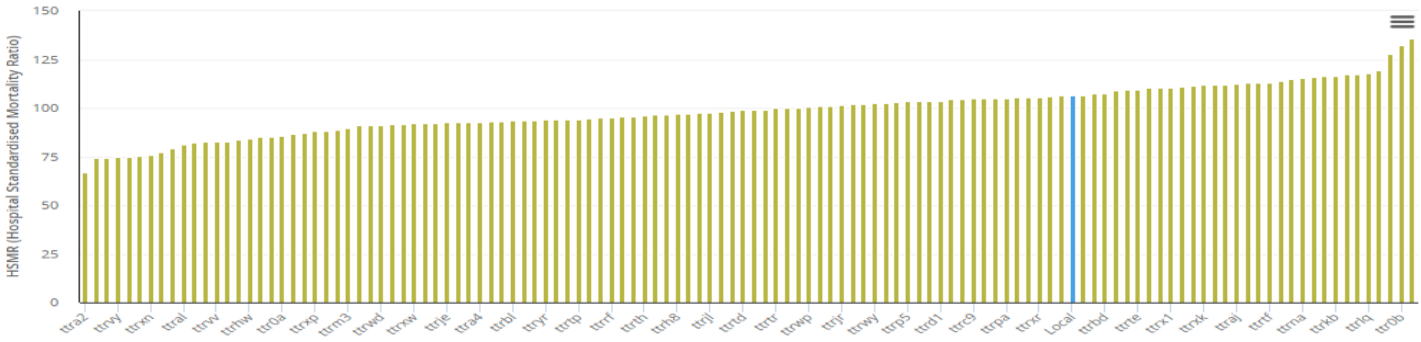
HSMR

HSMR	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Trust Monthly	102.8	113.0	97.6	100.4	110.0	101.7	112.8	102.2	109.9	107.7	113.4	100.7
Trust 12 month rolling	95.7	98.5	99.5	100.0	101.8	101.0	102.5	99.4	99.7	102.9	105.1	106.5
National Peer 12 month rolling	97.8	98.4	98.6	99.1	99.5	98.8	98.0	96.4	95.8	96.3	97.4	98.2
Variance from the national peer	-2.1	0.0	0.9	1.0	2.3	2.2	4.6	3.0	3.9	6.6	7.7	8.3

HSMR, monthly



HSMR, national peer comparison

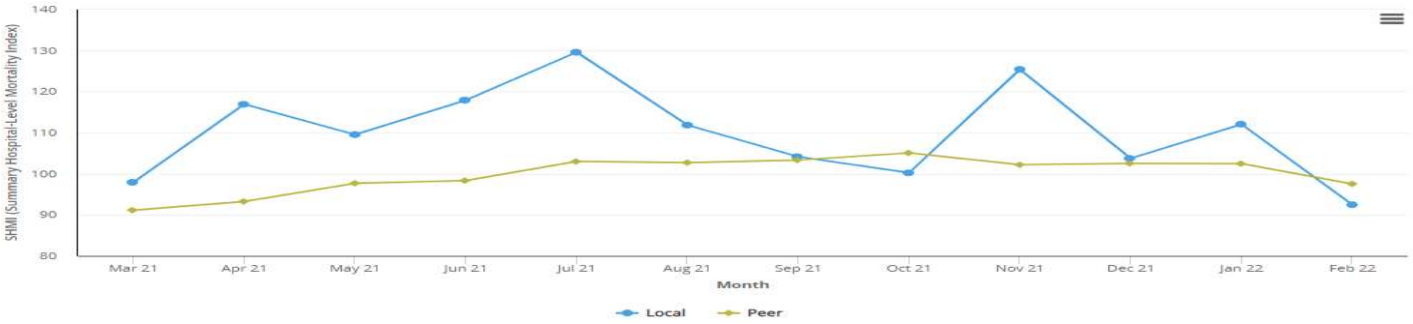


Appendix 2c

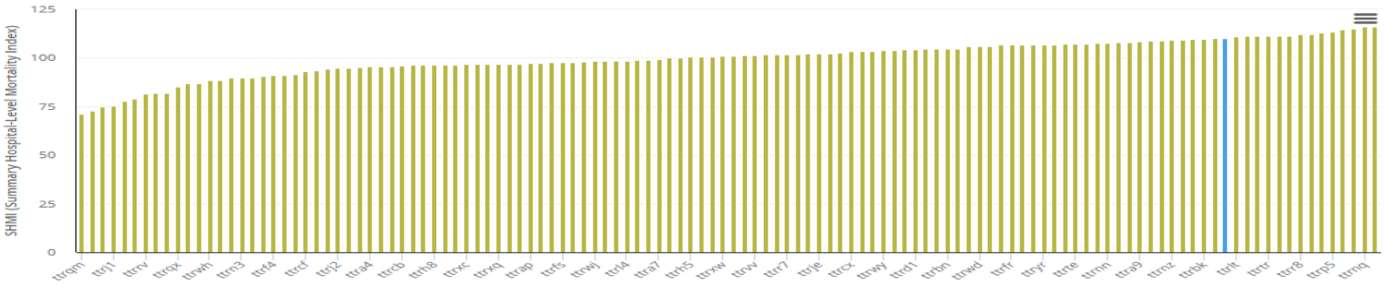
SHMI

SHMI	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Trust Monthly	97.9	116.9	109.5	117.9	129.6	111.8	104.1	100.2	125.4	103.7	112.1	92.5
Trust 12 month rolling	107.7	106.7	105.7	105.3	107.4	108.0	108.1	106.8	109.0	109.5	110.3	110.3
National Peer 12 month rolling	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Variance from the national peer	7.7	6.7	5.8	5.3	7.5	8.0	8.1	6.8	9.0	9.5	10.3	10.3

SHMI, monthly



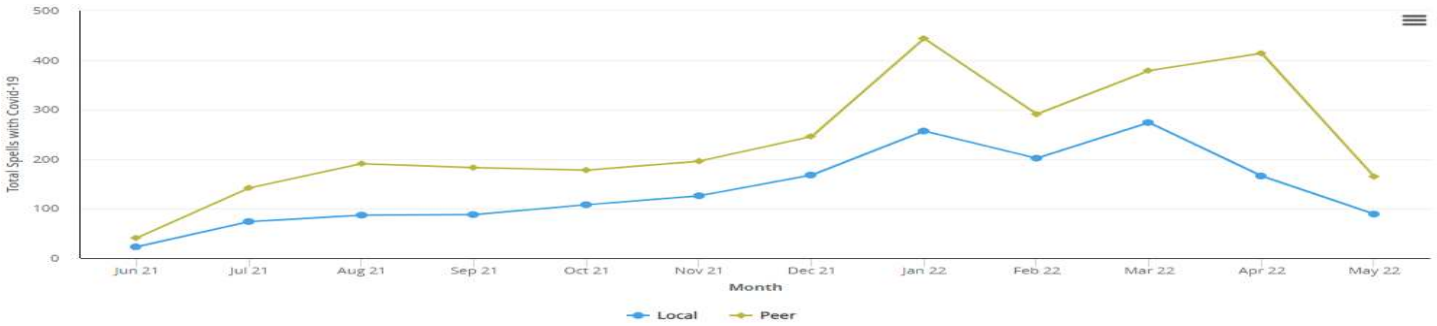
SHMI, National peer comparison



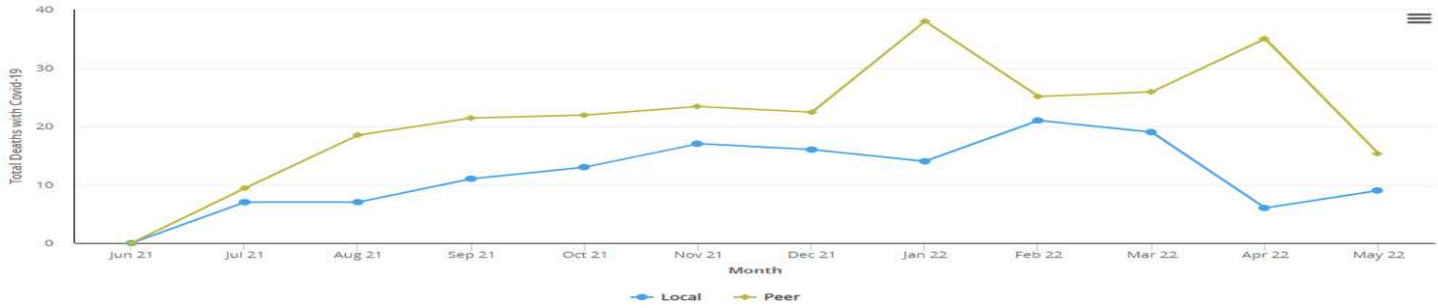
Appendix 2d

COVID –19

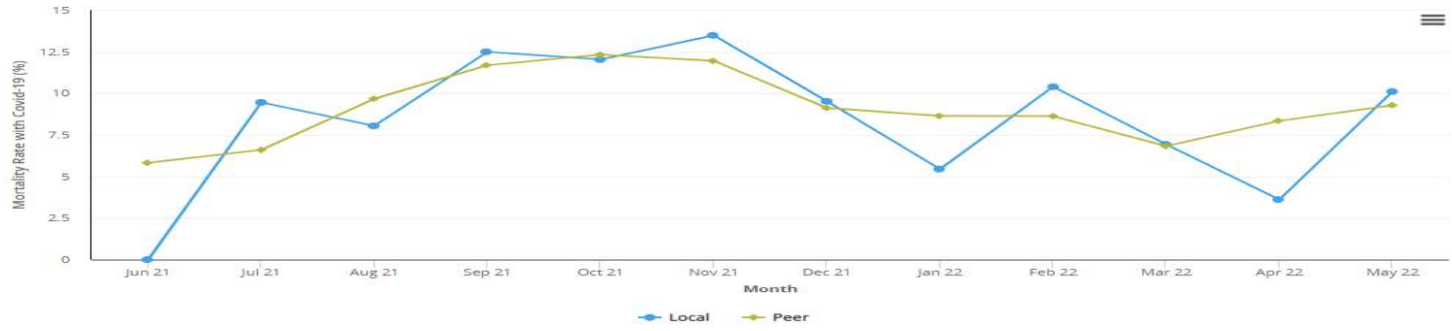
Spells with Covid-19



Deaths with Covid-19



Mortality Rate with Covid-19



Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: 8 September 2022**
Report Title	**Workforce Report**	**Agenda Item: 12**
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 July 2022 (Month 4) 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	
Appendices/Attachments	

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators as at 31 July 2022 (Month 4), covering the preceding 13 months.

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

Indicator	Measure	Target	07/2021	08/2021	09/2021	10/2021	11/2021	12/2021	01/2022	02/2022	03/2022	04/2022	05/2022	06/2022	07/2022
Staff in post (as at report date)	WTE		3328.5	3321.9	3328.6	3342.5	3347.7	3349.0	3390.5	3410.0	3414.4	3418.4	3418.8	3417.5	**3445.6**
	Headcount		3810	3799	3807	3823	3827	3830	3878	3904	3900	3902	3904	3901	**3930**
Establishment *(as per ESR)*	WTE		3675.1	3714.0	3724.7	3730.4	3725.7	3718.1	3722.9	3727.6	3716.9	3723.9	3839.8	3842.5	**3840.8**
	%, Vacancy Rate	10%	9.4%	10.6%	10.6%	10.4%	10.1%	9.9%	8.9%	8.5%	8.1%	8.2%	11.0%	11.1%	**10.3%**
Staff Costs (12 months) *(as per finance data)*	%, Temp Staff Cost (%, £)		11.6%	11.7%	11.9%	12.1%	12.3%	12.5%	12.7%	12.9%	13.1%	13.4%	13.7%	14.0%	**14.3%**
	%, Temp Staff Usage (%, WTE)		12.2%	12.4%	12.6%	12.7%	12.8%	12.9%	13.0%	13.1%	13.2%	13.5%	13.7%	13.8%	**14.0%**
Absence (12 months)	%, 12 month Absence Rate	5.5%	4.6%	4.7%	4.8%	5.0%	5.0%	5.0%	5.0%	5.1%	5.3%	5.4%	5.4%	**5.4%**	*5.4%*
	- %, 12 month Absence Rate - Long Term		*2.8%*	*2.8%*	*2.8%*	*2.9%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	***3.0%***	*3.0%*
	- %, 12 month Absence Rate - Short Term		*1.8%*	*1.9%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.1%*	*2.3%*	*2.4%*	*2.4%*	***2.4%***	*2.4%*
	%,In month Absence Rate - Total	5.5%	4.6%	5.0%	5.4%	6.1%	5.5%	6.0%	6.3%	5.4%	5.6%	5.0%	4.3%	**4.3%**	*4.0%*
	- %, In month Absence Rate - Long Term		*3.3%*	*3.2%*	*3.0%*	*3.5%*	*3.3%*	*3.3%*	*3.0%*	*2.8%*	*2.5%*	*2.3%*	*2.6%*	***2.6%***	*2.5%*
	- %, In month Absence Rate - Short Term		*1.3%*	*1.9%*	*2.4%*	*2.5%*	*2.3%*	*2.7%*	*3.3%*	*2.6%*	*3.1%*	*2.7%*	*1.7%*	***1.7%***	*1.4%*
	- %, In month Absence Rate - COVID-19 Sickness Absenc	1.5%	0.5%	0.6%	0.6%	0.6%	0.6%	1.2%	2.3%	1.6%	2.2%	1.5%	0.5%	**0.5%**	*0.3%*
Starters, Leavers and T/O rate (12 months)	WTE, Starters		331.7	327.9	333.0	349.4	347.1	362.3	390.3	376.5	382.0	409.1	427.3	433.9	**447.8**
	Headcount, Starters		377	374	376	393	395	411	441	428	431	459	481	490	**507**
	WTE, Leavers		223.0	216.8	227.7	232.0	241.5	254.8	277.9	296.9	329.4	364.6	380.6	400.1	**417.1**
	Headcount, Leavers		264	258	271	276	289	304	332	357	395	435	456	480	**500**
	%, Leaver Turnover Rate	9%	7.7%	7.5%	7.8%	7.9%	8.3%	8.8%	9.5%	10.2%	11.2%	12.3%	12.9%	13.6%	**14.2%**
	%, Stability Index		86.6%	86.5%	86.2%	85.6%	85.2%	85.9%	85.5%	85.3%	84.8%	83.7%	82.9%	82.7%	**82.8%**
Statutory/Mandatory Training	%, Compliance	90%	96%	95%	96%	95%	96%	96%	95%	94%	94%	94%	94%	95%	**95%**
Appraisals	%, Compliance	90%	89%	90%	91%	91%	91%	91%	91%	90%	92%	90%	90%	88%	**89%**
Time to Hire (days)	General Recruitment	35	48	46	59	53	56	52	72	65	72	58	52	65	**59**
	Medical Recruitment (excl Deanery)	35	68	52	53	81	65	43	52	49	68	47	79	63	**89**
Employee relations	Number of open disciplinary cases		6	6	7	9	10	9	10	7	9	4	4	9	**13**

2.1. The table below shows the nursing shift fill rates.

	Day		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	**68%**	**85%**	**91%**	**99%**
A & E	82%	71%	95%	65%
AMU	55%	132%	90%	127%
DOCC	80%	52%	93%	-
MAU 2	67%	108%	99%	123%
NNU	72%	60%	96%	81%
Phoenix Unit	80%	55%	98%	60%
Ward 10	0%	8%	1%	0%
Ward 15	76%	91%	93%	143%
Ward 16	60%	115%	84%	115%
Ward 17	72%	90%	94%	115%
Ward 18	85%	111%	136%	130%
Ward 19	66%	79%	101%	141%
Ward 20	84%	91%	108%	99%
Ward 21	67%	124%	96%	118%
Ward 22	84%	93%	118%	129%
Ward 23	79%	96%	104%	123%
Ward 24	62%	105%	78%	100%
Ward 3	61%	89%	85%	102%
Ward 5	70%	66%	101%	126%
Ward 7	67%	76%	98%	102%
Ward 8	65%	89%	112%	99%
Ward 9	58%	80%	66%	92%
Ward 25	72%	104%	105%	111%
Ward 4	61%	57%	82%	96%

2.2. The Trust's **vacancy rate** (10.3%) has decreased slightly due to an increase in headcount by 29 in month (total headcount 3930). The Trust's staff in post figure continues to rise (3417.5 wte) with an additional 117.1 wte in post compared to the same period in the previous year.

2.3. **Staff absence** has started to return to within tolerance with 4% absence for the month with a smaller proportion of this due to Covid (0.3%), as predicted. Sickness absence figures are in line with other NHS employers in the ICS, and reflect the lower prevalence of Covid in the community. Sickness absence is currently unpredictable and the usual trends are unable to be relied upon for predicting when levels will return to what they were pre-Covid.

2.4. The **stability index figure** (defined as *proportion of staff in post at end of period who were in post at beginning of period)* has started to stabilise and has had no real change in a 3 month period, currently at 82.8%. **Staff turnover** has increased to 14.2%. The number of leavers and starters remain high for the Trust, a picture which is shared amongst public and private sector, which creates instability in teams and dips in performance. Several social media campaigns and events have occurred in M4 which

will have a positive impact on some of the hard to recruit areas and there are further plans for events in the summer, with an HCA Open Day in M5 and the Recruitment Fair in Central MK in September.

2.5. **Time to hire** continues to fluctuate and the current pressures on the recruitment team to fill newly established posts and meet the high number of vacant posts each month is having a significant impact on this target. Candidates are also becoming more transient as they apply for multiple positions across organisations and withdrawals during each stage of the recruitment process is becoming more common. The recruitment team are also challenged by vacancies within the team and during M5 resources are being pulled across the workforce directorate to support the team.

2.6. The number of **open disciplinary cases** has risen in month. A detailed Employee Relations case report is produced monthly to JCNC and on a quarterly basis for Workforce Board.

2.7. **Statutory and mandatory training** compliance is at 95% and **appraisals** compliance at 89%. Divisions are addressing any underperformance against these KPIs locally and are asked to create recovery plans against target. The only area that remains **compliant** for appraisal is **Core Clinical**.

2.8. There are 159.3 nursing vacancies across the Trust. There are 36 applicants in pre-employment stages and 41 International Nurses who have passed their OSCE and are due to receive their NMC registration in M4 and M5, which will offset this vacancy rate.

2.9. There are 100.4 HCSW vacancies (B2 and B3) across the Trust. This figure does not include our Nurse Associates, 8 of which are due to qualify in October. There are 40 applicants in pre-employment, which will offset the vacancy rate once they start in post.

2.10. International recruitment continues to be a success. To date 148 have been interviewed and 142 offers have been made. However, 19 have withdrawn since offer. 98 nurses have arrived in the UK and joined the Trust with 41 of these having now passed their OSCEs. A further 39 are due to sit their OSCEs in M5 and M6.

2.11. Day shift fill rates remain lower than night shift fill rates. This is because nights attract enhanced pay and so are more popular with agency and bank workers. To address this a day bank enhancement has been introduced. Areas with over 100% fill rates will have required additional staffing on particular shifts due to acuity or the requirement for additional mental health support or enhanced observers.

3. Continuous Improvement, Transformation and Innovation

3.1. HR Services are implementing **electronic staff expenses** Trust Wide in Q3. There will be training available to staff alongside guidelines and service desk support during the transition period. Further communications will be sent out in M6.

3.2. HR Services are progressing with several automation projects to remove the remaining 'paper' processes from HR Systems. This includes **self-booking** for agencies so that vacant shifts can be identified by external agencies as soon as possible to reduce any delays in filling posts.

3.3. The Recruitment Team will be implementing **electronic DBS Checks** for candidates in Q3. This will remove the need for a face to face identity check and candidates will be able to use an app to upload both their Right to Work and DBS Documents for checking from home. The app will give an immediate response as to whether the documents have successfully been verified which should reduce the time to hire as this is one of the biggest negative impacts on time to hire.

3.4. The current **payroll contract** comes to an end in December 2022. The workforce and finance teams have conducted a procurement exercise and a preferred supplier has been selected. Finance and Investment Committee received and approved a paper in regard to this in August. The contract will now be signed and transition works undertaken to ensure a smooth, seamless transfer to the new provider.

3.5. The national Agenda for Change **pay award** will be implemented across the country in September payslips. It is recognised that the pay award and corresponding pension contribution rate increase may have a detrimental impact on take home pay for some staff.

4. Culture and Staff Engagement

4.1. Plans are in place for the **Protect and Reflect Event** to launch at the beginning of October. Staff will come to the Academic Centre to get vaccinated and complete their staff survey.

4.2. The Trust will be re-opening the staff **Covid vaccination centre** during September.

4.3. Plans are in place for sessions at the **Event in the Tent** to raise the profile of the different ways people can share feedback, ideas and/or raise concerns with their manager and with the wider Trust management and Executive teams.

4.4. The recently rolled out FTSU e-Learning is being well received across the Trust with almost 65% of staff having completed it. When a new course becomes live staff are given a short grace period to become compliant prior to the compliance rate being included in overall Trust compliance figures.

4.5. The Trust has signed up to the East of England Anti-Racism campaign and posters and a series of engagement events are planned to raise the profile of this work.

5. Current Affairs & Hot Topics

5.1. The Equality, Diversity and Inclusion Team are currently working statutory returns for the Trust. The **Cultural Inclusion Training** has now finished its pilot and, following

feedback, will be amended before launch in Q3. The **Cultural Intelligence Master Class** will be made available to a new cohort in Q3. This cohort will be made up of some of the senior leaders of the organisation and staff members will be contacted directly with an invitation to attend.

5.2. The **Health Education England self-assessment** annual return has been put together by corporate, nursing, and medical education teams. The form is attached as Appendix 1 and is for Trust Board to review and approve prior to submission.

6. Recommendations

Members are asked to note the report.

HEE Provider Self-Assessment – 2022

HEE Self-Assessment Tool

HEE Self-Assessment - Introduction
The HEE Self-Assessment (SA) is a process by which providers carry out their own quality evaluation against a set of standards. It is based on the philosophy of continuous quality improvement, the identification of quality improvement potential, the development of action plans, implementation, and subsequent evaluation.

Providers are asked to complete this online form indicating where they have or have not met the standards as set out in the SA. There is the opportunity under most of the questions for providers to provide comments to support their answer, this is optional and not mandatory.

Completing the SA
Some questions within the SA will ask you to provide some further information based on your responses.

Where standards have not been met: In these instances, you will be given the opportunity to provide some information detailing why the standard has not been met and any work that is underway to ensure it will be met in future.

Where standards have been met: Where you have met the standards, some questions may give you the opportunity to add comments to support your answer.

Responses by Professional Group: For some questions we have asked you to provide a response per professional group. Throughout the SA we have arranged these groups by their regulators. For example, some questions will ask for you to respond for GMC or NMC associated learners or educators. There is an N/A option should these learner groups not be relevant for your organisation.

Further Questions
If you have any queries regarding the completion of the HEE SA, please review the FAQ document. If you still require further information, you can contact your regional HEE Quality Team.

Region Selection

Please select your region from the list below:

Please select your provider from the list below:

Section 1 - Provider

2. Please provide details of 3 challenges within education and training that you would like to share with HEE. (100 word limit on each response)

Example 1	Ensuring there are enough practice assessors/ supervisors to support students in practice and enable sign off of practice placements including future nurse competencies.
Example 2	Advanced Clinical Practice academic education and training including medical supervisory practice to ensure high standards of competence and practice for this extended role.
Example 3	Enhancing the Healthcare Support Worker training package to support recruitment and retention – with increased numbers of applicants new to health care and overall challenges in this workforce arena including pastoral support.

3. Please provide details of up to 3 key achievements within education and training that you would like to share with HEE. (100 word limit on each response)

Example 1	HEE Capacity Tool - Successful applications of the HEE capacity tool and the development and implementation of an action plan.
Example 2	Being creative with a hybrid of virtual/online and face to face training post pandemic ie. Venepuncture and Cannulation training – The theoretical education is now online with the practical and competence aspect delivered face to face. This has led to and overall increase in training capacity and number of staff trained .
Example 3	Preceptorship Programme development for multidisciplinary new registrants including nurses, midwives, therapist and ODP's with plans to include pharmacists. Internationally recruited nurses having a hybrid preceptorship programme to meet their specific needs and empower their leadership abilities to take on a more senior role within the organistion.

4. Please tick the box below to confirm that your Self-Assessment response has been signed off at board level before submission back to HEE.

☐ By selecting this box I confirm that the responses in this SA have been signed off at board level

5. Please confirm the date that board level sign off was received:

DD/MM/YYYY

Section 2 - Contracting

6. Do you have board level engagement for education and training?

☐ Yes

If yes, please provide their name and job title; if no, please provide further detail.

Danielle Petch - Director of Workforce

Ian Reckless - Medical Director

Yvonne Christley - Chief Nurse

7. Can the provider confirm that the funding provided via the education contract to support and deliver education and training is used for explicitly this purpose?

☐ Yes

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

All education funding is used appropriately to meet the education and training requirements for the Trust based on a Training and Development Needs Analysis including feedback from annual appraisals and follows the guidance provided for the specific funds.

Expenditure reports are submitted on request. Educational faculty to provide scrutiny of expenditure across the organisation and annual educational and training report.

8. Is an activity in the Education Contract being delivered through a third party provider?

☐ No

If yes, please detail who with:

N/A

9. Has the provider reported any breaches in relation to the requirements of the NHS Education Contract for any sub-contractor?

☐ No

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

N/A

10. Is the provider able to give assurance that they are compliant with all HEE education and training data requests?

☐ Yes

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

All HEE education and training data requests are completed and returned in a timely manner, e.g. CPD Expenditure Updates and Salary Support quarterly returns.

11. Have there been any health and safety breaches that involve a trainee or learner?

X ☐ No

If yes, please provide detail:

N/A

12. Does the provider engage with the ICS for system learning?

☐ Yes

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

The Library Managers at Milton Keynes, and Bedfordshire hospitals work collaboratively and successfully bid for an Embedded Knowledge Specialist as part of a national pilot. This role is developing at pace and learning is shared for the benefit of hospital and ICS staff.
ICS Leadership forum newly developed has discussed opportunities to have joint training across patient pathways and in different arenas going forward.

Section 3a - Quality

13. Is the provider aware of the requirements and process for a HEE Quality Intervention, including who is required to attend and how to escalate issues with HEE?

X ☐ Yes

If no, please provide detail:

14. Have any conditions been imposed on the provider from regulators?

	Yes	No	N/A
GDC	☐	☐	✓
GMC	☐	✓	☐
GPhC	☐	✓	☐
HCPC	☐	✓	☐
NMC	☐	✓	☐
GOsC	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If yes, please provide further detail:

N/A

15. Has the provider actively promoted the National Education and Training survey (NETS) to learners?

☐ Yes

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Email with link sent to all learners by the Learning Environment Leads and link put on Trust Intranet – also discussed in a variety of meetings and arenas to encourage feedback from students.

16. Has the provider reviewed and where appropriate taken action on the basis of the results of the National Education and Training Survey (NETS)

☐ Yes

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

The results of the NETS has built upon work already undertaken: This has led to increased provision of training and refreshers for PA/PS who support students, increased ward/clinical area support for PA/PS and student, student support sessions and enhancement of the initial welcome meeting.
Serice changes to support junior Drs following feedback and regular feedback sessions for areas where results have not met expected standards. Results also triangulated with quality metrics and staff survey results to inform action plans to make improvements.

17. Does the provider have a Freedom to Speak Up Guardian and do they actively promote the process for raising concerns through them to your learners?

☐ Yes

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

FTSU Guardian and the Role is introduced at staff inductions and advertised widely across the Trust on a regular basis. Also the guardian regularly attends preceptorship and meets students . As an organisation we have expanded the number of guardians.

18. Does the provider have a Guardian of Safe Working, and do they actively promote the process for raising concerns through them to their learners?

☐ Yes

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Role introduced at Doctors induction and introduction to exception reporting tools

19. Please confirm whether you have an Equality, Diversity and Inclusion Lead (or equivalent):

☐ Yes

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Idrees Mohammed - EDI Lead for MKUH

20. Please confirm that the provider liaises with their Equality, Diversity and Inclusion Lead (or equivalent) to:

	Yes	No
Ensure reporting mechanisms and data collection take learners into account?	✓	☐
Implement reasonable adjustments for disabled learners?	✓	☐
Ensure policies and procedures do not negatively impact learners who may share protected characteristics?	✓	☐
Analyse and promote awareness of outcome data (such as exam results, assessments, ARCP outcomes) by protected characteristic?	✓	☐
Ensure International Medical Graduates (IMGs) receive a specific induction in your organisation?	✓	☐
Ensure policies and processes are in place to manage with discriminatory behaviour from patients?	✓	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

We are reviewing induction programmes to make them more inclusive. EDI team is liaising with the BAME / LGBTQ+ / ability network and the Freedom to Speak Up team to ensure inclusive engagement and build a culture og inclusion kindness and belonging for all students.

21. Patient Safety and the promotion of a Patient Safety culture is integral to the HEE Quality Framework. Can you confirm as a provider that you have the following:

	Yes	No
A named Board representative for Patient Safety	✓	☐
A named Patient Safety Specialist/s	✓	☐
A process to ensure that all staff are made aware of and can access the NHS Patient Safety Syllabus Level 1 training on the e-Learning for Healthcare platform	✓	☐

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

We have a named Board representative & 2 patient safety specialists. All staff can access the NHS Patient Safety syllabus level 1 training via ESR. Members of the safety board have been asked to undertake the basic training and more senior clinical leaders to undertake the higher training . Currently there are discussions to being held to determine if this training should become mandatory.

22. Has the provider developed and implemented a service improvement plan to ensure progression through the Quality and Improvement Outcomes Framework for NHS Funded Knowledge and Library Services?

☐ Yes

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

A service improvement plan was submitted as part of the Quality and Improvement Outcomes framework and work is ongoing to implement and revise the plan as necessary supported by the Head of Quality Improvement for the Trust.

23. Has the provider been actively promoting, to all learners, use of the national clinical decision support tool funded by HEE?

☐ Yes

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

BMJ Best Practice is actively promoted at all corporate and professional inductions. It is also promoted on the Trust intranet and by leaflets etc.

Section 3b - HEE Quality Framework Domain 1 - Learning environment and culture

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

24. The learning environment is one in which education and training is valued and championed.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐

	Yes	No	N/A
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Education is a key component of the Trust Nursing and Midwifery strategy with the specific ambition for lifelong learning. This supports education/training provision from the organisation, senior management to the offering to staff, such as CPD, apprenticeship and HEE funded opportunities, such as TNA and METIP 2023/24.

25. The learning environment is inclusive and supportive for learners of all backgrounds and from all professional groups.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

The EDI Team work collaboratively with the Practice Education Team, Freedom to Speak Up and Staff Networks to ensure we build an inclusive environment and support learners from all backgrounds by creating cultural awareness and EDI-oriented programmes which focus on Compassionate Culture, Inclusive Leadership and Belongingness.

26. The organisational culture is one in which all staff, including learners, are treated fairly, with equity, consistency, dignity and respect.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

27. There is a culture of continuous learning, where giving and receiving constructive feedback is encouraged and routine.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Use of 360 feedback in medical education and promoted via Foundation Training. This compliments the increased offering of the 360 to all at MKUH, due to increased numbers of facilitators alongside the future offering of clinical supervision.

28. Learners are in an environment that delivers safe, effective, compassionate care and prioritises a positive experience for patients and service users.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐

	Yes	No	N/A
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

The learning environment forms around the MKUH values and CQC requirements. This is set against the educational audits shared within partnerships meetings. This compliments current reporting mechanisms for students. The trust uses technology to care delivery, such as audits to ensure the learning environment remains supportive to all learners.

29. The environment is one that ensures the safety of all staff, including learners on placement.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

The Trust utilises technology to record/monitor patient care via audits and staffing levels in live time, and are reviewed from ward to executive level to ensure care delivery is monitored with actions, such as daily safety huddles. This is in addition to mandatory training/risk assessments and engagement with staff side.

30. All staff, including learners, are able to speak up if they have any concerns, without fear of negative consequences.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Freedom to speak up Guardian and Champions, that all staff can access and through the Grievance policy as appropriate.

31. The environment is sensitive to both the diversity of learners and the population the organisation serves.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

We have approximately a 34% BAME workforce which matches our local area population. We strive to promote diversity and inclusion, we also understand that both elements need careful consideration. Diversity without inclusion or inclusion without diversity will not lead to an inclusive and organic learning environment.

32. There are opportunities for learners to take an active role in quality improvement initiatives, including participation in improving evidence led practice activities and research and innovation.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐

	Yes	No	N/A
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Promoted via various routes, Foundation trainees have to participate in QIPS as part of sign off

33. There are opportunities to learn constructively from the experience and outcomes of patients and service users, whether positive or negative.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Patient Surveys and patient participation groups. These form into a patient dashboard accessed by clinical areas to form discussions with team members. Compliments are shared with clinical areas and staff members. There are also arenas available to staff such as appreciate inquiry, debrief sessions.

34. The learning environment provides suitable educational facilities for both learners and supervisors, including space and IT facilities, and access to library and knowledge services and specialists.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail for each facility:

All of above are provided on site for all learners

35. The learning environment promotes multi-professional learning opportunities.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Training of this nature take place as part of all learner teaching programmes. These have led to the development of the immersive ward situations for all professionals. The clinical environment also promotes MDT opportunities to learn from each other, such as shadowing, secondments, pathway placements.

36. The learning environment encourages learners to be proactive and take a lead in accessing learning opportunities and take responsibility for their own learning.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐

	Yes	No	N/A
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Adult learning, all of above are promoted

Section 3c - HEE Quality Framework Domain 2 - Educational governance and commitment to quality

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

37. There is clear, visible and inclusive senior educational leadership, with responsibility for all relevant learner groups, which is joined up and promotes team-working and both a multi-professional and, where appropriate, inter-professional approach to education and training.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐

	Yes	No	N/A
NMC Learners	✓		
GOsC Learners			✓
Any other learner groups (please define in notes)			✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

EDI, Learning & Development and Apprenticeship Lead is envisioning building a culture of learning as part of our inclusion and belongingness initiative, which will lead to knowledge sharing, cultivating best practice, strengthening relationships (internal & external) and promoting personal and team growth across the Trust.

38. There is active engagement and ownership of equality, diversity and inclusion in education and training at a senior level.

	Yes	No	N/A
GDC Learners			✓
GMC Learners	✓		
GPhC Learners	✓		
HCPC Learners	✓		
NMC Learners	✓		
GOsC Learners			✓
Any other learner groups (please define in notes)			✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

EDI and HR Team have developed a Cultural Awareness programme which is being rolled out across the Trust, which emphasises ownership of equality, diversity & inclusion. EDI Team has developed a programme for building inclusive strategies, this will help build compassion from the top and build an ownership culture.

39. The governance arrangements promote fairness in education and training and challenge discrimination.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

40. Education and training issues are fed into, considered and represented at the most senior level of decision making.

	Yes	No	N/A
GDC Learners	☐	☐	✓

	Yes	No	N/A
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Issues escalated to Board level if required and then actioned

41. The provider can demonstrate how educational resources (including financial) are allocated and used.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Tariff funds and CPD funding which are allocated to relevant departments are audited regularly

42. Educational governance arrangements enable organisational self-assessment of performance against the quality standards, an active response when standards are not being met, as well as continuous quality improvement of education and training.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

43. There is proactive and collaborative working with other partner and stakeholder organisations to support effective delivery of healthcare education and training and spread good practice.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GoC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

The team engage with student, Universities and those staff within the trust around education training. This feeds into the ICS/ICB and HEE matters around this area to ensure appropriate delivery and development.

44. Consideration is given to the potential impact on education and training of services changes (i.e. service re-design / service reconfiguration), taking into account the views of learners, supervisors and key stakeholders (including HEE and Education Providers).

	Yes	No	N/A
GDC Learners	☐	☐	✓

	Yes	No	N/A
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Section 3d - HEE Quality Framework Domain 3 - Developing and supporting learners

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

45. There is parity of access to learning opportunities for all learners, with providers making reasonable adjustments where required.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐

	Yes	No	N/A
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Reasonable adjustments are met and supported to ensure fairness to all. An inclusive talent management programme which builds on providing fair access to learning opportunities for all is currently under development.

46. The potential for differences in educational attainment is recognised and learners are supported to ensure that any differences do not relate to protected characteristics.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐

	Yes	No	N/A
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

47. Supervision arrangements enable learners in difficulty to be identified and supported at the earliest opportunity.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

All learners are allocated supervisors/mentors and have ability to signpost learners to appropriate resources.

48. Learners receive clinical supervision appropriate to their level of experience, competence and confidence, and according to their scope of practice.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

All Assessors receive training and support in this area to ensure consistency in assessment. This aligned to their curriculum, such as PA/PS for the NMC. Others may undergo training via the university to meet requirements such as HCPC. Equally, support will be given to supervisors if requested.

49. Learners receive the educational supervision and support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

This is applicable to all learners at MKUH.

50. Learners are supported to complete appropriate summative and/or formative assessments to evidence that they are meeting their curriculum, professional and regulatory standards, and learning outcomes.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐

	Yes	No	N/A
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Students and learners will be required to complete assessments that form part of their training or university based course. This may lead to the completion of proficiencies in line with their curriculum, such as the HCPC or NMC standards.

51. Learners are valued members of the healthcare teams within which they are placed and enabled to contribute to the work of those teams.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓

	Yes	No	N/A
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

All learners are listened to and staff value their input in clinical placements.

52. Learners receive an appropriate, effective and timely induction and introduction into the clinical learning environment.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Induction programmes are made available to all new learners to support their introduction to the learning environment.

53. Learners understand their role and the context of their placement in relation to care pathways, journeys and expected outcomes of patients and service users.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	
No - Please provide further detail	

54. Learners are supported, and developed, to undertake supervision responsibilities with more junior staff as appropriate.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer

Section 3e - HEE Quality Framework Domain 4 - Developing and supporting supervisors

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

55. Formally recognised supervisors are appropriately supported, with allocated time in job plans/ job descriptions, to undertake their roles.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners		☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Those completing supervision will be allocated time according to their clinical area. This may lead to work plans and JD stating this expectation, such as advanced practice, or PA/PS provision.

56. Those undertaking formal supervision roles are appropriately trained as defined by the relevant regulator and/or professional body and in line with any other standards and expectations of partner organisations (e.g. Education Provider, HEE).

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐

	Yes	No	N/A
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners		☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Assessors receive training and support in this area to ensure consistency in assessment. This is aligned to their curriculum, such as PA/PS for the NMC. Others may undergo training via the university to meet requirements such as HCPC. Equally, support will be given to supervisors if requested.

57. Clinical Supervisors understand the scope of practice and expected competence of those they are supervising.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐

	Yes	No	N/A
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

This is in line with the expectations within their JD/JS and workplans, but also in line with the expected levels via regulator input, such as NMC/HCPC, or other such HEE advancing practice.

58. Educational Supervisors are familiar with, understand and are up-to-date with the curricula of the learners they are supporting. They also understand their role in the context of leaners' programmes and career pathways, enhancing their ability to support learners' progression.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

This is in line with the expectations within their JD/JS and workplans, but also in line with the expected levels via regulator input, such as NMC/HCPC, or other such HEE advancing practice.

59. Clinical supervisors are supported to understand the education, training and any other support needs of their learners.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

This is in line with the expectations within their JD/JS and workplans, but also in line with the expected levels via regulator input, such as NMC/HCPC, or other such HEE advancing practice.

60. Supervisor performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for continued professional development and role progression and/or when they may be experiencing difficulties and challenges.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

This is in line with the current appraisal process within the trust and aligns to their JD/JS and workplan.

Section 3f - HEE Quality Framework Domain 5 - Delivering programmes and curricula

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

61. Practice placements must enable the delivery of relevant parts of curricula and contribute as expected to training programmes.

	Yes	No	N/A
GDC Learners	☐	☐	✓

	Yes	No	N/A
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Regular partnership meetings occur to ensure that the clinical area is aware of the expectation of the curriculum. This is also facilitated by link lectures to support staff and students to ensure practice matched to the theory and expectations.
No - Please provide further detail	

62. Placement providers work in partnership with programme leads in planning and delivery of curricula and assessments.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Regular partnership meetings occur to ensure that the clinical area is aware of the expectation of the curriculum. This is also facilitated by link lectures to support staff and students to ensure practice matched to the theory and expectations.
No - Please provide further detail	

63. Placement providers collaborate with professional bodies, curriculum/ programme leads and key stakeholders to help to shape curricula, assessments and programmes to ensure their content is responsive to changes in treatments, technologies and care delivery models, as well as a focus on health promotion and disease prevention.

	Yes	No	N/A
GDC Learners	☐	☐	✓

	Yes	No	N/A
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Regular partnership meetings occur to ensure that the clinical area is aware of the expectation of the curriculum. This is also facilitated by link lectures to support staff and students to ensure practice matched to the theory and expectations.
No - Please provide further detail	

64. Placement providers proactively seek to develop new and innovative methods of education delivery, including multi-professional approaches.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐

	Yes	No	N/A
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Simulation training is a good example of innovative methods of teaching, one example is the use of Virtual Reality training for undergraduate medical student.
No - Please provide further detail	

65. The involvement of patients and service users, and also learners, in the development of education delivery is encouraged.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

The involvement of patients and others within the development of education is encouraged. This may be within the development of programmes that encompass cultural or other factors, such as preceptorship and international nurse programmes.

66. Timetables, rotas and workload enable learners to attend planned/ timetabled education sessions needed to meet curriculum requirements.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

A number of learners and students from higher education institutions will either be supernumerary or will receive protected time as per the trust policy. This is reflected within the rostering system within MKUH.

Section 3g - HEE Quality Framework Domain 6 - Developing a sustainable workforce

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

67. Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

As stated previously there are regular meetings with stakeholders, such as higher education institutions to ensure support is consistent and attrition is minimised.

68. Does the provider provide opportunities for learners to receive appropriate careers advice from colleagues

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

The Trust has a practice education team and workforce matron, who offer career advice. This would be offered to those prior to CPD or apprenticeship in line with workforce needs, or prior to qualification, such as student nurses.

69. The provider engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐

	Yes	No	N/A
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

The Trust has a practice education team and workforce matron who work together to ensure education and workforce needs are aligned. This in addition to workforce meetings led by HR.

70. Transition from a healthcare education programme to employment and/or, where appropriate, career progression, is underpinned by a clear process of support developed and delivered in partnership with the learner.

	Yes	No	N/A
GDC Learners	☐	☐	✓
GMC Learners	✓	☐	☐
GPhC Learners	✓	☐	☐
HCPC Learners	✓	☐	☐
NMC Learners	✓	☐	☐

	Yes	No	N/A
GOsC Learners	☐	☐	✓
Any other learner groups (please define in notes)	☐	☐	✓

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

As stated previously the Trust has a practice education team and workforce matron who work together to ensure education and workforce needs are aligned. This had led to career conversations with student nurse/midwives prior to qualification to ascertain work area preference and discuss development, such as preceptorship.

Final Submission

Before completing your final submission please ensure you have completed the following:

1. Completed all questions within the Self-Assessment (including the free text sections)
2. You have confirmed that you have received Board level sign off for your submission (Section 1 - Provider)

71. Confirm Final Submission to HEE *

☐ Complete Submission

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Board of Directors Meeting in Public**	**Date: 08/09/22**
Report Title	**Violence and Unacceptable Behaviour Prevention Update**	**Agenda Item: 13**
Lead Director	**Kate Jarman** **Danielle Petch**	**Director of Corporate Affairs** **Director of Workforce**
Report Author		

Key Highlights/ Summary	*A summary of work and progress on preventing violence and unacceptable behaviour across the Trust.*			
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Noting** [ ]	**For Review** [ ]

Strategic Objectives Links	*Safety, experience, effectiveness*
Board Assurance Framework (BAF)/ Risk Register Links	*Staff experience, safety and retention.*

Report History	*TEC, Health and Safety Committee, Workforce Board*
Next Steps	*Workforce Assurance Committee*
Appendices/Attachments	*List of Attached Reports*

Violence and Unacceptable Behaviour Prevention Update

There has been significant work over a period of months to address incidents of violence, aggression and unacceptable behaviour against staff. This report provides a summary of work to date.

Background and Context

In the first quarter of 2022/23 105 reported incidents on RADAR (the Trust's internal reporting system) related to violence and unacceptable behaviour. High reporting locations and subcategories of incidents are listed in the below tables.

Location	Number of incidents
ED	26
Ward 1	9
Ward 14	2
Ward 15	2
Ward 16	5
Ward 18	4
Ward 19	6
Ward 22	6
Ward 3	12
Ward 5	3
Ward 8	5

Violence & unacceptable behaviour incidents by subcategory	22/23

	Q1
Other abuse or unacceptable behaviour	37
Physical abuse	28
Racial abuse	6
Sexual abuse	2
Verbal abuse	32

There has been a noted increase in the severity of the violence perpetrated against staff by patients, including serious assaults.

Action

The Trust has responded with a series of actions and interventions, which remain a continued focus and programme of work. These include:

1. The Trust already has in place conflict resolution, breakaway and restraint training, which is offered to specific staff groups. Conflict resolution training has traditionally been provided for all patient-facing staff but more recently has been mandated for all staff. Likewise, breakaway and/or restraint training has been available to certain staff groups on a risk assessed basis. This was usually offered to colleagues in areas most at risk of experiencing violence, for example our Emergency Department. More recently the Violence and Unacceptable Behaviour Prevention Steering Group have recommended this be available to all patient facing staff and this recommendation has been agreed.

2. A poster campaign is already in place as a result of the work of the Violence and Unacceptable Behaviour Prevention Steering Group. These posters, which were co-developed and agreed by the Group, can be seen across the Trust and have been instrumental in raising awareness of this important issue since they were first displayed in October 2021.

3. The Violence and Unacceptable Behaviour Prevention Steering Group has been meeting since May 2021 and reviewed the NHS England ‘Violence prevention and reduction standard’ as one of their first tasks. This review identified areas for improvement and these have formed a key part of the strategy and work of the Group. The membership of the Group

includes two Executive Directors, a Deputy Director, an ADO, Heads of Service, union representatives, including an RCN representative and other colleagues from across the Trust.

4. The Group has been chaired since its inception in 2021 by one of two Directors; Kate Jarman, Director of Corporate Affairs and Danielle Petch, Director of Workforce. Where Danielle and Kate are unavailable to attend the Group is chaired by one of our Deputy Directors. The Executives do update as to the progress of the Group at Trust management meetings and the Director of Workforce has discussed these issues at the Board.

In addition to the above the Group have already implemented or are taking forwards:

1. A repeat review of incidents which have been reported to identify any new or emergent themes
2. Holding a series of listening events, asking colleagues to share their experiences and learning
3. Launched a Victim's Code so staff know their rights and the help which is on offer
4. Improved and documented processes to support staff when violence and unacceptable behaviour does occur, including thorough debrief and on-going support
5. Helping staff to seek prosecution
6. Identifying and sharing when a patient is known to display violent and unacceptable behaviours
7. Nominated members of the security team linked to specific areas so they are briefed on the patient cohort and any likely issues
8. Dedicated on site police presence
9. Review of patient environments and identifying specific triggers
10. Strategy and policy review and refresh
11. A review of available research and peer learning to identify what other Trusts are doing

Next Steps

Work will continue, with focussed programmes in ED – including bespoke environmental work, further listening events and training; training and education work for wards with high numbers of patients with dementia; and training and education for Healthcare Assistants who often provide one-to-one care. Progress will be reported regularly through the Workforce Assurance Committee.

Appendix 1: Violence and Unacceptable Behaviour Prevention Strategy

Violence and Unacceptable Behaviour Prevention Strategy			
Classification :	Strategy		
Authors Name:	Alan Brooks Marion Fowler		
Authors Job Title:	Head of Security Health & Safety Advisor		
Authors Division:	Corporate		
Departments/Group this Document applies to:	All Trustwide		
Approval Group: Health & Safety Committee – 25/07/22 Trust Executive Group – 10/08/22		**Date of Approval:**	10/08/2022
		Last Review:	July 2022
		Review Date:	July 2023
Unique Identifier: Governance allocate new numbers	**Status:** Final	**Version No:** 1	
Strategy to be followed by (target staff): All staff			
To be read in conjunction with the following documents: Health & Safety Policy Violence & Unacceptable Behaviour Policy Incident Reporting Policy Risk assessment process & procedure RIDDOR reporting process & procedure First Aid at Work Policy			

CQC Fundamental standards:
Regulation 12 – Safe care and treatment
Regulation 15 – people and premises
Regulation 17 – Good governance
Regulation 18 – Staffing
Regulation 19 – Fit and proper

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1.0 Introduction

The **Health and Safety Executive (HSE)** defines work-related violence as:

"any incident in which a person is abused, threatened or assaulted in circumstances relating to their work".

This definition includes verbal abuse and threats as well as physical attacks. Health and safety law applies where it is foreseeable that a risk of violence and/or unacceptable behaviours may arise out of, or in connection with, the work activity.

Incidents are known to negatively impact at individual, organisational and societal levels.

Incidents are likely to affect overall wellbeing, sense of self-esteem and dignity. Physical health impacts might include injuries, cuts or bruises. Mental health effects may include anxiety, stress, post-traumatic stress disorder, and potential for increase in suicide risk. Individuals may feel frightened, sad, powerless, angry or helpless, incur problems sleeping and find themselves suffering from chronic fatigue. Individuals may also suffer loss of income if having to take time away from work following an incident.

It is incumbent on all employers to ensure the risks associated with violence and unacceptable behaviours are identified and measures taken to prevent/reduce the occurrences, impact and to support staff and others affected appropriately.

This strategy identifies the commitment and measures taken within Milton Keynes University Hospital NHS Foundation Trust in managing violence and unacceptable behaviour.

2.0 Strategy Statement

The Trust Board and Chief Executive Officer (CEO) of MKUH are accountable for ensuring violence and unacceptable behaviour is identified and managed appropriately across the organization. They will ensure and seek assurance the measures identified in this strategy and supporting policy are implemented and continue to be regularly reviewed. They will support any additional measures required so far as is reasonably practicable.

The Trust Board and CEO of Milton Keynes University Hospital NHS Foundation Trust (MKUH) do not accept that instances of violent and unacceptable behaviour are an inevitable part of daily work.

Such behaviours take many forms, these will be outlined in the Trust Violence & Unacceptable Behaviour Policy and can involve staff, patients and others, affecting both physical and mental wellbeing.

Violent and unacceptable behaviour should not be accepted by any individual; it is not an occupational hazard and we actively encourage all staff :

- **Do Not Accept it**
- **Report it**
- **Prevent it**

There will be some circumstances where an episode of unacceptable behaviour is due to circumstances; medical conditions, receiving bad news for example. As part of this strategy and the supporting policy we seek to better understand the causes of an individuals behaviour and endeavour to prevent such incidents if possible. Where incidents do occur despite strategies to prevent, we will take measures to support our staff/others.

The implementation of the violence and unacceptable behaviour prevention strategy aims to encourage all clinical and non clinical services to review practices and philosophies of care in order to maximise the safety of everyone. Looking at three stages of prevention, primary, secondary and tertiary.

Through this strategy we promote collaborative working across our stakeholders to ensure services are safe for all; with teams committed to a culture of incident reporting, meaningful debrief and in the case of patients, clinical risk review to inform organizational learning and development in order to reduce/prevent further incidents and ensure our staff feel supported.

This strategy does not exist in isolation, its intention is to provide a strategic framework and work alongside supporting policies.

3.0 Strategy Aims

To define the strategic direction of violence and unacceptable behaviour management within MKUH. It outlines the general actions we will take. The supporting policy will outline those actions in more detail along with clear roles and responsibilities for implementation.

To meet the aims set out in the NHS England violence prevention and reduction standard: December 2020; Health & Safety legislation and the standards previously set by NHS Protect

4.0 Our Vision

We collectively accept that incidents of violence and unacceptable behaviour are not inevitable and will seek to address and reduce occurrences.

We commit to providing a framework that supports a safe and secure working environment for our staff and others affected, safeguarding them against abuse, aggression and violence.

We commit to ensuring appropriate sanctions are taken against perpetrators of violence and unacceptable behaviours.

We commit to providing suitable and timely support to staff and others affected by violence and unacceptable behaviours.

We will do this by :

- Nominating a lead director for oversight in relation to the management of violence and unacceptable behaviour.
- Identify a lead role for outlining policy, providing support and direction in managing behaviours, supporting staff and seeking action against perpetrators.
- Documenting and implementing policies and procedures to guide staff
- Undertaking risk assessments and acting on the outcomes
- Where violence and unacceptable behaviour is demonstrated a process of letters concerning future behaviour by an individual will be forwarded in an effort to reduce the occurrences.
- The Trust will actively seek maximum sanctions against individuals through the criminal justice system where appropriate
- Implementing such measures as deemed necessary to safeguard individuals – CCTV, bodycams, alarms for example
- Reviewing workplace environments, medical practices/interventions, looking at primary prevention and de escalation methods, secondary and tertiary interventions.
- Providing support to staff in a meaningful and constructive way
- Providing staff with a platform to report incidents
- Reviewing incident data and trends in order to better understand the locations, causes and impact of such incidents
- Communicating and raising awareness in relation to behavioural management, escalation and support
- Developing and providing training for staff that ensures they understand policy requirements and how to deal with violent and unacceptable behaviours when they do happen

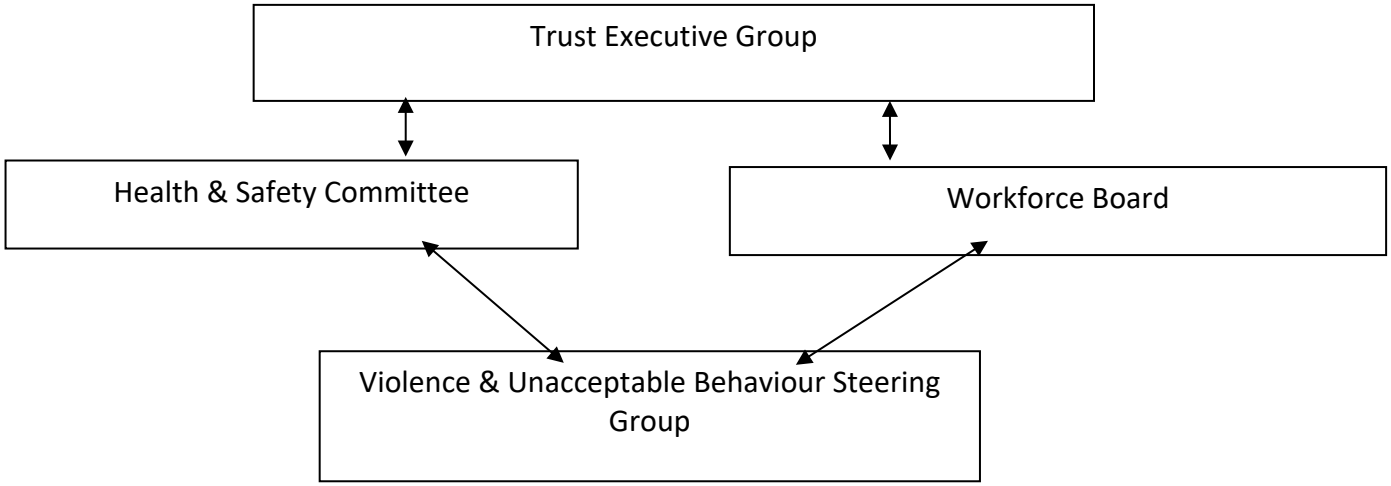
- Empowering staff to report incidents – Do not accept it, report it, prevent it
- Empowering staff to seek further action against perpetrators and feel supported in that process
- Ensuring we are listening and taking action through appropriate methods of audit, monitoring and acting upon incidents and staff feedback
- Providing a platform through a designated Violence & Unacceptable Behaviour Steering Group for escalation and ongoing monitoring of Trust processes.
- Consult with stakeholders including our union and staff side representatives

5.0 Definitions

- Individuals – staff, patients, visitors and other third parties
- Primary interventions – addressing the root causes before it has happened
- Secondary interventions – reactive response – de escalation techniques
- Tertiary interventions – physical interventions, post incident reviews, debriefs

6.0 Governance Structure

This strategy will be reviewed annually alongside the policy and NHS England standard. Escalations and assurance reporting will happen through the below governance structure.



7.0 Implementation and dissemination of document

This strategy will be promoted through the CEO weekly message and uploaded to the intranet. It will also be promoted through a targeted communications campaign identified as part of the strategy vision.

8.0 Statement of evidence/references

Reference:

NHS England : Violence prevention and reduction standard – December 2020

Underpinning legislation:

Health & Safety at Work etc Act 1974
Management of Health & Safety at Work Regulations 1999
Reporting of Injuries Diseases and Dangerous Occurrence Regulations 2013
The Health & Safety First Aid at Work Regulations 1981
Safety Representatives and Safety Committees Regulations 1977
Health and Safety (Consultation with Employees) Regulations 1996

Associated legislation:

The Corporate Manslaughter and Corporate Homicide Act 2007
Protection from Harassment Act 1997 – Legislation.gov.uk
Assaults on Emergency Workers (Offences) Act 2018
Equality Act 2010 - Legislation.gov.uk
Offences against the person legislation
Section 39 Criminal Justice Act 1988

9.0 Governance

9.1 Document review history

Version number	Review date	Reviewed by	Changes made
1	**2022**	**New document**	

9.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Violence & Unacceptable Behaviour Steering Group	V&A standard review	17/06/22		No comments to add	
Health & Safety Committee Mike Betts, Manual Handling Advisor Tina Worth, Head of Risk & Clinical Governance	Legislative background and direction	17/06/22	20/06/22 20/06/22	Check references to policy/strategy align to document name EQIA to be completed	Yes Yes
JCNC	Union/staff side consultation	05/07/22		No comments to add	

Estates Governance Group	Oversight of violence & abuse management practices		21/06/22	No comments to add	
Health & Safety Committee			25/07/22	Approved	
Trust Executive Committee	Oversight assurance of violence and abuse management	28/07/22	10/08/22	Approved	

9.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
Understanding of strategy	audit/survey monkey/staff survey	Head of Security/Health & Safety Advisor	Annual	V&A Steering Group Health & Safety Committee
Meeting NHS England Standard, legislation	NHS standard H&S legislation	Head of Security/Health & Safety Advisor	Annual	V&A Steeting Group Health & Safety Committee
Incident trend analysis to look at reduction in incidents/severity/location	RADAR	Head of Security/Health & Safety Advisor	Quarterly	V&A Steering Group Health & Safety Committee

Improvement in staff survey responses	Staff Survey Union feedback	Director of Workforce/Deputy Director of Workforce	Annual and monthly through JCNC	JCNC V&A Steering Group Health & Safety Committee

9.4 Equality Impact Assessment

As part of its development, this strategy and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified.

Equality Impact Assessment			
Division	**Corporate**	**Department**	**Estates/Risl & Governance**
Person completing the EqIA	**Marion Fowler**	**Contact No.**	**01908995097**
Others involved:	**Alan Brooks**	**Date of assessment:**	**01/07/2022**
Existing strategy/service	N/A	**New strategy/service**	**Managing Unacceptable Behaviour**
Will patients, carers, the public or staff be affected by the strategy/service?	Staff		
If staff, how many/which groups will be effected?	All staff		
Protected characteristic	**Any impact?**	**Comments**	

Age	NO	Positive impact – in risk assessing episodes and severity of behaviours, it may be necessary to exclude some women from working in high risk areas to safeguard them and their unborn child. This will be determined by departmental and pregnancy risk assessments.
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	YES	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?	*V&A Steering Group, Estates Governance, Health & Safety Committee, JCNC, Trust Executive Committee*
How are the changes/amendments to the policies/services communicated?	*Email, intanet, promotion through department visits, listening events, drop ins*

What future actions need to be taken to overcome any barriers or discrimination?

Who will lead this?	Who will lead this?	Who will lead this?	Who will lead this?
Review date of EqIA	**July 2023**		

Appendix 2: Corporate Risk Assessment

Risk Assessment Form

Type of Risk Assessment *(tick any that apply)*:

Compliance		**Legal**		**Financial**		**Health & Safety**	**X**	**Environmental**	
Patient Safety		**Operational**		**Medical Equipment**		**Strategic / Business**		**Project**	

Location/Department:	**Name of Assessor:**	**Job Role:**	**Date of Risk Assessment: 21/07/2022**
Trustwide	**Marion Fowler**	**Health & Safety Advisor**	**Next Review date : January 2023**

Review Period *(tick the relevant option)*:

Risk assessments should be reviewed at least annually or when significant change to scenario being assessed, legislative update, incident/accident or when prompted.

Monthly		**Quarterly**		**Bi-Annual**		**Annual (minimum)**		**Other (specify) 6 months**	**X**

Approving Manager:	**Job Role:**	**Date:**	**RADAR Risk Register Reference** *(where appropriate)*:

Describe the task/environment/hazard being assessed:

Violence and unacceptable behaviour towards staff and others across the Trust

Reported Incidents and intelligence suggest ongoing increases in unacceptable behaviours aimed at staff (some patient on patient) through patient interaction.

Nationwide issue with increases in violent crime, healthcare workers being attacked with weapons, sexually/physically/verbally assaulted, although a rarity death of workers has been reported in the public domain.

Perpetrators may know what they are doing, some individuals are unaware due to medical condition, detoxing/drug/alcohol for example. Increased number of mental health patients, patients with cognitive impairment and reports of understaffing in departments/lack of knowledge in managing such patients/insufficient specialist 1-1 support.

Trust is responsible for ensuring a safe place of work as per Health & Safety at Work etc Act 1974, its associated regulations and guidance, this includes taking measures to ensure individuals safety from violence and unacceptable behaviours so far as is reasonably practicable.

Hazard Number	Step 1. Identify the hazards		Step 2. Risk without controls			Step 3. What is already in place?	Step 4. Current Risk			Step 5. Action required	Risk Register
Hazard Number	**CAUSE What are the hazards?**	**IMPACT Who might be harmed and how? (include anyone at special risk, patients, staff, visitors, the Trust)**	**Inherent Risk Grading** *The level of risk if the controls fail?*			**CURRENT CONTROLS What are you already doing to control the risk?**	**Current Risk Grading** *The level of risk now*			**GAPS IN CONTROL What further action do you need to consider to control the risk? These actions need to be transferred to the action plan below.**	**Escalate onto Risk Register? Yes/No**
			Consequence	**Likelihood**	**Risk C x L**		**Consequence**	**Likelihood**	**Risk C x L**		
1	Violence and threatening behaviour Patient to staff Visitor to staff Staff on staff Patient on patient Visitor to visitor	**Staff/patients/visitors** Strangulation – asphyxiation/burns/death Physical injures from being hit/headbutted/kicked/attacked with weapons or items used as	5	5	25	**Prevent and deter** CCTV in high-risk areas Bodycams being trialled Presence of security/PCSO in ED Posters displayed in wards/department Staff communicate patient behaviours during handovers and not on patients notes	5	3	15	**Prevent and deter** Wider roll out of bodycam provision Review security provision and interim role to cover loss of PCSO Consideration of buzzer service in ED to allow patients to be called back if they take a comfort break Environmental study starting with ED	

	Physical assault Sexual assault Verbal assault Harassment Intimidation/threats	weapons - fractures, bruises, lacerations/head injury/concussion/death Scratches/bites – potential BBV infection – Hep B, Hep C, HIV Anxiety/stress/low morale/impact to mental health Patient extended length of stay Poor patient experience **<u>Trust</u>** Enforcement – HSE for breaches of Health & Safety Legislation Complaints Claims Litigation Payments/costs/increased insurance premiums Grievance Adverse publicity Difficulties in recruitment and retention				Follow conflict resolution training Deescalate/Staff withdraw from situation if person becomes challenging Where known aggressor – dynamic assessment, have an escape route, consider seeing patient in twos, do not work alone, do not work in a closed space, consider screens/barriers between aggressor and staff, consider security presence to see patient Ensure panic alarms/call bells within easy reach Call for assistance where situations are escalating Application of 3 tier warning system – verbal, behavioural, red card – overseen by Head of Security Enforcement/criminal prosecution where possible For scratches/bites/wounds – bleed/wash/cover and report - seek Occupational Health guidance and risk assessment **Training and information**				Widen environmental study to consider patients with MH, learning disability, dementia etc – holistic approach to care, environment, distraction therapies **Training and information for staff** Review breakaway training provision ensure rolling programme in place Update to Conflict resolution training to include what to do in the event of an incident, support, what happens next	

		Understaffing				Conflict resolution training mandatory for all staff Breakaway training available – ad hoc **Support for staff** Security available - Code victor 2222 Police available – 999 Support for staff through manager/Occupational Health & Wellbeing Services/Employee Assistance Programme Staff support through Staff Debrief available through Chaplain service Support also available through Head/Deputy Head of Security/Health & Safety Advisor Staff victims of crime support document – referral to Victims First				Embed and empower staff to report to police Training for staff in managing patients with MH, learning disability, dementia etc De escalation procedure/techniques **Support for staff** Clear pathway for staff support post incident through to prosecution and beyond Development of an information pocket card for staff Listening events on the road, staff engagement sessions	

						Where criminal action is to be taken support for staff available through Head/Deputy Head of Security **Reporting** Staff encouraged to report all incidents onto RADAR Staff encouraged to report incidents to the police Incidents, themes and trends discussed at bi monthly Health & Safety Committee Escalation of any incidents, themes, trends as they are identified during Health & Safety review **Policies and procedures** Policy in place (undergoing review) Risk assessments advised for all wards/departments acknowledging own bespoke risk scenarios				**Reporting** Ensure feedback from incidents to staff and lessons learnt shared amongst wider organisation Consider Trust stance on routine reporting to the police **Policies and procedures** Documented strategy Review policy, local risk assessments, warning system Review and implement flagging of behaviours on ecare and through staff communication between team(s)	

ACTION PLAN

Hazard number	Action required	By whom	By when	Date completed
	All actions being picked up through Violence & Unacceptable Behaviour Steering Group			

Grading the Risk			
Risk Rating	**Consequence** *(How bad it may be?)*	**Likelihood of Harm** *(The chance it may occur)*	**Rating** *(R=C x L)*
Decide the applicable **Consequence** and **Likelihood** for the risk: a) without any control measures in place (Inherent) b) taking into account existing control measures (Current)	1 Negligible 2 Minor 3 Moderate 4 Major 5 Catastrophic	1 Rare 2 Unlikely 3 Possible 4 Likely 5 Almost Certain	15-25 = High / Significant 8-12 = Moderate 4-6 = Low 1-3 = Very Low

		CONSEQUENCE *(I.e. the Impact/Severity)*				
		1	**2**	**3**	**4**	**5**
LIKELIHOOD *(i.e. frequency)*	**5**	5	10	15	20	25
	4	4	8	12	16	20
	3	3	6	**9**	12	15
	2	2	4	6	8	10
	1	1	2	3	4	5

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	Trust Board	**Date:** 08 September 2022
Report Title	2022-23 Executive Summary M4	**Agenda Item:** 14
Lead Director	**Name:** John Blakesley	**Title:** Deputy CEO
Report Author	**Name:** Performance and Information Team	**Title:**

Key Highlights/ Summary	Please refer to the Executive Summary			
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Noting** x	**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: M4 (July 2022)

1.0 Summary

This report summarises performance in July 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)	530	0
4.6	Diagnostic Waits <6 weeks	90%	99%

Given the impact of COVID-19, the performance of certain key constitutional NHS targets for July 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

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

ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1a	ED 4 hour target (includes UCS)		90%	90%	82.2%	80.0%				
4.2	RTT Incomplete Pathways <18 weeks		70%	70%		49.9%				
4.6	Diagnostic Waits <6 weeks		90%	90%		79.4%				
4.9	62 day standard (Quarterly)		85%	85%		62.3%				

ED performance showed a slight deterioration in July 2022, decreasing to 80.0% from 83.2% in June 2022. However, MKUH performance exceeded both the national overall performance of 71.0% and all the other trusts within its Peer Group (see Appendix 1).

The Trust's RTT Incomplete Pathways <18 weeks performance was 49.9% at the end of July 2022, with the total volume of open pathways now at 34,304, increasing from 32,410 in June 2022. 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 Q1 2022/23, the Trust's 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) was 62.3% against a national target of 85%, dropping from 66.3% in Q4 2021/22. The percentage of patients to begin cancer treatment within 31 days of a decision to treat increased to 97.0%, above 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 80.6% against a national target of 93%, a deterioration when compared to the previous quarter's performance of 87.1%.

3.0 Urgent and Emergency Care

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

ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.4	Cancelled Ops - On Day		1%	1%	1.30%	2.13%	✗	▼	✗	
3.2	Ward Discharges by Midday		25%	25%	15.4%	16.7%	✗	▲	✗	
3.4	30 day readmissions		7%	7%	7.4%	6.5%	✓	▲	✗	
3.6b	Number of Super Stranded Patients (LOS>=21 Days)		50			102	✗	▲		
3.9a	Ambulance Handovers <30 mins (%)		95%	95%	85.1%	77.8%	✗	▼	✗	
4.2	RTT Incomplete Pathways <18 weeks		70%	70%		49.9%	✗	▬		

Cancelled Operations on the Day

In July 2022, there were 49 operations that were cancelled on the day for non-clinical reasons, representing 2.13% of all planned operations. This was the highest percentage of cancelled operations on the day that has been reported since March 2018. The majority of the cancellation reasons were related to staffing issues, equipment issues, bed availability and insufficient time to operate.

Readmissions

The Trust's 30-day emergency readmission rate decreased from 7.6% in June 2022 to 6.5% in July 2022, representing an improvement in performance.

Delayed Transfers of Care (DTOC)

The number of DTOC patients reported at midnight on the last Thursday of July 2022 was 42 patients: 35 in Medicine and seven in Surgery, a notable improvement compared to 53 patients at the end of June 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 102, a month on month reduction for the first time this financial year.

Ambulance Handovers

In July 2022, the percentage of ambulance handovers to the Emergency Department taking less than 30 minutes was 77.8%, a significant deterioration in performance compared to 88.8% in June 2022.

4.0 Elective Pathways

ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	89.6%	91.3%	✓	▼	✓	
4.2	RTT Incomplete Pathways <18 weeks		70%	70%		49.9%	✗	▬		
4.4	RTT Total Open Pathways		33,998	35,070		34,304	✓	▼		

Overnight Bed Occupancy

Overnight bed occupancy was 91.3% in July 2022, increasing from 87.5% in June 2022, and the highest occupancy so far, this financial year.

RTT Incomplete Pathways

The Trust's RTT Incomplete Pathways <18 weeks at the end of July 2022 was 49.9% and the number of patients waiting over 52 weeks was 1,884 against a trajectory of 530. These patients were distributed across Surgery (1,704 patients), Women and Children (159) and Medicine (21).

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 July 2022, with a performance of 79.4%. This was an improvement in performance for the third month in a row, improving from 61.9% in 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. In fact, the total number of patients waiting for a diagnostic test was at its lowest for some time which demonstrates that the recovery plan is having a positive impact on both volume and performance.

5.0 Patient Safety

Infection Control

In July 2022, the following infections were reported:

Infection	Number of Infections	Division/ Ward
MSSA	2	Medicine (Ward 3) and Surgery (Ward 20)
E-Coli	1	Medicine (Ward 14)
MRSA bacteraemia	1	Medicine (Ward 22)
C.Diff	0	
Klebsiella Spp bacteraemia	0	
P.aeruginosa bacteraemia	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.

April to June 2022 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	May-22	June-22	July-22
Milton Keynes University Hospital NHS Foundation Trust	81.6%	83.2%	80.0%
Homerton Healthcare NHS Foundation Trust	81.5%	83.9%	79.0%
Southport and Ormskirk Hospital NHS Trust	77.0%	77.7%	73.8%
Buckinghamshire Healthcare NHS Trust	74.0%	72.2%	72.1%
The Hillingdon Hospitals NHS Foundation Trust	71.6%	71.6%	70.9%
Northampton General Hospital NHS Trust	66.4%	67.5%	66.1%
Barnsley Hospital NHS Foundation Trust	69.1%	60.1%	63.1%
North Middlesex University Hospital NHS Trust	67.8%	65.8%	62.3%
Oxford University Hospitals NHS Foundation Trust	67.4%	65.0%	62.2%
Mid Cheshire Hospitals NHS Foundation Trust	59.9%	60.0%	58.0%
The Princess Alexandra Hospital NHS Trust	61.7%	61.6%	57.5%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	62.2%	59.3%	57.3%
Bedfordshire Hospitals NHS Foundation Trust	-	-	-
Kettering General Hospital NHS Foundation Trust	-	-	-

Board Performance Report 2022/23
July 2022 (M04)

Milton Keynes University Hospital NHS Foundation Trust

OBJECTIVE 1 - PATIENT SAFETY										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
1.1	Mortality - (HSMR) ★		98.2	98.2		106.5	✗	▼		
1.2	Mortality - (SHMI)		100.0	100.0		108.3	✗	▲		
1.3	Never Events		0	0	0	0	✓	▬	✓	
1.4	Clostridium Difficile		10	<4	4	0	✓	▲	✗	
1.5	MRSA bacteraemia (avoidable)		0	0	2	1	✗	▼	✗	
1.6	Falls with harm (per 1,000 bed days)		0.12	0.12	Not Available					
1.7b	Midwife to birth ratio (Actual for Month)					34		▼		
1.8	Incident Rate (per 1,000 bed days)		50	50	47.54	48.45	✗	▼	✗	
1.9	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▬	✓	
1.10	E-Coli		15	5	6	1	✓	▲	✗	
1.11	MSSA		8	<3	7	2	✗	▲	✗	
1.12	VTE Assessment		95%	95%	94.3%	87.8%	✗	▼	✗	
1.14	Klebsiella Spp bacteraemia		15	5	5	0	✓	▲	✓	
1.15	P.aeruginosa bacteraemia		10	<4	2	0	✓	▬	✓	

OBJECTIVE 2 - PATIENT EXPERIENCE										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	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%	1.30%	2.13%	✗	▼	✗	
2.5	Over 75s Ward Moves at Night		1,500	500	502	118	✓	▲	✗	
2.6	Mixed Sex Breaches		0	0	0	0	✓	▬	✓	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	89.6%	91.3%	✓	▼	✓	
3.2	Ward Discharges by Midday		25%	25%	15.4%	16.7%	✗	▲	✗	
3.3	Weekend Discharges		63%	63%	61.4%	56.1%	✗	▼	✗	
3.4	30 day readmissions		7%	7%	7.4%	6.5%	✓	▲	✗	
3.5	Patients not meeting Criteria to Reside		TBC			88	Not Available	▼		
3.6a	Number of Stranded Patients (LOS>=7 Days)		184			252	✗	▼		
3.6b	Number of Super Stranded Patients (LOS>=21 Days)		50			102	✗	▲		
3.7	Delayed Transfers of Care		25			42	✗	▲		
3.8	Discharges from PDU (%)		12.5%	12.5%	9.3%	9.2%	✗	▼	✗	
3.9a	Ambulance Handovers <30 mins (%)		95%	95%	85.1%	77.8%	✗	▼	✗	
3.9b	Ambulance Handovers <60 mins (%)		100%	100%	97.8%	97.8%	✗	▼	✗	

ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1a	ED 4 hour target (includes UCS)		90%	90%	82.2%	80.0%	✗	▼	✗	
4.1b	Total time in ED no more than 8 hours (Admitted)		100%	100%	54.3%	39.9%	✗	▼	✗	
4.2	RTT Incomplete Pathways <18 weeks		70%	70%		49.9%	✗	▬		
4.4	RTT Total Open Pathways		33,998	35,070		34,304	✓	▼		
4.5a	RTT Patients waiting over 52 weeks (Total)		0	530		1884	✗	▼		
4.5b	RTT Patients waiting over 52 weeks (Non-admitted)		0	TBC		1486	Not Available	▼		
4.6	Diagnostic Waits <6 weeks		90%	90%		79.4%	✗	▲		
4.7	All 2 week wait all cancers (Quarterly) 🖉		93%	93%		80.6%	✗	▼		
4.8	31 days Diagnosis to Treatment (Quarterly) 🖉		96%	96%		97.0%	✓	▲		
4.9	62 day standard (Quarterly) 🖉		85%	85%		62.3%	✗	▼		

OBJECTIVE 5 - SUSTAINABILITY										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
5.1	GP Referrals Received		Not Available		26,001	5,833	Not Available	▼	Not Available	
5.2	A&E Attendances		104,759	36,214	34,977	8,881	✓	▼	✓	
5.3	Elective Spells		25,821	8,906	8,197	2,108	✗	▼	✗	
5.4	Non-Elective Spells		34,421	11,682	9,748	2,566	✓	▼	✓	
5.5	OP Attendances / Procs (Total)		407,339	137,417	128,981	30,066	✗	▼	✗	
5.6	Outpatient DNA Rate		6%	6%	7.5%	7.5%	✗	▲	✗	
5.7	Virtual Outpatient Activity		25%	25%	16.2%	13.7%	✗	▼	✗	
5.8	Elective Spells (% of 2019/20 performance)		110%	110%	97.6%	87.9%	✗	▼	✗	
5.9	OP Attendances (% of 2019/20 performance)		104%	104%	98.4%	86.9%	✗	▼	✗	

OBJECTIVE 7 - FINANCIAL PERFORMANCE										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
7.1	Income £'000		332,163	112,497	111,271	32,243	✓	▲	✗	
7.2	Pay £'000		(208,343)	(71,234)	(71,611)	(18,106)	✗	▼	✗	
7.3	Non-pay £'000		(98,408)	(33,768)	(33,873)	(9,309)	✗	▼	✗	
7.4	Non-operating costs £'000		(25,412)	(11,401)	(11,255)	(6,657)	✓	▼	✓	
7.5	I&E Total £'000		(0)	(3,906)	(5,468)	(1,829)	✗	▼	✗	
7.6	Cash Balance £'000			46,076		46,224	✓	▼		
7.7	Savings Delivered £'000		12,049	1,850	1,850	648	✓	▲	✓	
7.8	Capital Expenditure £'000		(18,288)	(2,667)	(2,667)	(1,179)	✗	▲	✓	

OBJECTIVE 8 - WORKFORCE PERFORMANCE										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
8.1	Staff Vacancies % of establishment		10.0%	10.0%		10.3%	✗	▲		
8.2	Agency Expenditure %		5.0%	5.0%	6.0%	5.3%	✗	▲	✗	
8.3	Staff Sickness % - Days Lost (Rolling 12 months) 🖉		5.5%	5.5%		5.5%	✓	▼		
8.4a	Appraisals (excluding doctors)		90%	90%		89.0%	✗	▲		
8.4b	Doctors due appraisal in the given month who have completed that appraisal by month end	TBC				48.6%		▲		
8.4c	Doctors who have completed appraisal since 01 April 2022	TBC				19.8%		▲		
8.5	Statutory Mandatory training		90%	90%		95.0%	✓	▬		
8.6	Substantive Staff Turnover		9.0%	9.0%		14.2%	✗	▼		
8.7	Percentage of employed consultants with (at least one) fully signed off (3-stage) job plan since 01 April 2021					83.6%		▲		

OBJECTIVES - OTHER										
ID	Indicator	DQ Assurance	Threshold 2022-23	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
O.1	Total Number of NICE Breaches		8	8		26	✗	▼		
O.2	Rebooked cancelled OPs - 28 day rule		90%	90%	97.6%	97.6%	✓	▼	✓	
O.4	Overdue Incidents >1 month		TBC	TBC		336	Not Available	▲		
O.5	Serious Incidents		75	25	42	12	✗	▼	✗	

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

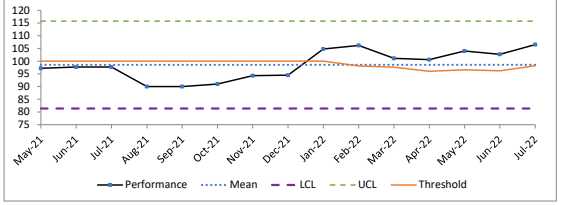
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory 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

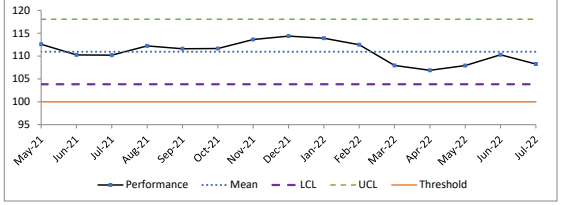
SD=3

1.1 Mortality - HSMR (Rolling 15 months)

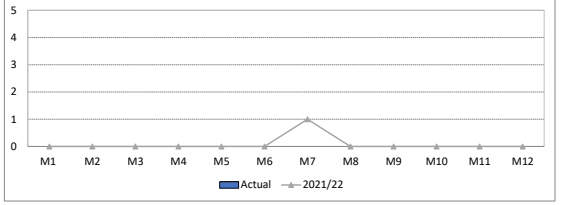


SD=3

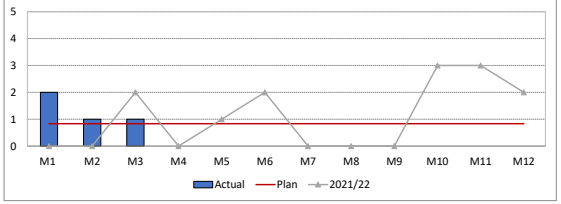
1.2 Mortality - SHMI (Rolling 15 months)



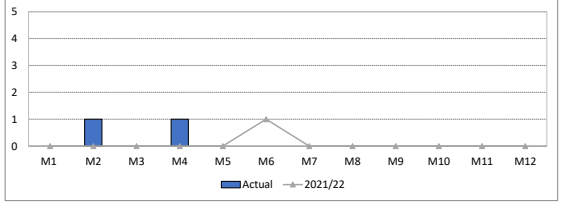
1.3 - Never events



1.4 - C.Diff Infections

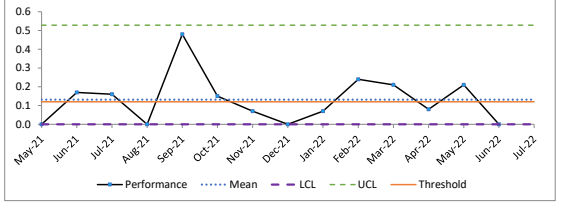


1.5 - MRSA Bacteraemia



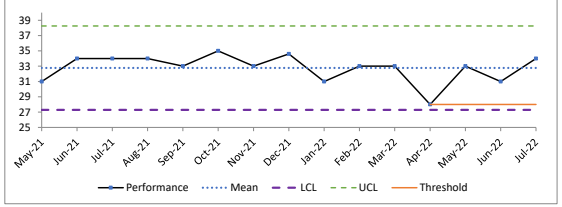
SD=3

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



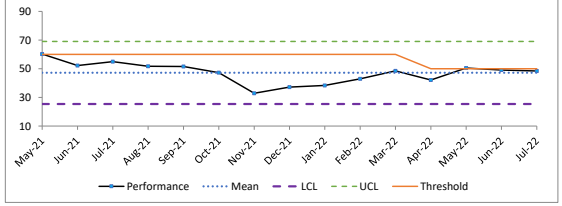
SD=3

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

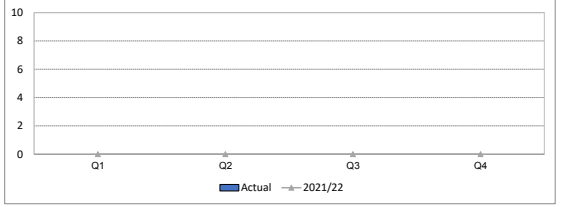


SD=3

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

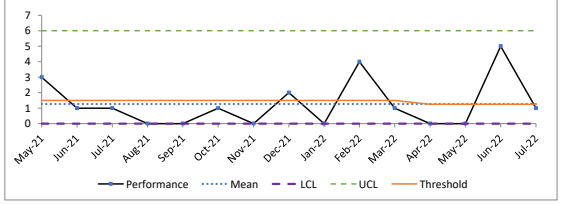


1.9- Duty of Candour Breaches



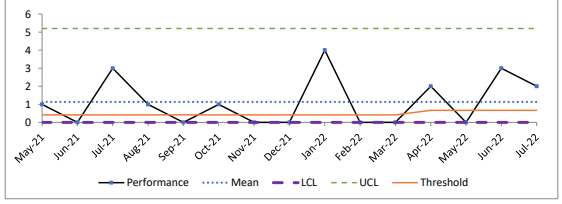
SD=3

1.10 - E-Coli



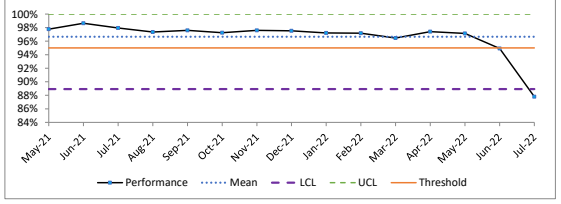
SD=3

1.11 - MSSA



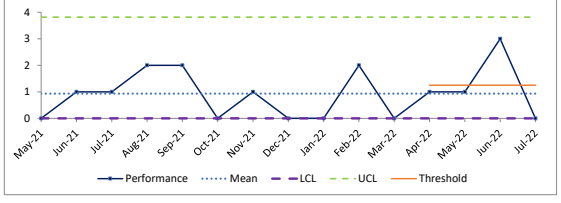
SD=3

1.12 - VTE Assessment



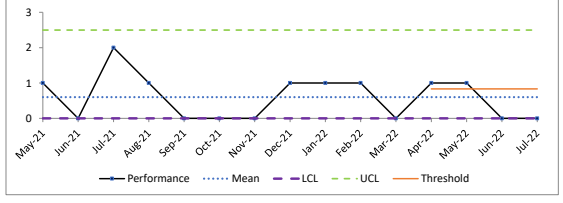
SD=3

1.14 - Klebsiella Spp bacteraemia



SD=3

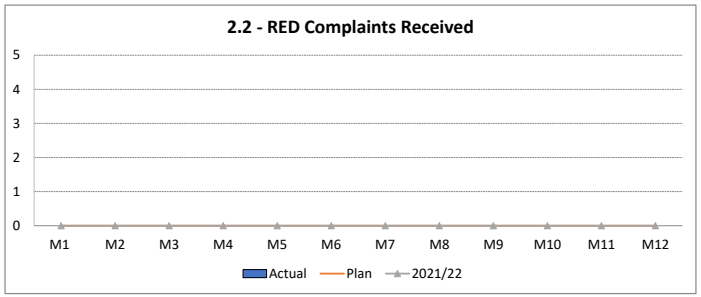
1.15 - P.aeruginosa bacteraemia

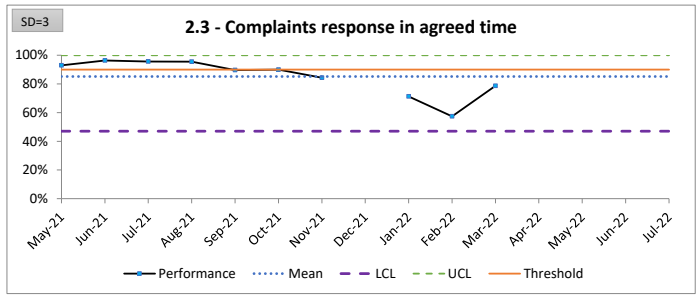


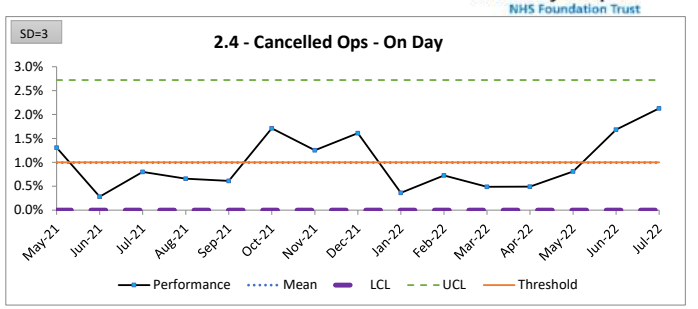
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

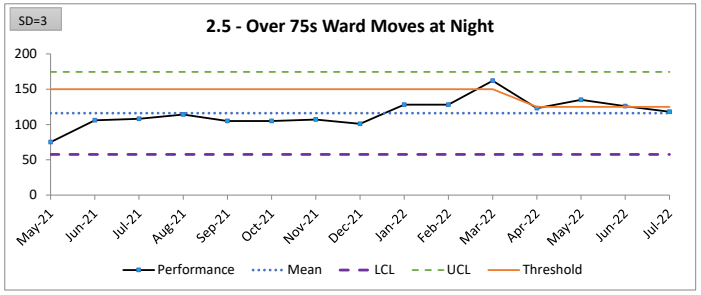
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

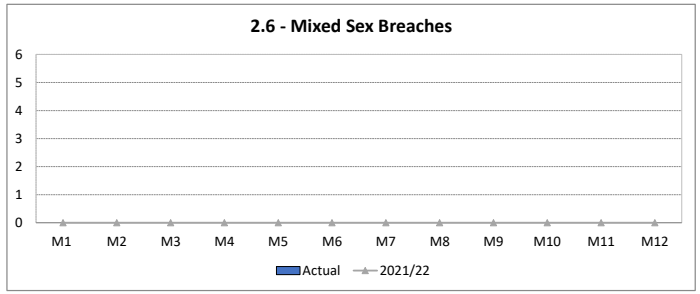
OBJECTIVE 2 - PATIENT EXPERIENCE











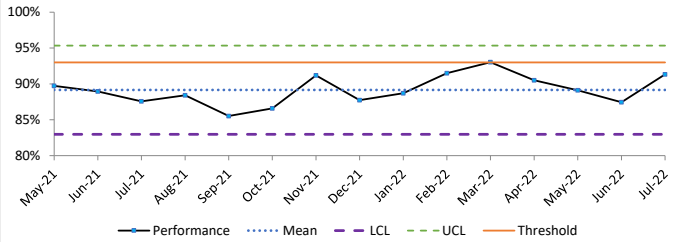
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

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

OBJECTIVE 3 - CLINICAL EFFECTIVENESS

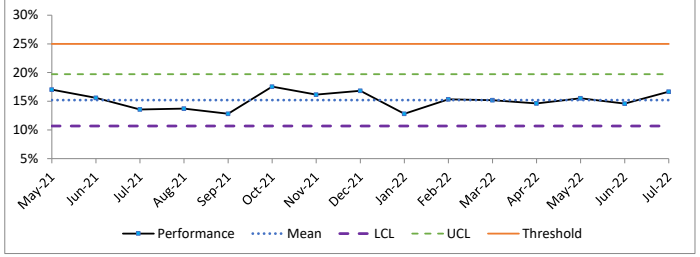
SD=3

3.1 - Overnight bed occupancy rate



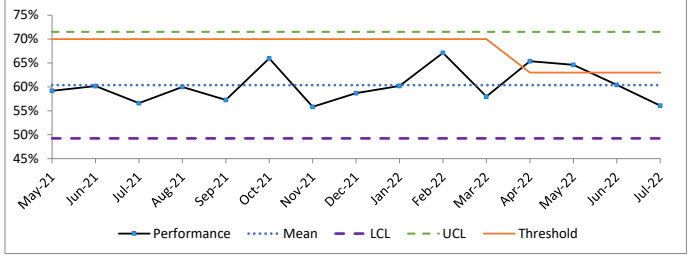
SD=3

3.2 - Ward Discharges by Midday



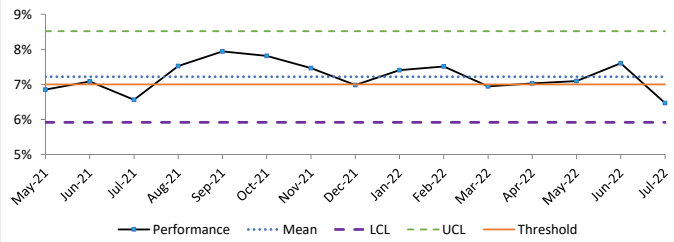
SD=3

3.3 - Weekend Discharges



SD=3

3.4 - 30 Day Readmissions



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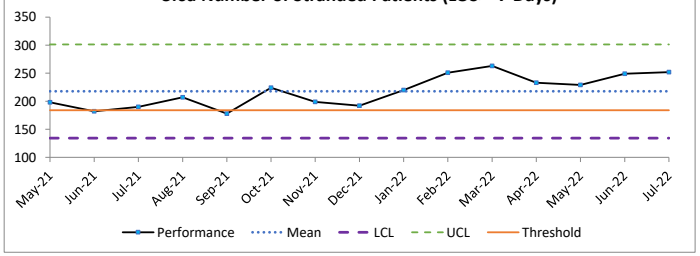
3.6a Number of Stranded Patients (LOS>=7 Days)



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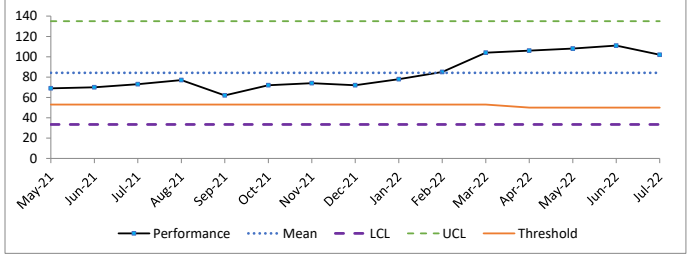
3.6b Number of Super Stranded Patients (LOS>=21 Days)



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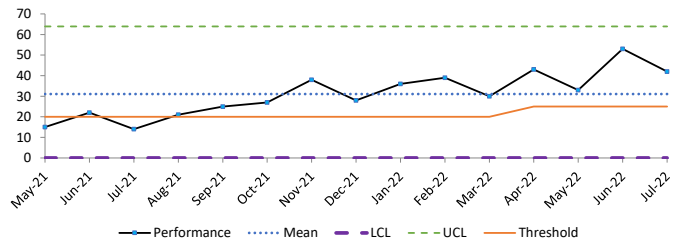
3.7 - Delayed Transfers of Care



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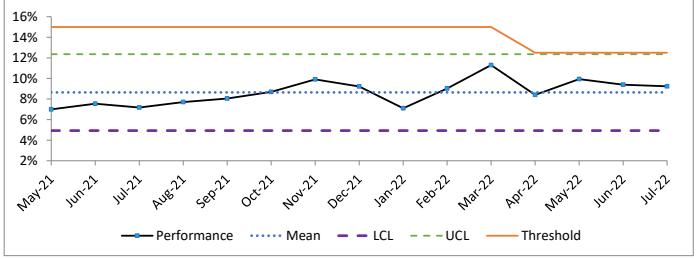
3.8 - Discharges from PDU (%)



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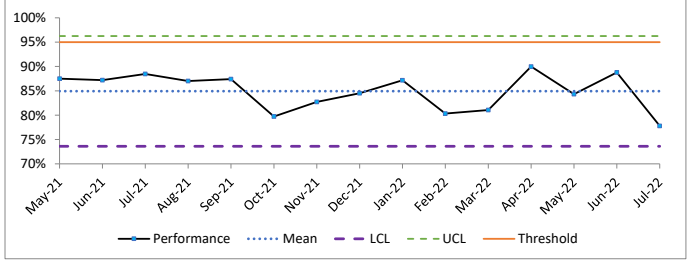
3.9a - Ambulance Handover < 30 mins(%)



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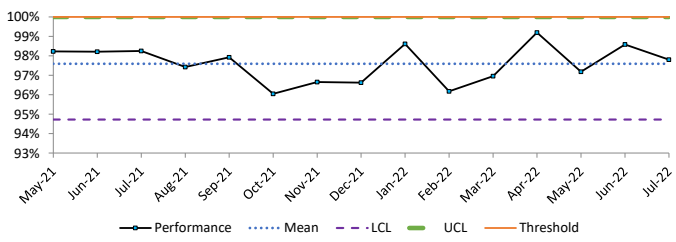
3.9b - Ambulance Handover < 60 mins(%)



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- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
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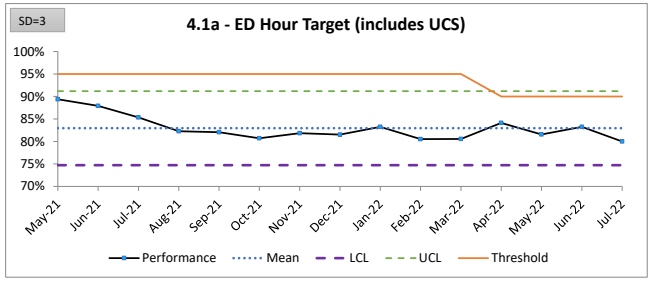
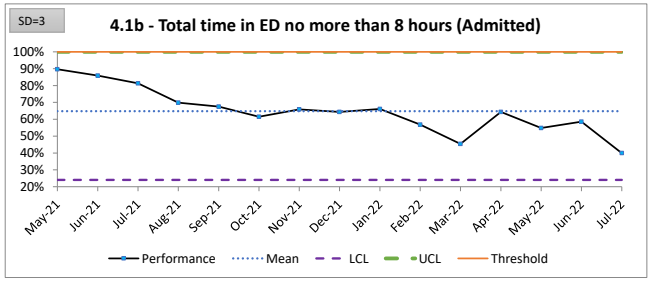
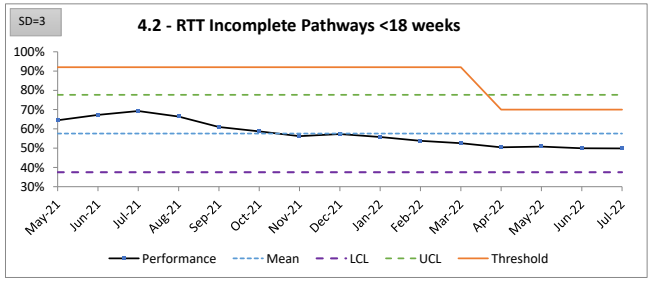
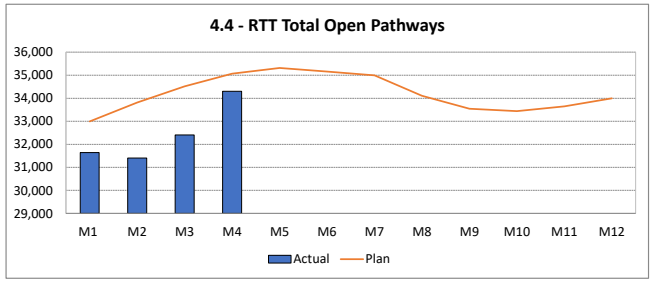
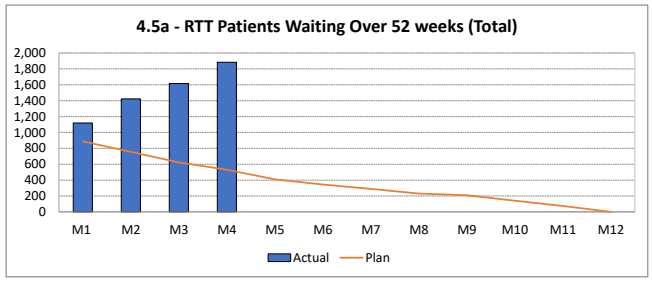
OBJECTIVE 4 - KEY TARGETS

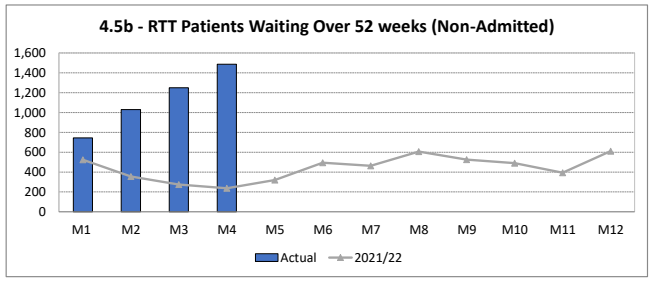


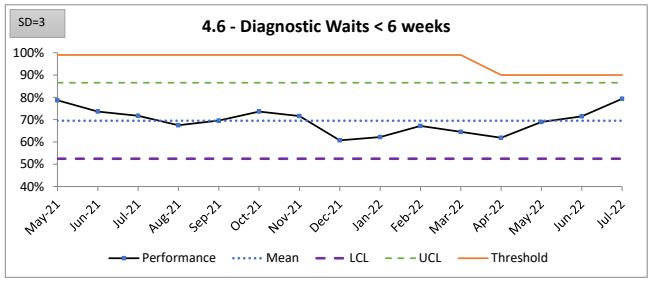


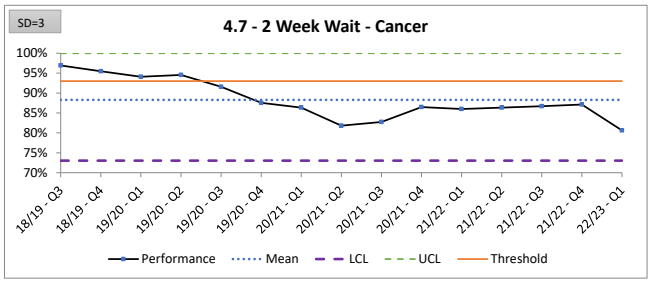


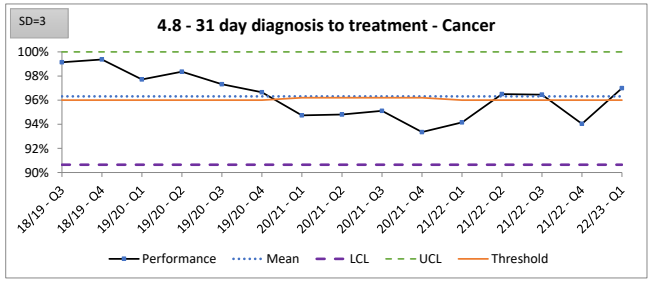


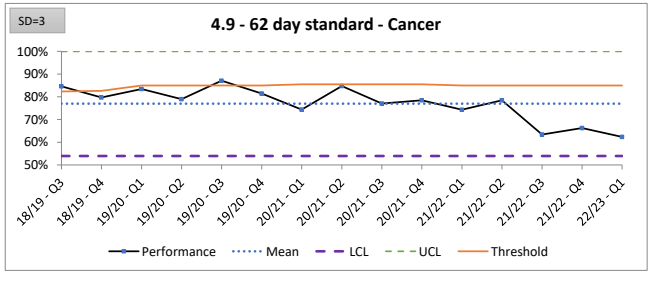












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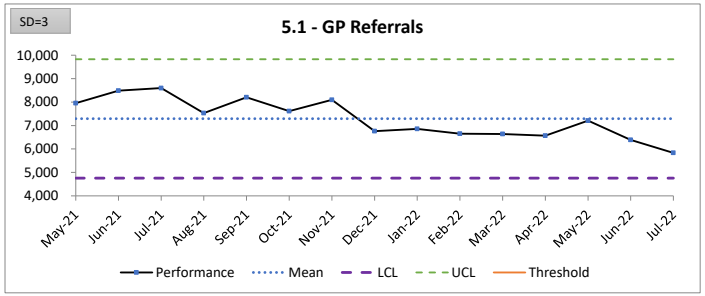
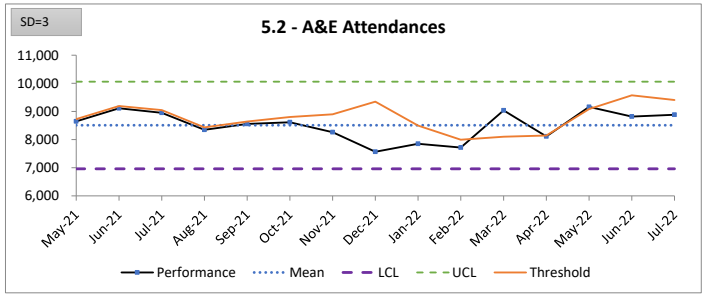
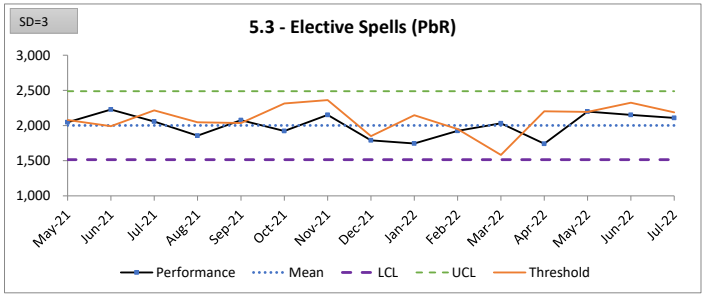
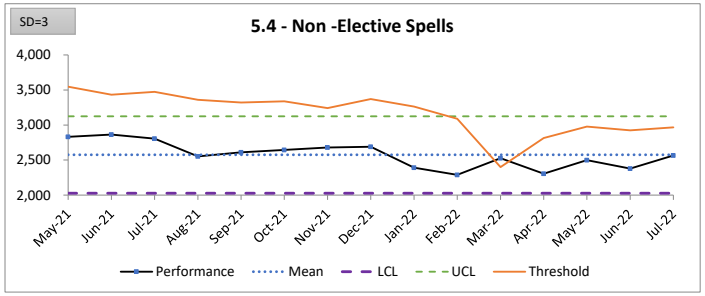
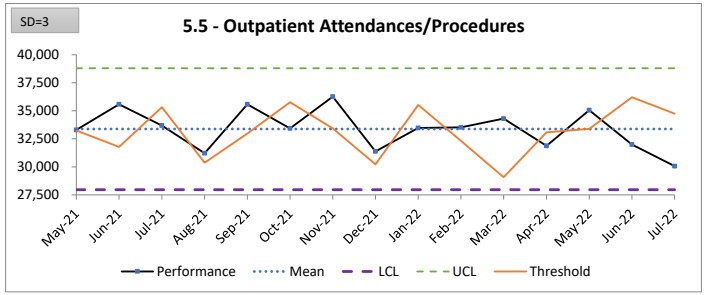
OBJECTIVE 5 - SUSTAINABILITY

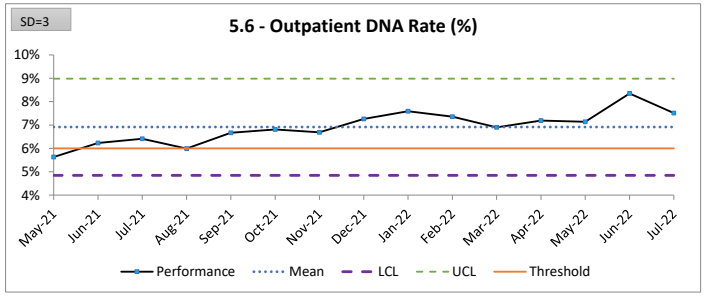












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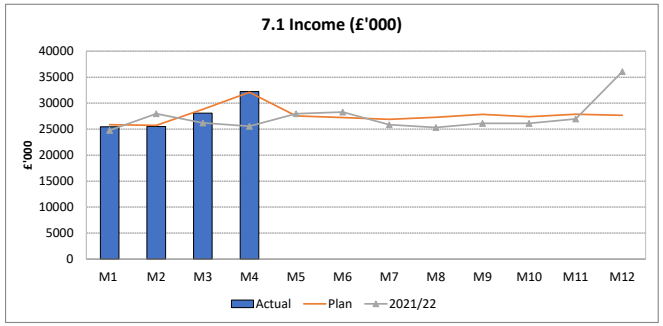
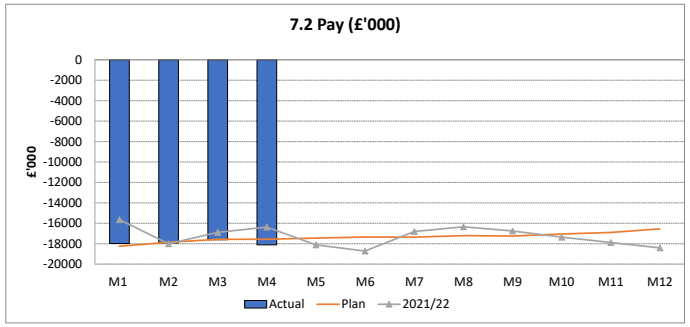
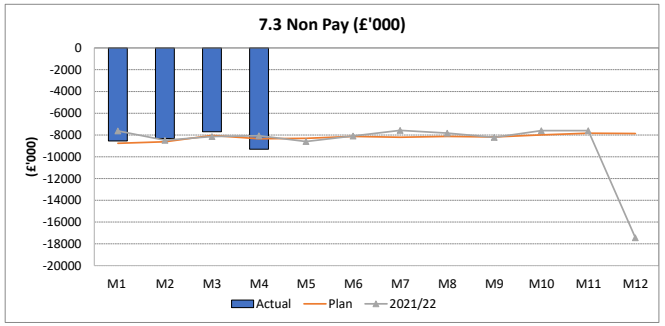
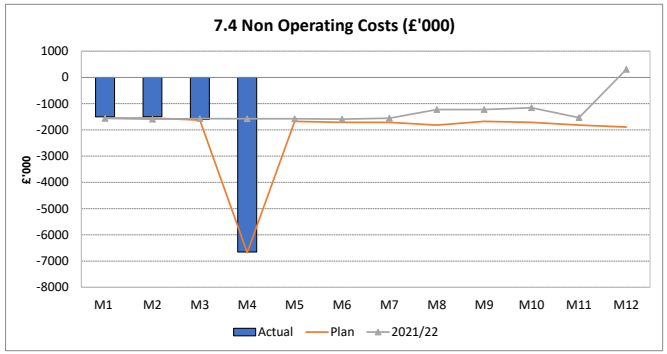
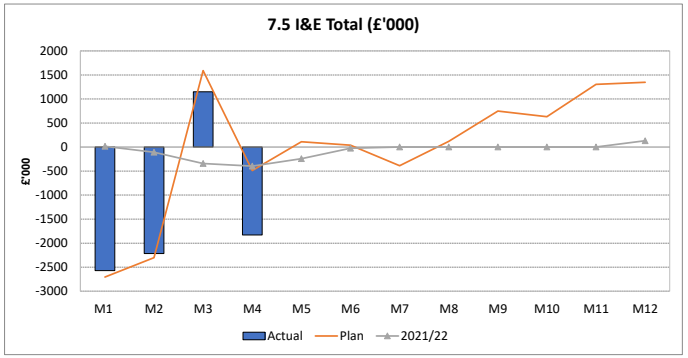
OBJECTIVE 7 - FINANCIAL PERFORMANCE

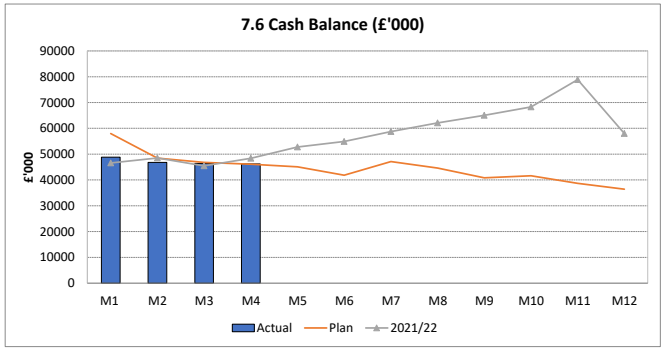


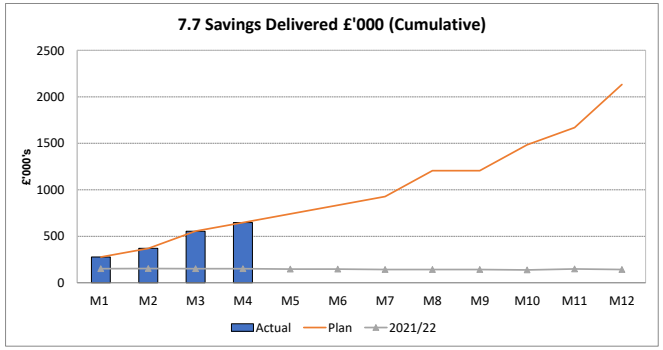


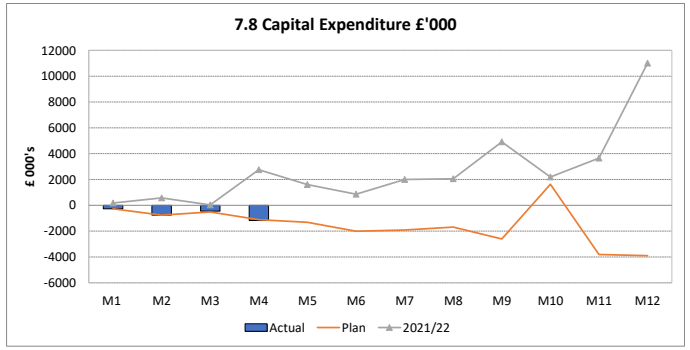




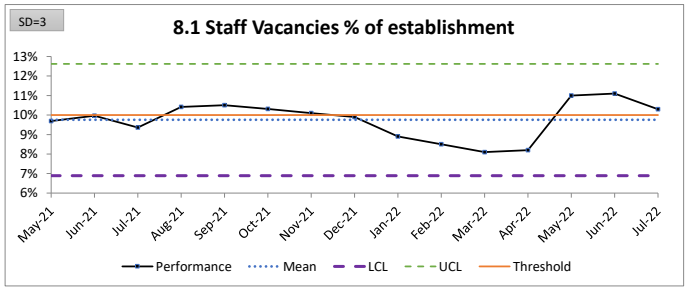


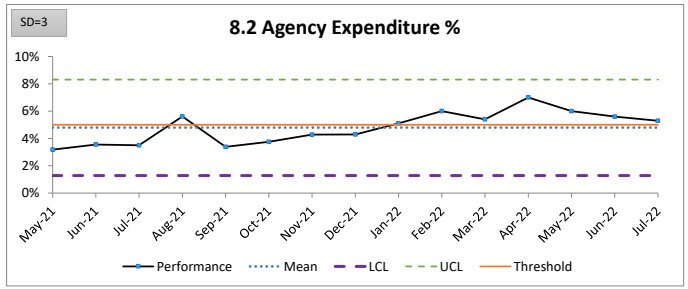


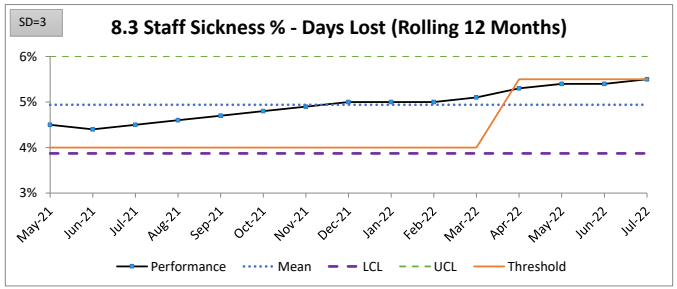


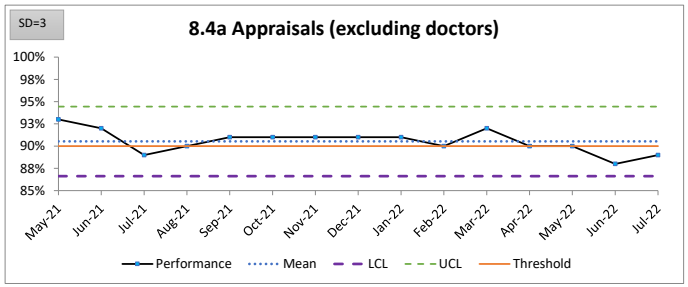


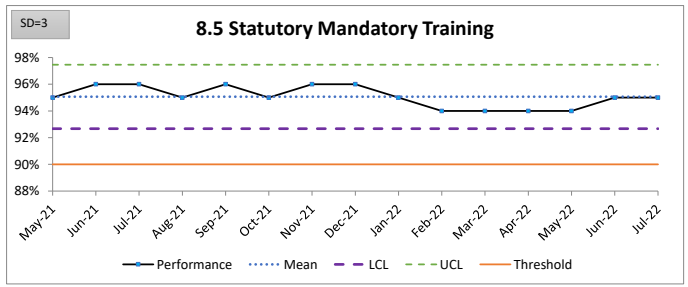
OBJECTIVE 8 - WORKFORCE PERFORMANCE

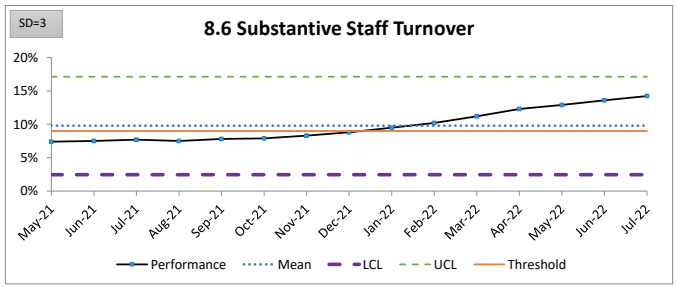












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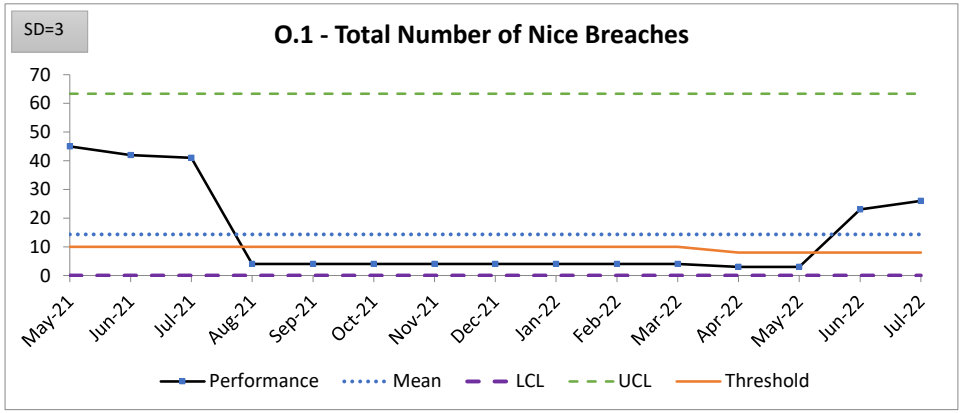

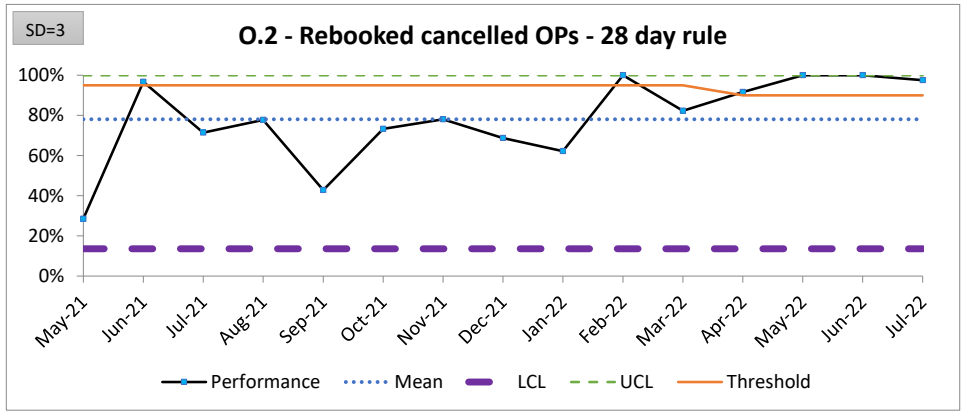

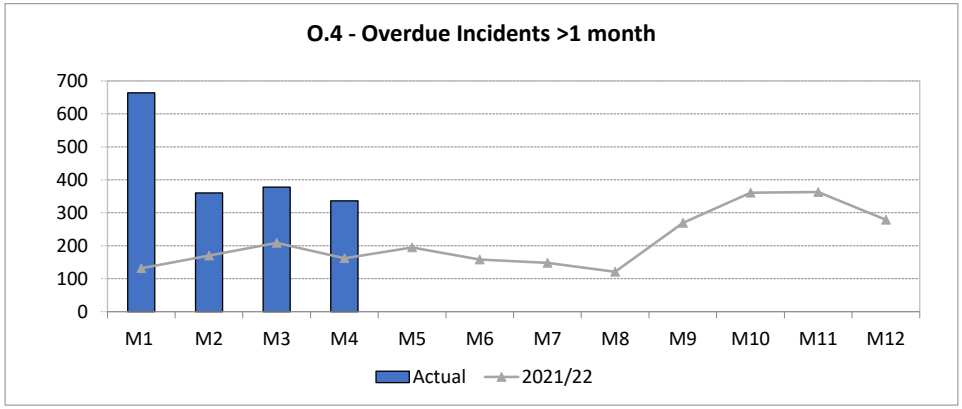

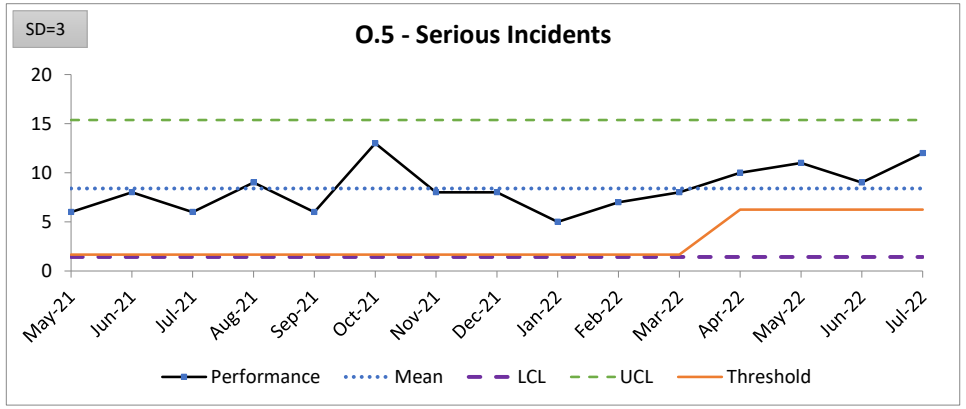

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Performance activity on a rolling 15 months/quarterly
Average on a rolling 15 months/quarterly
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NHS
Milton Keynes University Hospital
NHS Foundation Trust

Meeting title	**Public Board**	**Date: 08 September 2022**
Report title:	**Finance Paper Month 4 2022-23**	**Agenda item: 15**
Lead director **Report authors**	Terry Whittle Sue Fox Cheryl Williams	Director of Finance Deputy Head of Financial Management Financial Controller
FoI status:	Private document	

Report summary	An update on the financial position of the Trust at Month 4 (July 2022).			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** x	**Decision** ☐
Recommendation	Trust Board is asked to note the financial position of the Trust as of 31st July 2022 and the proposed actions and risks therein.			
Strategic objectives links	5. Developing a Sustainable Future 7. Become Well-Governed and Financially Viable 8. Improve Workforce Effectiveness			
Board Assurance Framework links				
CQC outcome/ regulation links	Outcome 26: Financial position			
Identified risks and risk management actions	See Appendix			
Resource implications	See paper for details			
Legal implications including equality and diversity assessment	This paper has been assessed to ensure it meets the general equality duty as laid down by the Equality Act 2010			

Report history	None
Next steps	
Appendices	Pages 12-14

FINANCE REPORT FOR THE MONTH TO 31st JULY 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 (see below (8)). Non-clinical revenue is slightly above plan due to income received for Covid testing and overseas recruitment.

(3. & 4.) Operating expenses – Pay costs are worse than plan caused by higher than expected temporary staffing costs. Non-pay is also worse than plan due to increased costs for drugs and clinical supplies and services relating to non-elective activity.

(5.) Non-operating expenditure – non-operating expenditure is underspent due to interest received.

(8.) Elective Recovery Fund– Lower ERF has been recorded in equating to approximately £1.8m as activity is lower than plan. The Trust has only recognised income equivalent to the ERF floor.

(9.) Covid expenditure – lower costs mainly relating to lower backfill costs covering staff shortages relating to Covid sickness absence.

(11.) Financial Efficiency– The Trust has achieved savings required up to month 4. The Trust has a shortfall in identified and approved schemes compared to the full year savings required and is working to mitigate the gap (via additional savings/ERF/cost control).

(12.) Cash – The Trust cash balance is £46.2m, equivalent to 52 days cash to cover operating expenses. Balances include £23.5m for capital schemes.

(13.) Capital – The Trust is in line with the revised plan. The Trust is forecasting to be within its approved CDEL allocation.

(14.) ICS Financial Position – BLMK ICS is overall adverse to plan by £1.4m due to lower ERF reported by providers up to M4.

Measures

Ref	All Figures in £'000	Month 4 YTD Plan	Month 4 YTD Actual	Month 4 YTD Var	Full Year Plan	Full Year Forecast	Full Year Var	RAG
1	Clinical Revenue	100,910	99,358	(1,551)	307,824	307,824	-	
2	Other Revenue	11,592	11,912	321	24,340	24,340	-	
3	Pay	(71,230)	(71,611)	(382)	(208,343)	(208,343)	-	
4	Non Pay	(33,748)	(33,873)	(124)	(98,408)	(98,408)	-	
5	Financing & Non-Ops	(6,566)	(6,445)	121	(20,804)	(20,804)	-	
6	Surplus/(Deficit)	957	(659)	(1,616)	4,609	4,609	-	
7	Control Total Surplus/(Deficit)	(3,883)	(5,469)	(1,586)	-	-	-	

Memos

8	ERF Delivery	2,460	615	(1,845)	7,381	7,381	-	
9	COVID expenditure	(3,541)	(2,131)	1,410	(5,776)	(5,776)	-	
10	High Cost Drugs	(7,080)	(6,952)	128	(21,197)	(21,197)	-	
11	Financial Efficiency	1,850	1,850	-	12,049	12,049	-	
12	Cash	46,076	46,224	148	36,417	36,417	-	
13	Capital Plan	(2,667)	(2,667)	-	(18,288)	(18,288)	-	
14	ICS Financial Position	(3,896)	(5,388)	(1,492)	-	-	-	

Key message

The Trust is reporting a £5.4m deficit for the period to July which is £1.6m worse than plan. This variance is due to lower than budgeted clinical income relating to elective recovery activity (£1.8m), partially offset by increased non-clinical income. Inflationary cost pressures were less than planned to month 4. Exposure to further inflationary price rises this year remains high.

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

FINANCIAL PERFORMANCE- OVERVIEW MONTH 4

2. **Summary Month 4**

For the month of July 2022, financial performance (on a Control Total basis) is a £1.8m deficit, this is £1.3m worse than plan.

All Figures in £'000	Month 4 Plan	Month 4 Actual	Month 4 Var	Month 4 YTD Plan	Month 4 YTD Actual	Month 4 YTD Var	Plan Plan	Plan Forecast	Plan Var
Clinical Revenue	25,428	25,525	97	100,910	99,358	(1,551)	307,824	307,824	0
Other Revenue	1,650	1,708	59	6,572	6,902	331	19,169	19,169	0
Total Income	27,077	27,233	156	107,481	106,260	(1,221)	326,993	326,993	0
Pay	(17,551)	(18,106)	(555)	(71,230)	(71,611)	(382)	(208,343)	(208,343)	0
Non Pay	(8,350)	(9,309)	(959)	(33,748)	(33,873)	(124)	(98,408)	(98,408)	0
Total Operational Expenditure	(25,901)	(27,416)	(1,514)	(104,978)	(105,484)	(506)	(306,751)	(306,751)	0
EBITDA	1,176	(182)	(1,358)	2,503	777	(1,727)	20,242	20,242	0
Financing & Non-Op. Costs	(1,667)	(1,647)	20	(6,386)	(6,245)	141	(20,242)	(20,242)	0
Control Total Deficit (excl. top ups)	**(491)**	**(1,829)**	**(1,338)**	**(3,883)**	**(5,469)**	**(1,586)**	**0**	**0**	**0**
Control Total Deficit (incl. top ups)	**(491)**	**(1,829)**	**(1,338)**	**(3,883)**	**(5,469)**	**(1,586)**	**0**	**0**	**0**
Donated income	5,010	5,010	0	5,020	5,010	(10)	5,171	5,171	0
Depreciation	(48)	(47)	1	(181)	(200)	(19)	(563)	(563)	0
Impairments & Rounding	0	0	0	1	0	(1)	1	1	0
Reported deficit/surplus	**4,471**	**3,134**	**(1,337)**	**957**	**(659)**	**(1,616)**	**4,609**	**4,609**	**0**

3. Clinical Income
Clinical income shows a favourable variance of £0.1m which is due to higher activity from commissioners outside of the block contract.

4. Other Income
Other income shows a favourable variance of £0.1m. Higher than planned income for covid testing was received which is offset by non-pay costs.

5. Pay
Pay spend is above plan with additional temporary staffing costs offset by substantive vacancies. Overseas nurses are currently supernumerary, and vacancies are being backfilled with agency due to delays in obtaining NMC test of competency qualifications. Further detail is included in Appendices 1 and 4.

6. Non-Pay
Non pay is above plan due to an increase in expenditure on drugs and clinical supplies and services. Further detail is included in Appendices 1 and 5.

7. Non-Operating Expenditure
Non-operating expenditure is lower than plan in-month due to interest received.

Key message
For the month of July 2022, the position on a Control Total basis is a £1.8m deficit, which is worse than plan. This is due to lower elective recovery income which has stalled due to operational pressures across the hospital, principally COVID related staff absence.

FINANCIAL PERFORMANCE - OVERVIEW YTD

8. **Summary Year to Date**

Cumulative financial performance (Apr-Jul) on a Control Total basis is a deficit of £5.5m. This is worse than plan by £1.8m. Overspends on pay costs and clinical supplies are compounded by reduced clinical income.

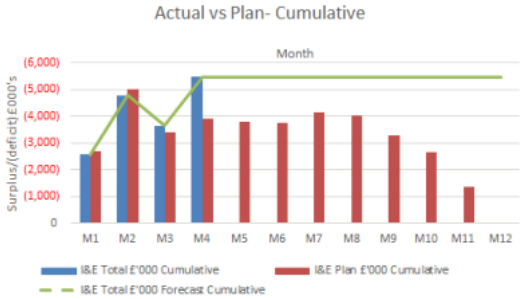
9. Clinical Income YTD
Clinical income shows a negative variance of £1.6m which is due to lower ERF funding. Further detail is included in Appendix 1.

10. Other Income YTD
Other income shows a favourable variance of £0.3m. A reduction in car park income is offset by an increase in covid testing income.

11. Pay YTD
Pay spend is above plan with additional temporary staffing costs only partly offset by substantive vacancies. Bank spend has increased due to enhanced rates to increase uptake in clinical areas. Further detail is included in Appendices 1 & 4.

12. Non-Pay YTD
Non pay is above plan due to expenditure on drugs relating to non-elective activity. Further detail is included in Appendices 1 & 5.

13. Non-Operating Expenditure YTD
Non-operating expenditure is lower than plan YTD due to interest received.



Key message
Up to July 2022, the position on a Control Total basis is a deficit of £5.5m. This is worse than plan. Overspends on pay and non-pay are compounded by lower clinical income.

ACTIVITY PERFORMANCE & ERF

14. The Trust has recognised 25% of the expected ERF income available for the month on the basis that this is the minimum "floor" as 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 Q1 due to operational pressures that hindered achievement of planned levels of elective activity.

15. Activity vs Plan (as per CIVICA)

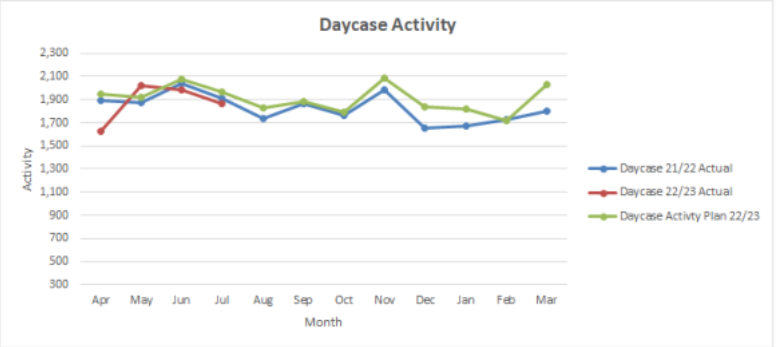
Day case activity-
Day cases have decreased since Month 3 and are marginally down against the 22/23 plan and 21/22 actuals, though month-on-month movement is in line with the previous year and current year's plan.

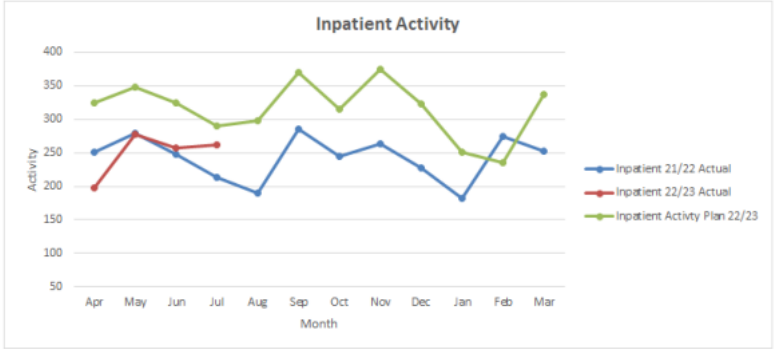
Elective Inpatient Activity-
Inpatient activity has increased since Month 3 and is down against the 22/23 plan but up on 21/22 actuals.

Outpatient Activity-
Outpatient activity has decreased since Month 3 and is down against the 22/23 plan but marginally up against 21/22 actuals.

Non-Elective Spells-
Non elective activity has increased since Month 3 and continues to be down against the 22/23 plan and 21/22 actuals.

A&E activity-
A&E activity has slightly decreased since Month 3 and is now only marginally below 21/22 activity and 22/23 plan.





Key message
Day case activity decreased in July, but inpatient elective and non-elective activity increased. 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

16. The efficiency target is £1.8m to July 2022 and the schemes that have been signed off are delivering £1.2m. The remainder of the efficiency target is being achieved through managing the incremental cost of operational pressures bringing total efficiencies to £1.8m.

17. The Trust is increasing the focus on financial efficiency through the Better Value programme. The Trust has identified circa £6m from schemes against the total plan level of £12m. Work is ongoing to review all the Q1 budgets to identify surplus funds.

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	2,470	73%	2,723	**1,838**	54%	1,995
Surgery	2,709	1,897	70%	1,862	**1,444**	53%	1,444
W&C	1,451	1,000	69%	928	**1,000**	69%	928
Core Clinical	2,716	1,670	61%	1,987	**1,102**	41%	1,177
Corporate	1,629	752	46%	784	**616**	38%	641
Central Ops	103	0	0%	0	**0**	0%	0
Latest position	**12,007**	**7,789**	**65%**	**8,283**	**6,000**	**50%**	**6,184**

Key message
YTD the Trust has delivered its £1.8m efficiency requirement. This has been achieved through transactional savings 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

18. The YTD spend on capital after accounting for donated assets and derecognised assets is £2.67m, which is in line with the Trust's revised capital plan (excluding national funding).

19. 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**

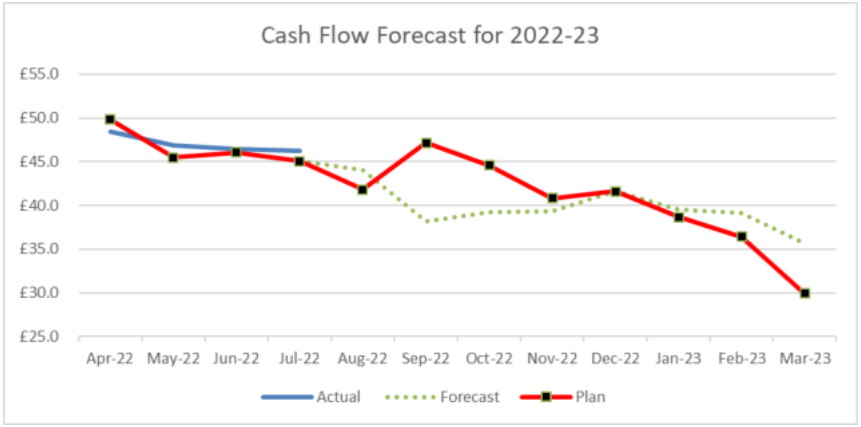
Capital Item	YTD Plan up to end of July £m	Actual up to end of July 22 £m	YTD Variance to YTD Plan £m	Status
Pre-commitments				
CBIG	0.52	0.31	- 0.20	
Strategic	1.70	2.02	0.32	
Slippage from Pre-commitments				
Total Pre-commitments	**2.21**	**2.33**	**0.12**	
Scheme Allocations For 22/23 schemes				
CBIG including IT	0.18	0.13	-0.05	
Strategic Radiotherapy	0.02	0.02	0.00	
Strategic Contingency	0.00	0.00	0.00	
Total Proposed Scheme Allocations	**0.20**	**0.15**	**- 0.05**	
Total Pre-commitments and Scheme Allocations (ICS CDEL Allocation)	**2.41**	**2.48**	**0.07**	
Nationally approved schemes				
NHP	0.24	0.19	- 0.06	
Endoscopy	0.00	0.00	0.00	
Total Nationally approved schemes	0.24	0.19	- 0.06	
CDEL Approved capital plan	**2.65**	**2.67**	**0.01**	
Donated Assets (excluded from CDEL)				
Maple Centre	0.00	0.00	0.00	
Pathlake	0.00	0.00	0.00	
Staff Rooms	0.00	0.00	0.00	
Total Donated Assets	-	**0.00**	**0.00**	
Awaiting Approval				
New Leases Impact under IFRS 16 (applied but not confirmed)	0.01	0.00	-0.01	
NHP - external fees	0.00	0.00	0.00	
Total awaiting approval	**0.01**	**0.00**	**-0.01**	
Submitted CDEL capital plan	**2.67**	**2.67**	**0.00**	

Key message
Capital expenditure is in line with the revised phasing of the plan which was submitted as part of the resubmission of the annual plan in June.

CASH

20. Summary of Cash Flow

The cash balance at the end of June was £46.2m, this was £1.1m higher than the planned figure of £45.1m. This is a decrease on last month's figure of £46.4m. (see opposite).
See appendices 6-8 for the cashflow detail.



21. 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.

22. 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 M4 YTD Number	Actual M4 YTD £'000	Actual M3 YTD Number	Actual M3 YTD £'000
Non NHS				
Total bills paid in the year	22,861	67,137	17,782	52,695
Total bills paid within target	20,343	62,031	15,602	48,757
Percentage of bills paid within target	**89.0%**	**92.4%**	**87.7%**	**92.5%**
NHS				
Total bills paid in the year	616	2,753	462	1,876
Total bills paid within target	469	1,735	358	1,257
Percentage of bills paid within target	**76.1%**	**63.0%**	**77.5%**	**67.0%**
Total				
Total bills paid in the year	**23,477**	**69,890**	**18,244**	**54,570**
Total bills paid within target	**20,812**	**63,766**	**15,960**	**50,014**
Percentage of bills paid within target	**88.6%**	**91.2%**	**87.5%**	**91.7%**

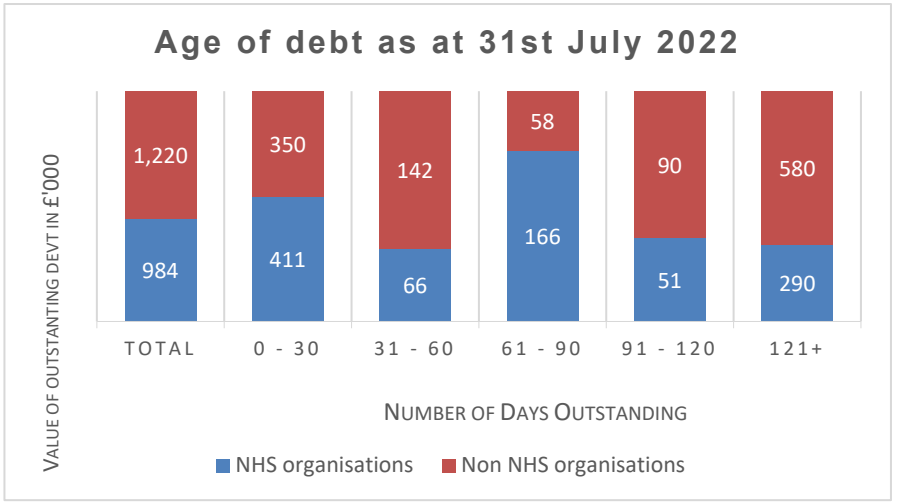
Key message
Cash is above plan by £1.1m, and the Trust has fallen below the 95% target for BPPC, mainly due to issues experience by SBS during their repatriation of AP services, and ongoing agency invoicing issues. Management is working to rectify payment performance to levels required.

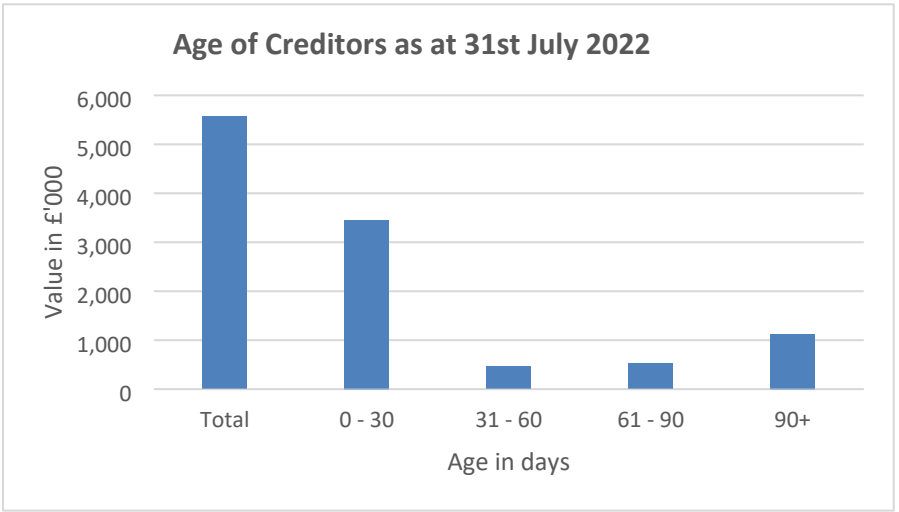
BALANCE SHEET

23. 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 £10.9m; this is driven by the inclusion of Right of Use assets related to the adoption of IFRS 16 1 April 2022 offset by in year depreciation.
- Current assets have decreased by £5.1m, this is mainly due to the decrease in cash £11.8m offset by an increase in receivables (£6.7m).
- Current liabilities have decreased by £5.3m, this is mainly due to the decrease in Trade Payables £5m and deferred income £1.5m offset by the inclusion of Right of Use assets related to the adoption of IFRS 16 1 April 2022 (£1.2m)
- Non-Current Liabilities have increased from March 22 by £11.8m, this is due to the inclusion of Right of Use assets (£11.8m) related to the adoption of IFRS 16 1 April 2022.





24. Aged debt

The debtors position as of 31st July is £2.2m, which is a decrease of £0.3m from the Jun'22 position. Of this total £0.9m is over 121 days old, the detail is shown in Appendix 10.

The three largest NHS debtors are Bedford Hospitals NHS Foundation Trust £0.04m for salary recharges, NHS England £0.2m relating to midwifery and non-contract recharges and CNWL £0.1m relating Jul'22 Non patient SLA's. 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.

25. Creditors

The creditor's position is £5.7m, which is a decrease of £1.4m from the May' 22 position. Of this £3.0m is over 30 days, with £2.7m 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

RECOMMENDATIONS TO BOARD

26. Trust Board is asked to note the financial position of the Trust as of 31st July and the proposed actions and risks therein.

APPENDICIES

Appendix 1

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

	FY23	M4 CUMULATIVE			M4			PRIOR MONTH	
	Annual Budget	Budget	Actual	Variance	Budget	Actual	Variance	M3 Actual	Change
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME									
Outpatients	48,977	16,608	15,461	(1,147)	4,181	3,809	(373)	2,564 ▲	1,244
Elective admissions	32,300	10,865	8,786	(2,079)	2,509	2,230	(279)	2,541 ▼	(310)
Emergency admissions	79,704	25,853	26,755	902	6,663	6,668	6	6,734 ▼	(66)
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	6,388	6,462	74	1,659	1,646	(13)	1,631 ▲	15
Other Admissions	2,845	1,004	623	(382)	218	186	(32)	151 ▲	35
Maternity	24,193	8,181	5,701	(2,480)	2,065	1,373	(693)	1,452 ▼	(79)
Critical Care & Neonatal	7,125	2,461	2,023	(437)	714	543	(171)	659 ▼	(117)
Imaging	6,116	2,058	1,975	(83)	526	482	(45)	482 ▼	(0)
Direct access Pathology	4,562	1,527	1,589	61	379	370	(9)	422 ▼	(52)
Non Tariff Drugs and Devices (high cost/individual drugs)	21,197	7,080	6,952	(129)	1,796	1,722	(74)	1,656 ▲	65
Other (inc. home visits and best practice tariffs)	6,138	2,057	4,131	2,074	512	222	(290)	2,621 ▼	(2,399)
CQUINS	0	0	0	0	0	0	0	0 ▲	0
Contract Risk Provision - General challenge & CIP offset	0	0	0	0	0	0	0	0 ▲	0
National Block/Top up	56,319	16,827	18,901	2,074	4,205	6,276	2,071	5,341 ▲	935
MKCCG Block adj	0	0	0	0	0	0	0	0 ▲	0
Clinical Income	**307,824**	**100,910**	**99,358**	**(1,551)**	**25,428**	**25,525**	**97**	**26,255 ▼**	**(730)**
Non-Patient Income	19,169	6,572	6,902	331	1,650	1,708	59	1,811 ▼	(102)
PSF Income	0	0	(0)	(0)	0	0	0	0 ▲	0
Donations	5,171	5,020	5,010	(10)	5,010	5,010	0	0 ▲	5,010
Non-Patient Income	**24,340**	**11,592**	**11,912**	**321**	**6,660**	**6,718**	**59**	**1,811 ▲**	**4,908**
TOTAL INCOME	**332,164**	**112,501**	**111,270**	**(1,231)**	**32,087**	**32,243**	**156**	**28,065 ▲**	**4,178**
EXPENDITURE									
Pay - Substantive	(189,757)	(63,952)	(59,646)	4,306	(15,990)	(14,981)	1,010	(14,710) ▼	(271)
Pay - Bank	(9,194)	(3,722)	(6,041)	(2,319)	(743)	(1,730)	(988)	(1,491) ▼	(239)
Pay - Locum	(3,188)	(1,011)	(1,414)	(402)	(279)	(379)	(99)	(374) ▼	(5)
Pay - Agency	(5,555)	(2,322)	(4,239)	(1,917)	(484)	(948)	(465)	(969) ▲	21
Pay - Other	(758)	(258)	(272)	(14)	(64)	(68)	(4)	(69) ▲	1
Pay CIP	41	14	0	(14)	3	0	(3)	0 ▲	0
Vacancy Factor	69	23	0	(23)	6	0	(6)	0 ▲	0
Pay	**(208,343)**	**(71,230)**	**(71,611)**	**(382)**	**(17,551)**	**(18,106)**	**(555)**	**(17,613) ▼**	**(493)**
Non Pay	(77,211)	(26,668)	(26,921)	(253)	(6,554)	(7,588)	(1,033)	(6,048) ▼	(1,540)
Non Tariff Drugs (high cost/individual drugs)	(21,197)	(7,080)	(6,952)	129	(1,796)	(1,722)	74	(1,656) ▼	(65)
Non Pay	**(98,408)**	**(33,748)**	**(33,873)**	**(124)**	**(8,350)**	**(9,309)**	**(959)**	**(7,704) ▼**	**(1,605)**
TOTAL EXPENDITURE	**(306,752)**	**(104,978)**	**(105,484)**	**(506)**	**(25,901)**	**(27,416)**	**(1,514)**	**(25,317) ▼**	**(2,098)**
EARNINGS BEFORE INTEREST, TAXATION, DEPRECIATION AND AMORTISATION (EBITDA)	**25,412**	**7,523**	**5,787**	**(1,737)**	**6,186**	**4,828**	**(1,358)**	**2,748 ▲**	**2,080**
Interest Receivable	0	0	153	153	0	46	46	41 ▲	5
Interest Payable	(338)	(113)	(126)	(13)	(28)	(32)	(4)	(44) ▲	12
Depreciation, Impairments & Profit/Loss on Asset Disposal	(14,474)	(4,462)	(4,462)	(0)	(1,186)	(1,208)	(21)	(1,097) ▼	(111)
Donated Asset Depreciation	(563)	(181)	(200)	(18)	(48)	(47)	0	(57) ▲	9
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	**10,037**	**2,767**	**1,152**	**(1,616)**	**4,924**	**3,586**	**(1,337)**	**1,591 ▲**	**1,995**
Dividends Payable	(5,429)	(1,811)	(1,810)	0	(453)	(453)	0	(502) ▲	49
OPERATING SURPLUS/(DEFICIT) AFTER DIVIDENDS	**4,608**	**957**	**(659)**	**(1,616)**	**4,471**	**3,134**	**(1,337)**	**1,090 ▲**	**2,044**

Statement of Cash Flow
As of 31st July 2022

	Audited Mth12 2021-22 £000	Mth 4 £000	Mth 3 £000	In Month Movement £000
Cash flows from operating activities				
Operating (deficit) from continuing operations	2,699	1,125	(2,447)	3,572
Operating (deficit)	**2,699**	**1,125**	**(2,447)**	**3,572**
Non-cash income and expense:				
Depreciation and amortisation	11,278	4,661	3,406	1,255
Impairments	715	0	0	0
(Gain)/Loss on disposal	(48)	0	0	-
(Increase)/Decrease in Trade and Other Receivables	9,003	(6,661)	(1,861)	(4,800)
(Increase)/Decrease in Inventories	(375)	(8)	(6)	(2)
Increase/(Decrease) in Trade and Other Payables	14,788	(4,668)	(6,631)	1,963
Increase/(Decrease) in Other Liabilities	5,945	(1,535)	(1,100)	(435)
Increase/(Decrease) in Provisions	(338)	(24)	(16)	(8)
NHS Charitable Funds	(561)	0	0	0
Other movements in operating cash flows	(1)	(3)	(3)	-
NET CASH GENERATED FROM OPERATIONS	**43,105**	**(7,113)**	**(8,658)**	**1,545**
Cash flows from investing activities				
Interest received	36	153	107	46
Purchase of intangible assets	(4,160)	(1,115)	(888)	(227)
Purchase of Property, Plant and Equipment, Intangibles	(37,974)	(3,448)	(1,939)	(1,509)
Net cash generated (used in) investing activities	**(44,598)**	**(4,410)**	**(2,720)**	**(1,690)**
Cash flows from financing activities				
Public dividend capital received	15,273	0	0	0
Capital element of finance lease rental payments	(201)	(102)	(77)	(25)
Interest element of finance lease	(267)	(126)	(94)	(32)
PDC Dividend paid	(4,663)	0	0	0
Receipt of cash donations to purchase capital assets	561	0	0	0
Cash flows from (used in) other financing activities	0	0	0	0
Net cash generated from/(used in) financing activities	**10,703**	**(228)**	**(171)**	**(57)**
Increase/(decrease) in cash and cash equivalents	**9,210**	**(11,751)**	**(11,549)**	(202)
Opening Cash and Cash equivalents	**48,765**	**57,975**	**57,975**	
Closing Cash and Cash equivalents	**57,975**	**46,224**	**46,426**	**(202)**

Appendix 3

Statement of Financial Position as of 31st July 2022

	Audited Mar-22	Jul-22 YTD Actual	YTD Mvmt	% Variance
Assets Non-Current				
Tangible Assets	189.6	188.5	(1.1)	(0.6%)
Intangible Assets	22.3	21.3	(1.0)	(4.6%)
ROU Assets	0.0	13.0	13.0	100.0%
Other Assets	1.0	1.0	0.0	1.3%
Total Non Current Assets	**212.9**	**223.8**	**10.9**	**4.9%**
Assets Current				
Inventory	4.1	4.1	(0.0)	(1.0%)
NHS Receivables	3.5	3.4	(0.1)	(2.4%)
Other Receivables	7.2	14.0	6.8	104.6%
Cash	58.0	46.2	(11.8)	(25.7%)
Total Current Assets	**72.8**	**67.7**	**(5.1)**	**(8.5%)**
Liabilities Current				
Interest -bearing borrowings	(0.2)	(1.4)	(1.2)	76.8%
Deferred Income	(19.4)	(17.9)	1.5	(7.6%)
Provisions	(2.4)	(2.4)	0.0	0.0%
Trade & other Creditors (incl NHS)	(60.4)	(55.4)	5.0	(9.7%)
Total Current Liabilities	**(82.4)**	**(77.1)**	**5.3**	**(7.0%)**
Net current assets	**(9.6)**	**(9.4)**	**0.2**	**(1.1%)**
Liabilities Non-Current				
Long-term Interest bearing borrowings	(5.4)	(17.2)	(11.8)	89.2%
Deferred Income	(1.5)	(1.5)	0.0	100.0%
Provisions for liabilities and charges	(1.8)	(1.8)	0.0	0.0%
Total non-current liabilities	**(8.7)**	**(20.5)**	**(11.8)**	**78.5%**
Total Assets Employed	**194.6**	**193.9**	**(5.8)**	**(3.0%)**
Taxpayers Equity				
Public Dividend Capital (PDC)	275.1	275.1	0.0	0.0%
Revaluation Reserve	52.6	52.6	(0.0)	(0.1%)
Financial assets at FV through OCI reserve	(2.3)	(2.3)	0.0	0.0%
I&E Reserve	(130.8)	(131.5)	(0.7)	0.5%
Total Taxpayers Equity	**194.6**	**193.9**	**(5.1)**	**(2.7%)**

GLOSSARY OF TERMS

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

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Trust Board**	**Date: 08 September 2022**
Report title:	**R&D Annual Summary**	**Agenda item: 16**
Lead director **Report author** **Sponsor(s)**	**Dr Ian Reckless**	**Medical Director**
FoI status:	**Publicly disclosable**	

Report summary				
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** [x]	**Decision** ☐
Recommendation	Receive and discuss			

Strategic objectives links	Improving clinical effectiveness Developing teaching and research
Resource implications	None
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	Annual summary of R&D activity for 2021/22
Next steps	Receive and discuss
Appendices	1. R&D Annual Highlights 2021/22

Executive Summary

1. MKUH has developed its R&D offering over the last 5-10 years and consistently enrols a higher number of patients in NIHR studies than peers of a similar size. This metric is key in growing / maintaining annual revenue funding via the LCRN.

2. The R&D 5-year strategy was reviewed at Board earlier in the year.

3. Inevitably, the pandemic in 2020/21 saw a very major impact on the R&D agenda with the delivery of 'routine studies' increasingly challenging, whilst a number of COVID-specific studies were conducted at pace. MKUH participated fully in the RECOVERY trial (and others) which led to the establishment of a firm evidence base for COVID treatments. 2021/22 has seen something of a 'bounce back' in terms of routine studies.

4. Quality and Clinical Risk Committee leads for the Trust on the R&D agenda and in previous years has supported the use of an infographic template by R&D for use in its annual reporting. The aim of this is to minimise the reporting burden whilst maximising the report's impact with a wide range of audiences / stakeholders. It has been well received.

5. Specific developments to highlight in 2021/22 include the development of the research agenda in surgical specialties at MKUH – both 'own label' studies, and relevant NIHR portfolio studies.

6. Although not mentioned in the 2021/22 annual summary, changes have been proposed to the way in which NIHR's Clinical Research Network (CRN) is structured. The changes are particularly disruptive to the extant Thames Valley footprint and we will keep a close eye on the situation as it develops in order to minimise any adverse impact on clinical research activity / engagement.

TheMKWay
CARE. COMMUNICATE.
COLLABORATE. CONTRIBUTE.

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Research & Development

Annual Highlights 2021 - 2022

Welcome

We are delighted to present the 2021-2022 Annual Report on behalf of the Research and Development (R&D) Department at Milton Keynes University Hospital NHS Foundation Trust (MKUH).

Looking back over the past 12 months the major theme has been the resumption of 'normal' research whilst at the same time continuing some COVID-19 research studies (such as RECOVERY) as the pandemic continues at a lower rate. As we wrote in last year's report, we have been amongst the highest recruiting hospitals of our size to the RECOVERY trial that identified a number of interventions as having significant benefit in saving the lives of COVID-19 patients.

We are pleased to report that the atmosphere of collaboration and enthusiasm from acute physicians, intensive care consultants and other colleagues across the Trust involved in research at MKUH continues.

The R&D manager, Antoanela Colda, research nurses and other research staff have continued to work tirelessly to support the key COVID-19 studies and to successfully restart non-COVID-19 studies that had been paused during the pandemic. We have also seen new areas of research starting at MKUH.

MKUH has been one of the first hospitals in the UK to use the CMR Surgical Robot to assist surgeons in general, urological and gynaecological surgery and this has generated some media interest. Research studies to assess the impact of this new technology are due to begin at MKUH led by Mr Barrie Keeler, Consultant Surgeon.

MKUH clinicians are also leading or key collaborators in other areas of research into new technology such as the research by Professor Oliver Pearce into the use of drones to deliver samples from hospital to laboratory and in the use of medical devices to monitor cardiac (Professor Attila Kardos) and orthopaedic patients (Professor Oliver Pearce).

Overall, MKUH continues to maintain a high level of recruitment of participants to COVID-19 and other research studies with a total recruitment in 2021 of 4,576 participants which is at the upper end of the NIHR Research Activity League Table for Small Acute Trusts.

The regular meetings (mainly by MS Teams) of the regional university networking group to develop collaborative research and training under the direction of Professor Oliver Pearce continues. Antoanela Colda, R&D Manager has continued to lead, develop and motivate the R&D Team. The new Cancer Centre is now fully operational and is a great opportunity for us to expand our cancer research activities.

We remain very grateful for the support that we receive from the Thames Valley and South Midlands NIHR Clinical Research Network who fund a significant part of our research team. We further thank the Trust and other hospital departments who have been very supportive of R&D activities.

The R&D team has once more worked tirelessly to support clinicians and ensure that studies were done to the highest standards of good clinical practice. Our R&D patient partners have provided important advice from a participant's perspective into R&D activity at MKUH.

As we have done in previous years we are presenting our activities as an infographic and hope you find it easy to read. If you need more information on any of our studies or about research at MKUH, please don't hesitate to get in touch.

Professor Simon Bowman
R&D Director

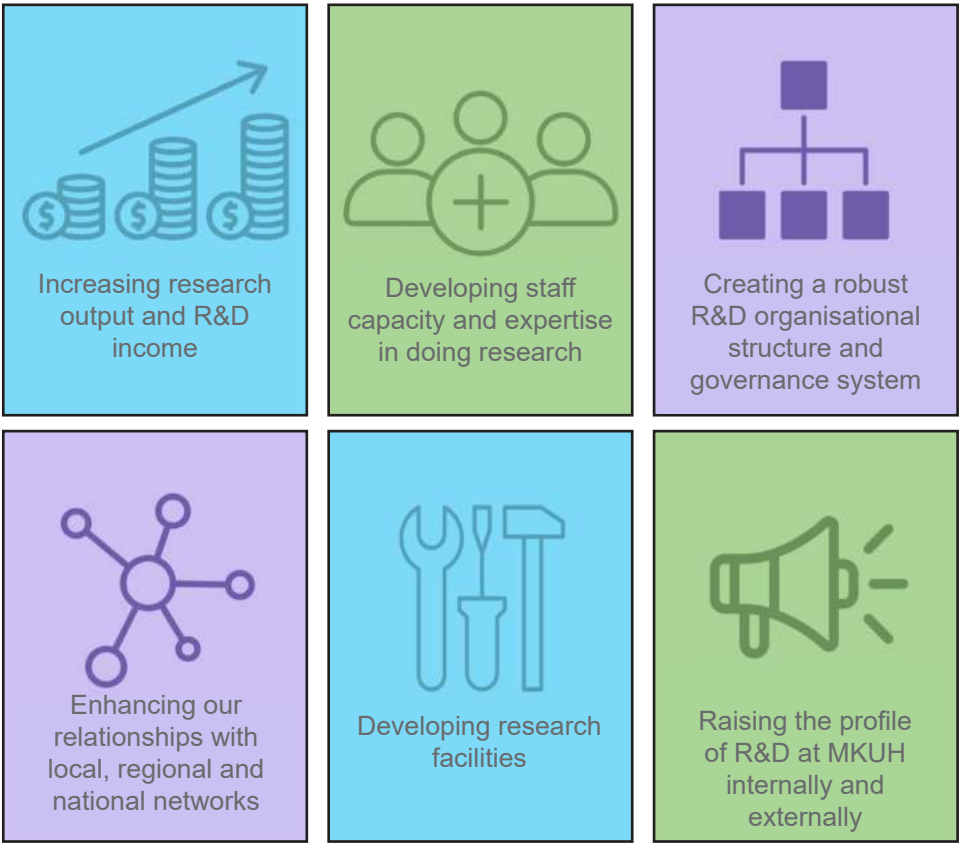
Dr Ian Reckless
Medical Director

Research and Development Strategic Aims

April 2021-March 2026

Research and Development is one of the three key aims that make up Milton Keynes University Hospital Strategy.

In order to achieve our ambitious plans over these five years, R&D Team have six strategic themes. Our strategic aims for R&D are:

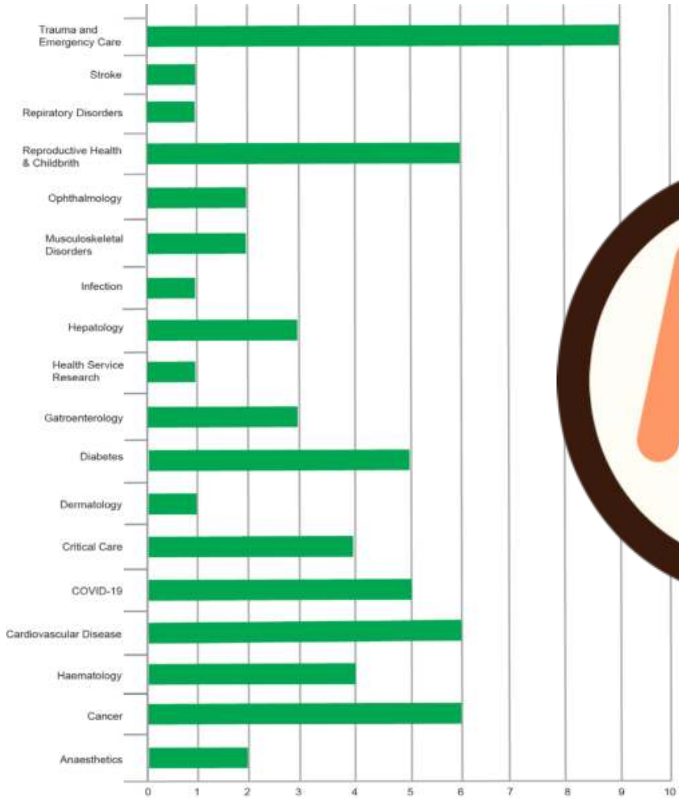


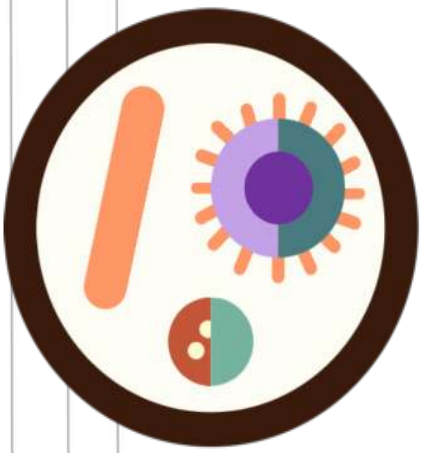
Highlights 2021/2022

At Milton Keynes University Hospital (MKUH) we are committed to delivering high quality care and giving patients equal access to clinical trials, providing them with the latest medical treatments/devices or offering an alternative/additional choice of treatment through research.

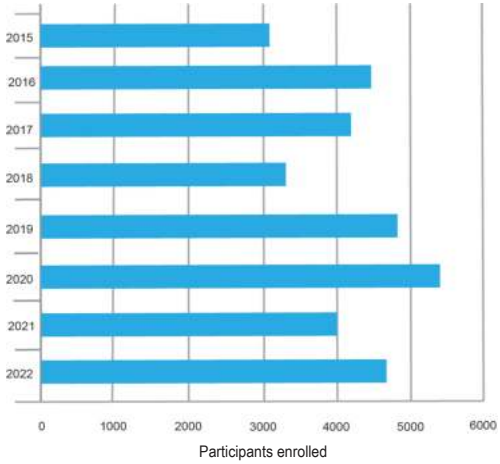
Performance:

Clinical speciality recruitment areas

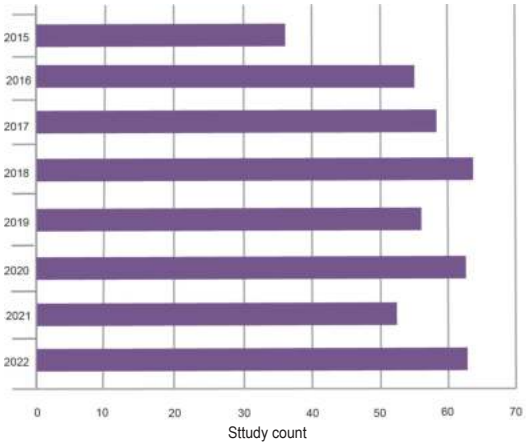




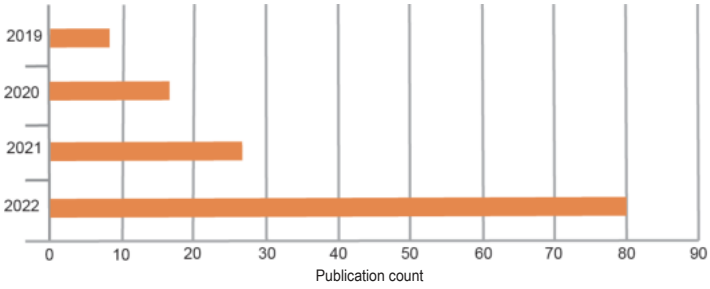
Total recruitment per financial year



Number of successfully recruiting studies per financial year



Number of publications per financial year



Studies

MKUH are hosting, participating and supporting trials in a range of specialities. These include commercial, non-commercial and sponsored studies helping to increase research activity, increasing and improving opportunities for participation.

Speciality areas include:

Awards and Achievements

We were delighted to congratulate our R&D staff receiving awards at the Thames Valley and South Midlands NIHR Clinical Research Network (CRN) Awards in 2021 for their outstanding contributions to research delivery.

This was hosted by Professor Joe Harrison and Professor Belinda Lennox:

- **All-round High Performing Team** (Highly commended): MKUH research team
- **Outstanding Research Staff Champion** (Highly commended): Edel Clare
- **Research Nurse of the Year** (Highly commended): Louise Mew
- **Research Rising Star** (Winner): Amy Oakley
- **Study of the Year:** Recovery.

Patient Satisfaction

Over the past year the importance of research has been spotlighted. During this time, patients have welcomed the approaches from the research team and have been willing to trial the medications which were thought to have the potential to improve outcomes in the fiight against COIVD-19.

Being supernumerary allowed us to spend time with isolated patients during the research process, providing reassurance and meeting some of the patients' comfort needs. This, along with keeping the clinical teams informed of the new research discoveries has felt beneficial to all.

Many patients reported that they felt we were offering them a lifeline through access to additional treatments. Although we ensured that all participants understood that there may be no benefit, we felt that they had more hope and optimism..

Raising the profile of R&D

The team have continued to work hard to raise the profile of research in the Trust and wider community, supporting and engaging with:

- local media: highlighting patients and staff stories, patients and public engagement sessions, radio interviews.
- Events: virtual school careers events, international clinical trials day
- External collaborations with local, national and international universities and partners
- Trust level: COVID-19 Antibody testing, supporting the COVID-19 vaccination programme, FIT testing (over 2,500 staff members tested)

Get involved!

Want to learn more about research at MKUH?
Are you interested in getting involved?
Contact the team today:
01908 996 685 or 01908 995 137

Emergency Preparedness Resilience and Response (EPRR)
Annual Assurance Review 2022

1.0 Background

This report covers Emergency Preparedness, Resilience and Response (EPRR) annual review for 2022 and summary of Core Standards Self-Assessment for MKUH.

2.0 NHS England Core Standards 2022 Compliance

2.1 Background

First published in January 2013, the NHS England Core Standards are the minimum EPRR standards which NHS organisations and providers of NHS funded care must meet. Core standards are assured by completion of self-assessments which enable NHS England to assess the preparedness of NHS organisations across a range of assurance indicators. The full list of compliance questions and answers can be found in the embedded document held in Appendix B.

2.2 2022 Requirements

For 2022 the self-assessment process for NHSE is illustrated in table below with national letter inserted for reference (Appendix C).

Ref	Process	Responsible	Timeline
1	NHS Trusts and providers of NHS Funded Care, undertake a self-assessment against the 2022 NHS England EPRR Core Standards relevant to their own organisation.	Trusts and Providers of NHS Funded Care	29th July - 9th September 2022
2	ICB EPRR Leads and NHS England - EoE EPRR Team to meet via M/S Teams to discuss and review the individual ICB's process, timelines and approach.	NHS England - EoE EPRR Team	W/C 8th August 2022*
3	NHS England - EoE confirm and challenge sessions with ICBs (to include the ICB and wider system provider assurance).	NHS England - EoE EPRR Team	17th - 25th October 2022*

4	ICBs to submit an EPRR System assurance summary to the NHS England - EoE EPRR Team by email**	ICB AEO and EPRR Leads	4th November 2022
5	LHRP Executive Group to have reviewed, scrutinised and endorsed compliance levels for each NHS funded organisation.	LHRP Chairs/Co-Chairs	By 30th November 2022
6	Regional Assurance summary to be submitted to the NHS England - EoE Regional Executive Team.	NHS England - EoE EPRR Team	By 8th December 2022
7	Regional Assurance summary to be submitted to the National NHS England EPRR Team.	NHS England - EoE EPRR Team	By 30th December 2022

***Exact timings to be agreed between NHS England - EoE and the ICB EPRR Leads**.
****Where CCGs have merged into one ICB, NHS England are only expecting to receive one core standards return for each ICB rather than individual returns from ICSs.***

2.3 Deep Dive Requirements

Each year the Core Standards review specific areas of EPRR through a 'Deep Dive' process where evidence is required and presented as part of the Core Standard return. This process **does not** contribute to the overall score, with 2022 'Deep Dive' theme covering 'Evacuation and Shelter' arrangements.

3.0 MKUH Assurance Rating

NHE England national letter outlines assurance rating for Core Standards as follows:

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

MKUH has RAG rated its 2022 EPRR Core Standards Self-Assessment and this is shown in tabular form below:

RAG Rating	EPRR Core Standards	Deep Dive 'Evac'	Total
Non-compliant	0	0	0
Partially compliant	2	1	4
Fully compliant	62	12	74
			78

The Self-Assessment shows 97% compliance with core standard questions resulting in the Trust being **Substantial Compliance Level**.

To ensure MKUH moves from 'Substantial' to 'Fully Compliant' prior to 2023 Core Standards submission an action plan has been developed, outlining the outstanding areas in Appendix A, including 'Deep Dive' summarised below.

- EPRR Assurance report to be presented to next Public Board following executive approval as evidence of compliance.

- Evacuation and Shelter Policy and arrangements to be revised following finalised NHS East of England 'Reinforced Autoclave Aerated Concrete' evacuation plan and SMART evacuation tool being received in October. This links to the Deep Dive area of improvement.

4.0 EPRR Work Plan 2022

The following outlines this year's work developed under EPRR programme to ensure statutory obligations set under Civil Contingencies Act 2004, EPRR Framework and other national guidance are met.

4.1 Revised EPRR Plans for 2022

- **MKUH Lockdown Policy** – EPO has supported Local Security Management Specialist (LSMS) to review lockdown process following recent incident and follow up exercise in January 2022.

- **All EPRR related policies and Incident Response plan** have been updated following new publications of EPRR framework 2022 and supporting guidance approved at Emergency Planning Steering Committee chaired by AEO.

- **Business Continuity Plans** annual review of all divisions and services with expectation to finalise all plans before end of 2022. EPO has further

supported IT and Estates on numerous of projects requiring contingency arrangements for the hospital site.

All new plans will form part of the EPRR training and exercise programme to ensure staff roles outlined within are tested and embedded. All plans are accessible to all staff on the EPRR Intranet page and Trust Documentation Site with communication cascade to notify all staff of revised plans when required. Hard copies are held within all Incident Coordination Centres (ICC).

4.2 EPRR Incidents of Note

Incident	Dates	Level of Response
COVID 19	13th Dec 2021 to 19th May 2022	National Level 4 response requiring 7 day ICC operations with command and control structures in place.
Heatwave*	18th-19th July	National Level 4 heatwave alert resulting in command and control arrangements.
ED Lockdown**	December 2021	In response to anti-vaxxer risks

*Structured debriefs were held with a post incident report to be developed and agreed with executive team outlining number of recommendations

**Tabletop exercise was run to test current lockdown capabilities with post exercise report developed outlining recommendations for EPRR and security response

4.3 Training and Exercising

Below outlines the training and exercises delivered since last annual report. All records are held with EPO in accordance with national guidance on record management for EPRR.

Name of Course / Exercise	Organiser	Date	Comment / Type of Exercise
Surviving the Courtroom	EPO	13/09/2021	Executive Training
Lockdown Exercise	EPO	09/02/2022	Tabletop
Exercise TALK-TALK	NHSEI (EoE)	08/03/2022	Communication Cascade
Mass Casualty Exercise	EPO	12/04/2022	Tabletop
Paediatric Major Incident Awareness	EPO	03/05/2022	Band 6 Bleep holders
BLRF Cyber Exercise	BLRF	04/05/2022	Partner Exercise
CBRN Exercise	EPO	10/05/2022	Tabletop
Exercise Walker	NHSEI (EoE)	11/05/2022	Regional Exercise
Legal Awareness Training	EPO	25/05/2022	On Call training
Mass Casualty Exercise	EPO	14/06/2022	Tabletop
Legal Awareness Training	EPO	17/06/2022	On Call Training
ED Major Incident Training	ED EPRR lead	17/06/2022	Middle grade Doctors
CBRN Exercise	EPO	05/07/2022	Tabletop
ED MAJAX Exercise	ED EPRR lead	13/07/2022	ED Staff
Exercise Toucan	NHSEI (Nat)	21/07/2022	Communication Cascade
ED Reception MI Training	EPO	28/07/2022	Awareness Training
Fire Exercise	EPO	12/08/2022	Tabletop

5.0 Next Steps

- For executive team to receive the report and to confirm they are assured of the Trusts compliance against statutory and national Core Standards for Emergency Preparedness, Resilience and Response

- For this report to be placed on public board agenda for final approval

Appendix A: MKUH Core Standards and Deep Dive Action Plan

Core Standards Ref	Question	Evidence Required	MKUH Answer	Self-Assessment	Action
EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	EPRR Report accepted at Executive Director meeting in September 2021, but not taken to public board	Partially compliant	Annual assurance Review 2022 report to be forwarded onto public board for final approval following executive director meeting
Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly	Evacuation and Shelter Policy in place, but further review required inline with RAAC regional plan and new SMART evac system to be provided in October	Partially compliant	SMART Training to be delivered and tied into Fire and evac policies with RAAC regional plan reference in revised version. Awaiting regional finalised RAAC plan

		• signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required			following exercise Walker recommendations
Deep Dive	**Question**	**Evidence Required**	**MKUH Answer**	**Self-Assessment**	**Action**
Evacuation and Shelter	The organisation has updated its evacuation and shelter arrangements since October 2021, to reflect the latest guidance.	N/A	Evacuation and Shelter Policy inline with current national guidance, but awaiting on RAAC regional plan for EoE being finalised following exercise walker finding/recommendations		Awaiting NHSE EoE finalised RAAC plans and delivery of SMART evacuation system

Appendix B: Core Standards MKUH Self-Assessment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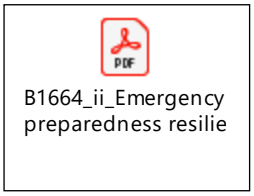
Appendix C: National Core Standards Letter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Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	Trust Board Meeting	**Date:** 31st August 2022
Report Title	Risk Report	**Agenda Item:** 18
Lead Director	**Name:** Kate Jarman	**Title:** Director of Corporate Affairs
Report Author	**Name:** Paul Ewers	**Title:** Risk Manager

Key Highlights/ Summary	*The report includes all significant risks across all Risk Registers (where the Current Risk Rating is graded as 15 or above), as of 31st August 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 31st August 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 41 significant risks identified on Risk Registers across the Trust, and of these risks, 8 are overdue their review dates. These risks have been escalated for corporate review.

- There were 2 new significant risks added since the last paper:
  RSK-366 *- IF items are left unattended causing a restriction in the width of hospital streets and main corridors*
  THEN this could cause a delay in evacuation in the event of a fire and/or a delay to the arrival of the fire responders and Fire & Rescue Service.

  RSK-374 *- IF patients on the cancer pathway wait longer than 62 days THEN there is the risk treatment has been delayed,*

- 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.

- There are 9 risks that have been identified as uncontrolled. These are therefore recorded as significant risks with no controls in place to reduce the risk. These risks will be reviewed with the relevant risk owners to identify whether there are controls in place and if not, discuss what controls need to be developed. These uncontrolled risks are listed below:
  RSK-093 *- 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.*
  RSK-202 *- 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*
  RSK-305 *- If there is insufficient strategic capital funding available THEN the Trust will be unable to invest in the site to maintain pace with the growth of the Milton Keynes population's demand for hospital services*
  RSK-015 *- IF there are ligature point areas in Ward 1 in various areas of the department THEN patients may use ligature points to self-harm*

RSK-025 *- IF there are vacancies of Band 5 and senior nursing skill mix 24/7 THEN wards could be experiencing some issues with nurse staffing levels and skill mix*

RSK-055 *- 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.*

RSK-142 *- 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*

RSK-203 *- IF there are negative impacts following, COVID-19 pandemic and rising fuel costs and the conflict in Ukraine and new legislation following Brexit THEN there is a risk that the supply of key clinical products may be disrupted*

RSK-343 *- If there is insufficient dietetic staff in post THEN the service may be unable to meet referrals demand*

3. CONCLUSION

The Trust Secretary and the Risk Manager are working to ensure that communication and reporting for risk is improved:

Communication: A monthly newsletter (Risk Guardian) is sent to all staff. Monthly emails to ward/sisters and matrons has started to be sent, showing the risks on their relevant CSU Risk Register, giving an opportunity for staff to identify any risks that have not be identified.

Reporting: New front sheets are being developed for the Board Assurance Framework and Risk Reports to give staff an overview of the key metrics associated with ensuring risks are being managed effectively. The full Risk Register documentations will be available as an appendix where a deeper dive into the risks are required. The aim is to both provide assurance and to have a more consistent approach to reporting on risk.

4. RECOMMENDATION

The Group is asked to review and discuss this paper.

5. APPENDICES

Appendix 1 - Significant Risk Register as of 31st August 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

Reference	Created on	Owner	Description	Impact of risk	Scope	Region	Last review	Next review	Status	Original score	Current score	Target	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	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	Organisation		10-Aug-2022	02-Oct-2022	Planned	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.	Low	Treat	10/08/2022 - reviewed by Paediatric Quadrumvirate no change
RSK-362	15-Jul-2022	Mary Plummer	IF hysteroscopy do not have enough scopes THEN they will have to cancel clinics	LEADING TO further breaches in 2 week wait and non urgent referrals, an increase in complaints and a possible reputational risk	Region	Women's Health	08-Aug-2022	13-Sep-2022	Planned	25	25	2	Purchase new scopes (27-Jul-2022)	6 scopes out of 17 are out for repair which can take up to 12 weeks.(15-Jul-2022),Review the option to loan scopes until new/repair scopes arrive(15-Jul-2022)	Low	Treat	No change to risk
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	Region	Emergency Department	09-Aug-2022	29-Sep-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	RIsk reviewed at ED CSU meeting. Ongoing work taking place with Marion Fowler. Review risk again by end of September 2022
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	LEADING TO: 1. increased length of stay due to TTO delay 2. increase in prescribing errors not corrected 3. increase in dispensing errors	Organisation		05-Aug-2022	29-Sep-2022	Planned	20	20	6	Actively recruiting staff (06-Aug-2022)	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),Prioritisation of wards(28-Jun-2022)	Low	Treat	Business Case has been submitted, due for review Q1 2022/23
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	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	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-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. In particular the provision of OT services.	Increased demand on occupational therapy and physiotherapy staff. Patients are likely to decondition if the demand is too high for the therapy staff to	Organisation		09-Aug-2022	08-Sep-2022	Planned	16	20	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.		Low	Treat	Risk reviewed at Therapies CSU Meeting. Current Risk should be graded as 20, not 15. Current Risk Rating updated.
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	Organisation		04-Aug-2022	08-Sep-2022	Planned	20	20	6	Review of Governance Structure (05-Aug-2022),Review Model of Care (25-Jul-2022),Review Equity Tool - Safe Staffing (04-Jul-2022),Review Workforce Model and Structure (04-Jul-2022),Recruitment and Retention of staff (05-Aug-	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	Low	Treat	Risk reviewed with Divisional Triumvirate. Controls updated
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	Overdue	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	Overdue	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	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	Low	Treat	Risk escalated to Risk & Compliance Board for addition to the Corporate Risk Register. Approved 21/06/2022
RSK-361	15-Jul-2022	Melissa Davis	IF demand in hysteroscopy continues to increase Then; Capacity for two week wait will decrease, and capacity for non urgent referrals will decrease	Leading to; Increased breach of 2 and 52 week waits, further increase in complaints and a possible reputational risk	Region	Women's Health	08-Aug-2022	13-Sep-2022	Planned	15	20	3	Advert for additional nursing staff,Business for additional staff	Increase clinic appointments with; -Locum consultants -Bank nursing staff(15-Jul-2022)	Low	Treat	No change to risk
RSK-366	08-Aug-2022	Kim Rahbek	IF items are left unattended causing a restriction in the width of hospital streets and main corridors THEN this could cause a delay in evacuation in the event of a fire and/or a delay to the arrival of the fire	LEADING TO risk to all users of death or serious injury caused by fire or smoke. Damage to the Trust's reputation. Significant operational impact due to additional building and infrastructure	Region	Estates	23-Aug-2022	29-Sep-2022	Planned	20	20	5	Staff are trained to keep escape routes clear as part of induction and mandatory fire training. This is also within Fire Warden training. (24-Aug-2022),A Thursday floor walk is being instigated (Sept 2022) and any items identified will be reported to the		Low	Treat	
RSK-368	10-Aug-2022	Mary Plummer	IF there is no colposcopy Lead Nurse Then; There is a risk that: -The lead colposcopist may not be supported in the development and review of evidence based local	Leading to; Not meeting the NHS Cervical screening: programme and colposcopy management	Region	Women's Health	17-Aug-2022	13-Sep-2022	Planned	20	20	1	Recruit lead nurse	Create business case for lead nurse(10-Aug-2022)	Low	Treat	
RSK-369	10-Aug-2022	Mary Plummer	IF there is insufficient medical and nursing staffing for outpatient colposcopies clinics THEN; There will not be enough clinics to facilitate the 2 week	Leading to; The service not meeting the Cervical screening: programme and colposcopy management practices	Region	Women's Health	17-Aug-2022	13-Sep-2022	Planned	15	20	3	Recruit lead nurse for colposcopy,Advert and employ additional nursing staff,Business case for additional staffing	Use of Locum and bank medical and nursing staff(10-Aug-2022),Consultants using SPA time to support clinic session(10-Aug-2022),Additional clinics on evenings and weekends(10-Aug-2022)	Low	Treat	
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	Organisation		21-Aug-2022	31-Oct-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	Low	Treat	Risk unchanged
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	Organisation		09-Jun-2022	18-Aug-2022	Overdue	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	Jodie Bonsell	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	LEADING TO a delay to sight saving treatment – time critical treatment.	Region	Head & Neck	23-Aug-2022	02-Oct-2022	Planned	20	16	4	Planning for second injection room - lack of space and need to need funding to convert room (24-Aug-2022),Increase Use of non medical, allied health professional injectors (21-Apr-2022),Weekend WLI clinics planned to catch up as temporary	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	controls updated

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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	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	Region	Therapies	09-Aug-2022	08-Sep-2022	Planned	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	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-	Medium	Treat	Risk reviewed at Therapies CSU Meeting. No change to risk.
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	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	Region	Musculoskeletal	30-Jun-2022	28-Jul-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	Low	Treat	Risk reviewed at MSK CSU/CIG meeting on 23rd June. No change to risk
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	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	23-Aug-2022	06-Oct-2022	Planned	25	16	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	Low	Treat	Risk reviewed by triumvirate. Current risk score reduced to 16.
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	Organisation		09-Aug-2022	08-Sep-2022	Planned	16	16	12		1. Dietetic manager has been given approval to source a band 6 experienced locum paediatric dietitian to provide cover.(22-Oct-2021),2. As a back up plan,a band 5 basic grade dietitian is also being sourced from the locum agency, with	Low	Treat	Risk reviewed at Therapies CSU Meeting. No change to risk
RSK-115	29-Oct-2021	Mark Brown	IF annual and quarterly test reports for Autoclaves and Washer Disinfectors used for critical processes are not being received in a timely manner from the Estates department and there is no Authorised Person (D) to maintain the day to day operational aspects of the role	LEADING TO possible loss of ISO 13485 accreditation due to non-compliance to national standards. Inconsistent checks or lack of scheduled tests for the steam plant also increase the risk.	Organisation		14-Aug-2022	04-Sep-2022	Pending	20	16	9	A meeting took place in January with estates managers, where HSDU were seeking assurance that the service would be covered. Estates have agreed to look for a plan to mitigate the risk and to keep HSDU fully informed. HSDU have informed the AE(D), so he	Estates management informed and plans in place to receive reports on time and to standard. Independent monitoring system in place monitoring machine performance.	Low	Treat	No AP(D) in post. no day to day operational cover. Once monthly report checks carried out by AE(D). Paperwork checks no operational checks.
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	LEADING TO increase in efficiency requirement from NHS funding regime to support DHSC budget affordability.	Organisation		14-Aug-2022	11-Sep-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	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	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	07-Aug-2022	29-Sep-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-	Low	Treat	Update at POT from Project Manager - LIMS LLD plans progressing. Microbiology delay against plans anticipated. Additional funding received, S4 to review and agree funding split
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	LEADING TO the Trust potentially not delivering its financial targets leading to TO potential cash shortfall and non-delivery of its key targets	Organisation		14-Aug-2022	11-Sep-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-	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		30-Jun-2022	29-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	Low	Treat	Risk increased to likely due to significant number of vacancies and difficulty with existing resource to cover shifts.
RSK-305	06-Dec-2021	Karan Hotchkin	If there is insufficient strategic capital funding available THEN the Trust will be unable to invest in the site to maintain pace with the growth of the Milton Keynes population's demand for hospital services	LEADING To financial loss and reputational damage	Organisation		14-Aug-2022	11-Sep-2022	Planned	16	16	9		The trust has a process to target investment of available capital finance to manage risk and safety across the hospital(06-Dec-2021)	Medium	Treat	Risk was approved by Finance and Investment committee on 30/12/2021
RSK-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	Organisation		28-Aug-2022	29-Sep-2022	Planned	15	15	10		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-	Low	Treat	Risks remains the same as no changes made
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	Region	Internal Medicine	03-Jul-2022	31-Aug-2022	Pending	15	15	4		On-going recruitment drive(11-Oct-2021)	Low	Treat	63 International nurses employed awaiting OSCE and then will fill our vacancies
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	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	Region	Anaesthetics & Theatres	20-Jul-2022	31-Dec-2022	Planned	12	15	6		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.	Medium	Treat	Risk reviewed at Anaesthetics & Theatres CIG - risk remains
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	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.	Region	Musculoskeletal	31-Jul-2022	28-Aug-2022	Overdue	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	Low	Treat	No change
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	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	11-Jul-2022	30-Jul-2023	Planned	15	15	6	Hospital new build to include Maternity theatres,Escalation policy available for staff to use in situations where a 2nd theatre is needed by can not be opened		Low	Treat	This risk will not change until the new build is complete. Next review in 07/2023
RSK-111	26-Oct-2021	Melissa Davis	IF there is a national shortage of midwives THEN there may be insufficient midwives to provide for the needs of MKUH patients	LEADING TO a local negative impact on delivering excellent patient care, patient experience and staff experience.	Region	Women's Health	08-Aug-2022	13-Sep-2022	Planned	16	15	6	The early recognition by GOLD and the Chief Executive to advertise for new midwives following the Ockenden report.,Also working with NMC to achieve PIN numbers early for newly qualified staff.,Enhanced bank rates.,Rolling job advert for	There are significant efforts to recruit new midwives.(26-Oct-2021)	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	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	Organisation		09-Aug-2022	08-Sep-2022	Planned	15	15	3		Existing staff are working some additional hours but this remains insufficient to meet the needs of the service(04-Nov-2021)	Low	Treat	Risk reviewed at Therapies CSU Meeting. No change to risk
RSK-203	23-Nov-2021	Lisa Johnston	IF the are negative impacts following , COVID-19 pandemic and rising fuel costs and the conflict in Ukraine and new legislation following Brexit THEN there is a risk that the supply of key clinical	LEADING TO some unavailabilty of clinical products, delays to deliveries and services may be disrupted or reduce resulting in impact on patient care	Organisation		14-Aug-2022	11-Sep-2022	Planned	16	15	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	Medium	Tolerate	Risk transferred from Datix
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	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	Overdue	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.
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	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:	Region	Estates	26-Jun-2022	30-Dec-2022	Planned	15	15	3	The MEL dept relocation is on the draft capital plan under estates (30-Jun-2022)	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-	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	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	08-Aug-2022	13-Sep-2022	Planned	15	15	6	Review trust level training for radar	Reminders are send to staff of incidents that are identified as part of review(12-Apr-2022)	High	Treat	No change to risk
RSK-324	09-Feb-2022	Helder Prata	IF there are significant nursing vacancies within the Paediatric Unit, including Maternity Leave and Long-Term Sickness - we are currently 38% of permanent staff roles unfilled- this is being partially mitigated with use of regular Agency and Bank staff	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	Region	Paediatric Services	07-Jul-2022	06-Oct-2022	Planned	15	15	9	We are using regular Paediatric Agency and Bank staff to fill gaps wherever possible, we are planning a minimum of 50% of permanent staff on each shift. We are constantly advertising and interviewing for replacement staff- we are steadily recruiting.		Low	Treat	Risk reviewed no change
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	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	Region	Therapies	11-Jul-2022	08-Aug-2022	Overdue	15	15	9	Approval for two bank staff until 1.7.22 (08-Aug-2022)		Medium	Treat	Admin team are continuing to experience staffing gaps with limited ways to mitigate this as their is limited access to bank. Currently the team have the Admin Manager and two Band 3
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	Region	Therapies	28-Jun-2022	30-Aug-2022	Overdue	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	Low	Treat	B5 post appointed to. Further B5 & B6 mat leave cover being re-advertised
RSK-374	23-Aug-2022	Sally Burnie	IF patients on the cancer pathway wait longer than 62 days THEN there is the risk treatment has been delayed,	LEADING TO potential harm a risk of potential harm physical or psychological or both	Region	Haematology & Oncology	24-Aug-2022	31-Oct-2022	Pending	12	15	9	weekly restore and recovery clinical meetings and weekly operational meetings		Medium	Treat	

Meeting Title	**Trust Board of Directors**	**Date: 08 September 2022**
Report Title	**Board Assurance Framework**	**Agenda Item: 19**
Lead Director	**Name: Kate Jarman**	**Title: Director of Corporate Affairs and Communication**
Report Author	**Name: Kwame Mensa-Bonsu**	**Title: Trust Secretary**

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 8) 2. **Risk Entry 5** (page 12) 3. **Risk Entry 11** (page 25) 4. **Risk Entry 14** (page 31) **B. Retirement** 5. **Risk Entry 18** (page xxx) will be retired after the September 2022 Trust Board meeting.
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 10), 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.			
	Highlights/Summary in July 2022: **A. Update –** The following risk entries was updated: 1. **Risk Entry 2** (page 8), 2. **Risk Entry 16** (page 35) 3. **Risk Entry 17** (page 37) **B. Retirement** 4. **Risk Entry 4** was retired after the July 2022 Trust Board meeting. 5. **Risk Entry 10** was retired after the July 2022 Trust Board meeting. **C. Review** 6. **Risk Entry 18** (page 39) 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 44) 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).			
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, Quality and Clinical Risk Committee and Trust Executive Committee meetings in June 2022
Next Steps	N/A
Appendices/Attachments	Board Assurance Framework

The Board Assurance Framework – Summary of Activity in August 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

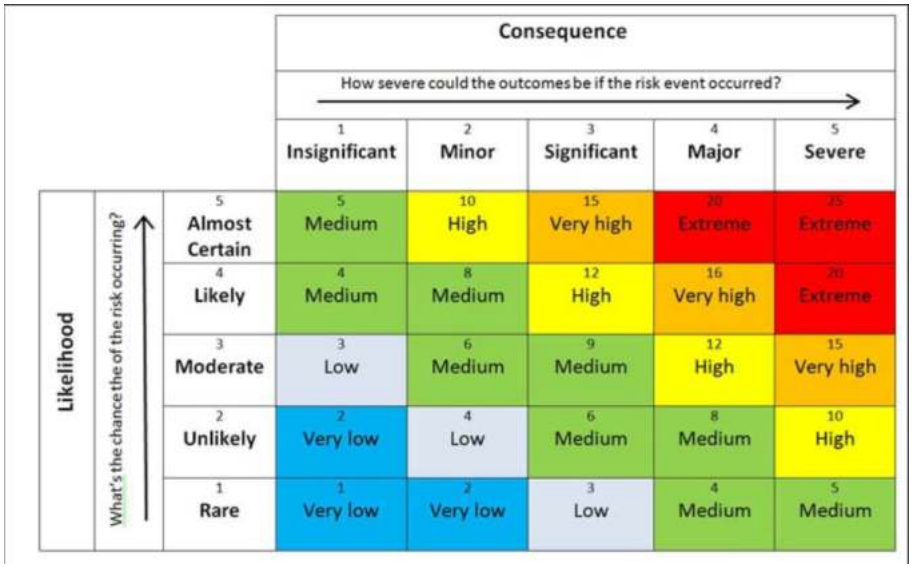
1. Keeping you safe in our hospital
2. Improving your experience of care
3. Ensuring you get the most effective treatment
4. Giving you access to timely care
5. Working with partners in MK to improve everyone's health and care
6. Increasing access to clinical research and trials
7. Spending money well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

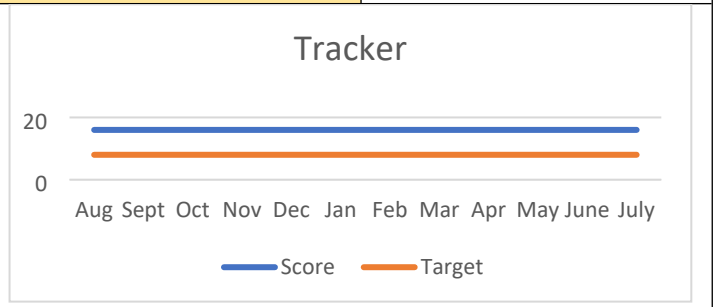
Green	**Positive assurance**: The Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat/ opportunity. There are no gaps in assurance or controls and the current exposure risk rating is at the target level; or gaps 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	29/07/2022	**Risk Rating**	16	8			

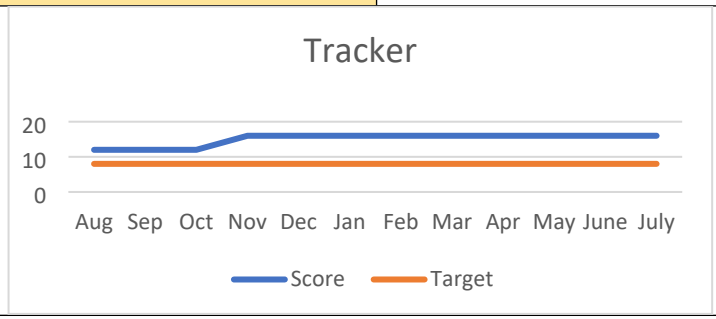
Cause	**Controls**	**Gaps in Controls**	**Action**	**Sources of Assurance**	**Gaps in Assurance**	**Action**	**Assurance Rating**
Significant increase in activity and number of patients through the ED Significantly higher acuity of patients through the ED	Clinically and operationally agreed escalation plan Adherence to national OPEL escalation management system Clinically risk assessed	ED staffing levels - vacancies in nurse staffing, higher than normal staff absences and sickness Increased volume of	Ongoing recruitment drive and review of staffing models and skill mix. Redeployment of staff from other areas to the ED at	Daily huddle / silver command and hospital site meetings in hours. Out of hours on call management structure. ED dashboard on Trust	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.	escalation areas available. Surge plans, COVID-specific SOPs and protocols have been developed. Emergency admission avoidance pathways, SDEC and ambulatory care services.	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.	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	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	21/07/22	**Risk Rating**	16	8		



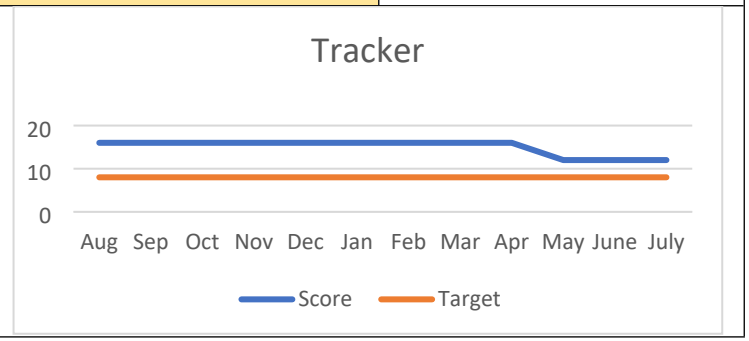
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Not appropriately reporting, investigating or learning from incidents. A lack of systematic sharing of learning from incidents.	Improvement in incident reporting rates SIRG reviews all evidence and action plans associated with Sis Actions are tracked Debriefing systems in place	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 Challenges evident following the introduction of new reporting software along with a revised national reporting form have been associated with some reduction in reporting and delays in the closure of incidents.	Appreciative Inquiry training programme started (December 2020) Commencement of patient safety specialist role (April 2021) Trust-wide communications in place Focused training and work with the supplier.	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	21/07/22	**Risk Rating**	12	8		

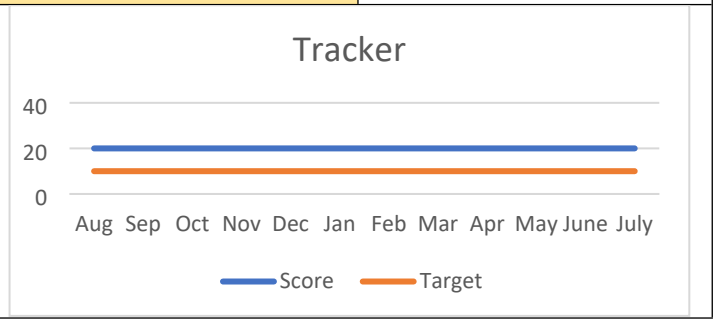


Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Rapid or sustained period of upheaval and change caused by the Covid-19 pandemic and need to respond and maintain	Board approved major incident plan and procedures Rigorous monitoring of capacity, performance 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 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	29/07/22	**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 Inability to match capacity with demand because	Compliance with national guidance Use of Independent Sector. Granular understanding of demand and capacity requirements with use of national tools.	Limitations to what Independent Sector Providers can take.	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	

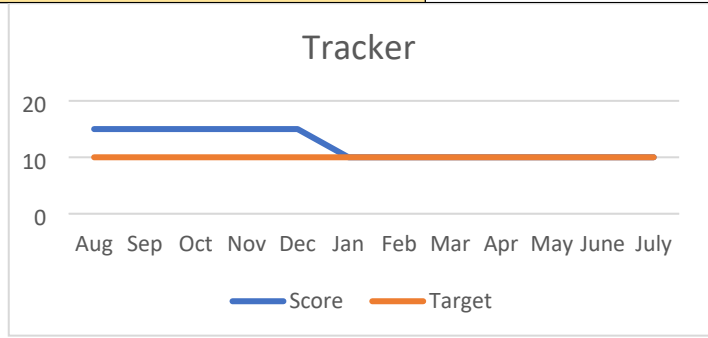
of the emergency pressure and discharge challenges – loss of elective ring-fenced unit for Orthopaedics	Robust oversight at Board, and sub committees. Divisional and CSU management of Waiting Lists. Agreement of local standards and criteria for alternative pathway management – clinical prioritisation and validation Long-wait harm reviews Extension of working hours and additional Waiting List Initiatives to compensate for capacity deficits through distancing and Infection Prevention and Control requirements. Additional capacity being sourced and	Historic issue with Appointment Slot Issues & capacity 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.			

	services reconfigured.						

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	21/07/22	**Risk Rating**	10	10		



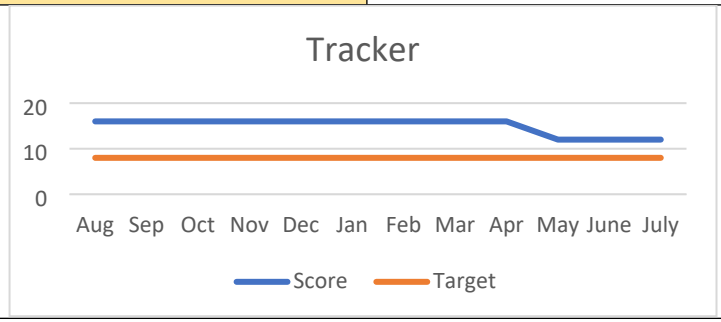
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Demand for ITU and inpatient beds exceeds capacity, including escalation capacity within the hospital and regionally. Risks have evolved over the	Increased capacity across the hospital Increased capacity 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	21/07/22	**Risk Rating**	12	8		



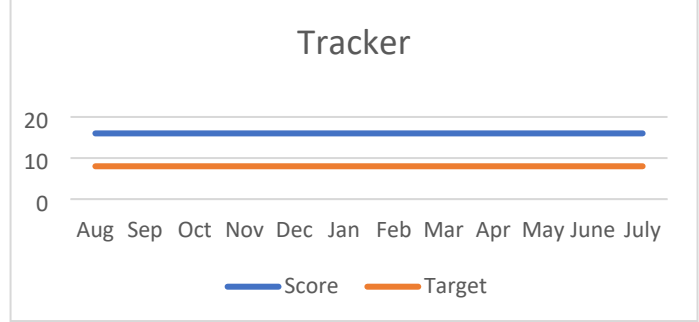
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Break down in the established relationship (subcontract) between Oxford University Hospitals and the private Genesis Care facility (Linford Wood, Milton Keynes) which has	Contingency for the provision of treatment to patients in Oxford and the ongoing provision of palliative and prostate radiotherapy at Linford Wood or in Northampton Promotion of agreement between	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	

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.	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	25/07/22	**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 • Welcome MK	

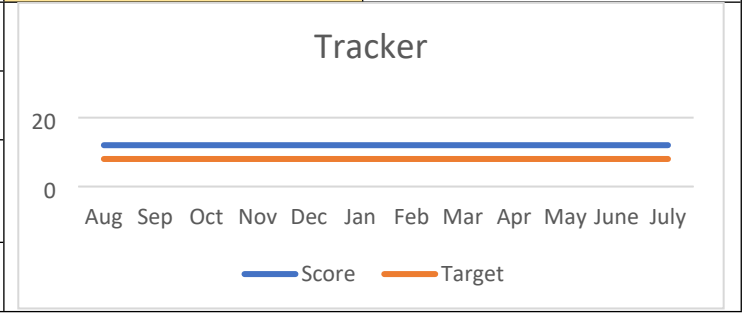
Adult Inpatient Survey Urgent and Emergency Care Survey Maternity Survey Cancer Patient Experience Survey	• Patent Experience Strategy • Learning Disabilities Strategy • Dementia Strategy • Nutrition steering group • Catering steering group • Domestic planning group • Discharge steering group • Induction 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		• 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	25/07/22	**Risk Rating**	12	8		



Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Lack of appropriate intervention to improve patient experience following receipt of complaints and PALS contacts.	Corporate Patient Experience Team function, resources and governance arrangements in place at Trust, division and department levels, including but not limited to: • Patent Experience Strategy	Quality surveillance system to triangulate feedback from complaints with incidents and other quality measures across the organisation. Audit of identified	Current review underway for systems to link and triangulate data. Divisions to audit learning	**Annual:** Complaints and PALS Report **Quarterly:** Quarterly reports with themes and areas of for improvement. Patient experience strategy action plan progress. Tendable Audits	Patient feedback. Cognitively impaired Learning Disabilities Sensory Deficit: vision, hearing, speech Language difficulties	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-produce information.	

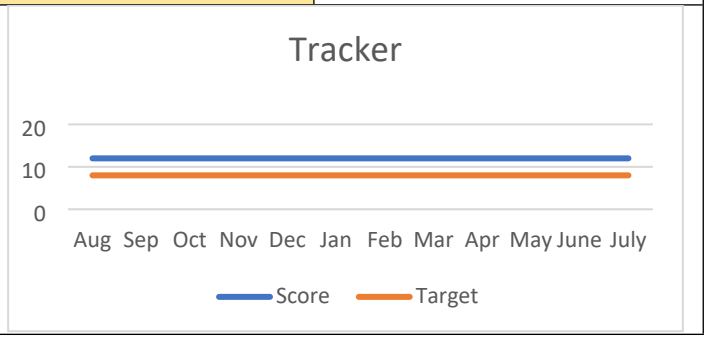
	• Learning Disabilities Strategy • Dementia Strategy • Nutrition steering group • Catering steering group • Domestic planning group • Discharge steering group • Induction training Customer service training – NHS Elect program Leadership training includes how to receive feedback from patients. Appreciative inquire approach to support complaints handling and response letters. Monthly divisional meetings with Head of Patient and Family	learning in divisions to ensure learning embedded.	from feedback and report to Patient Experience Board.	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. Complaints questionnaire for complaints re	Children and young people. Link with EDI leads and Trust Networks	Bi-Monthly Trust Board Patient Experience Report	

	Experience to review themes, complaints, associated changes, and learning.			process and experience. PALS KPIs responding to feedback in a timely manner to initiate change and learning. **Website:** 'You said we did			

RISK 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	29/07/22	**Risk Rating**	12	8		

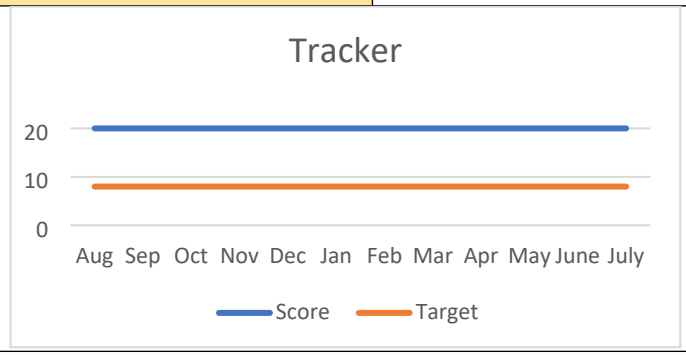


Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure because data quality processes are not robust	Robust governance around data quality processes 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 implementation has been completed - Director of Operations working with Patient Access Team and Services to rectify issues	Data Quality Board Validation of records being progressed External benchmarking	Unknown until validation process has been completed	None Currently	

			that have arisen from the implementation				

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	29/07/22	**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	Winter escalation plans to flex demand and capacity Plans to maintain urgent elective work and cancer services through periods of peak demand	Unpredictable nature of both emergency demand and the surge nature of Covid-19 Workforce and space (in 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	

for patients needing elective treatment – including cancer care	Agreed plans with local system National lead if level 4 incident, with established and tested plans Significant national focus on planning to maintain elective care						

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

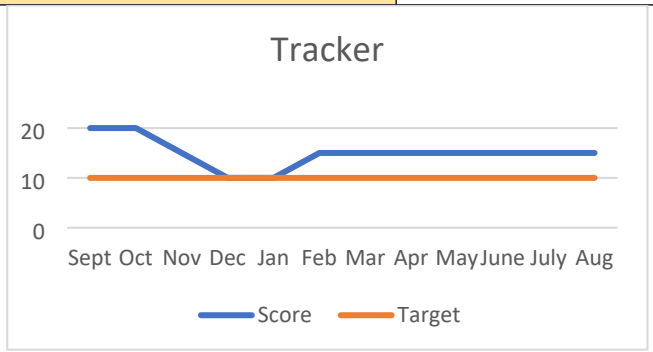
Strategic Risk	If the Trust introduces new digital solutions some staff may be concerned that this will replace their role. This may impact negatively on morale and may cause some staff to seek employment elsewhere unnecessarily. The belief that jobs may be at risk may also impact on Staff Side relations.				**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	03/08/22	**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	18/08/22	**Risk Rating**	15	10			

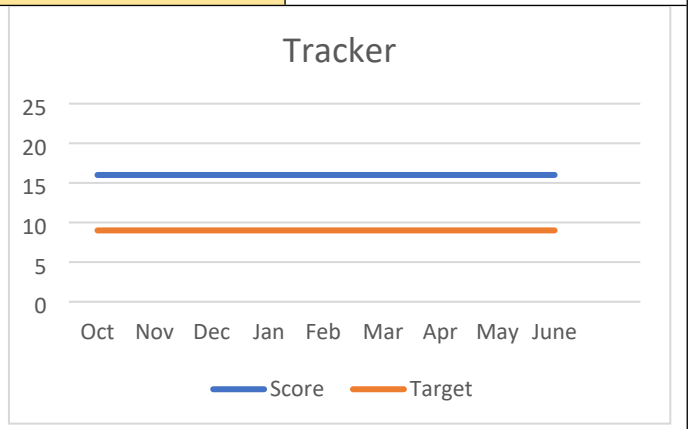
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Increasing Cyber-attacks across the world.	3 dedicated cyber security posts Good network protection from cyber security breaches such as Advanced Threat Protection (ATP) – A part of the national programmes to protect the cyber	None identified	Continued review	External review and reporting Internal audit reports on cyber security taken with the management actions	None currently	None currently	

	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		



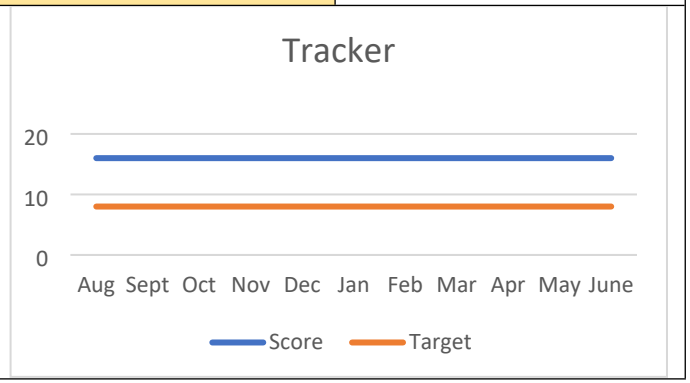
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
The current NHS capital regime does not provide adequate certainty over the availability of strategic capital finance. Consequently, it is difficult to progress development plans	The Trust has a process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



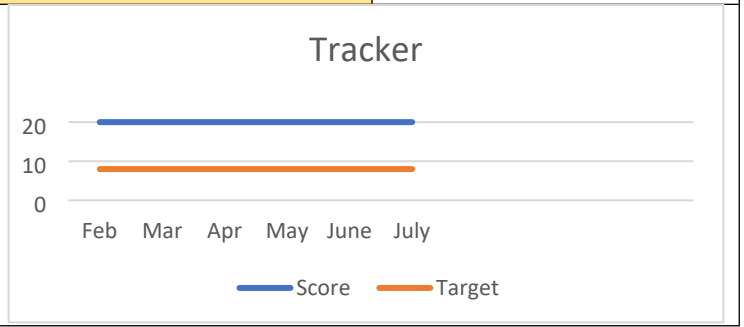
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Increase in operational expenditure in order to manage COVID-19 Reductions in non-NHS income streams as a direct result of COVID-19.	1. Cost and volume contracts replaced with block contracts (set nationally) 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	21/07/22	**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) – **Under Review**

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	Reconfiguration of cots to create more space Additional cots to increase capacity Parents asked to leave NNU during interventional procedures, ward rounds, etc to	External timeframe and approval process for HIP2 funding	Continued review	External review and reporting. Whilst a technical risk the likelihood has been downgraded on the basis of actual reporting	None Currently	None Currently				

risk that if the Trust continues to have insufficient space in its NNU, the unit's current Level 2 status could be removed on the basis that the Trust is unable to fulfil its Network responsibilities and deliver care in line with national requirements.	increase available space. HIP2 funding for new Women and Children's Hospital announced.						

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

Strategic Objective 8: Employing the Best People

Strategic Risk	If the Trust does not retain staff then posts will be vacant resulting in workforce shortages across the hospital or increased temporary staffing expenditure.					**Strategic Objective**	Employing the Best People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff	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	03/08/22	**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	

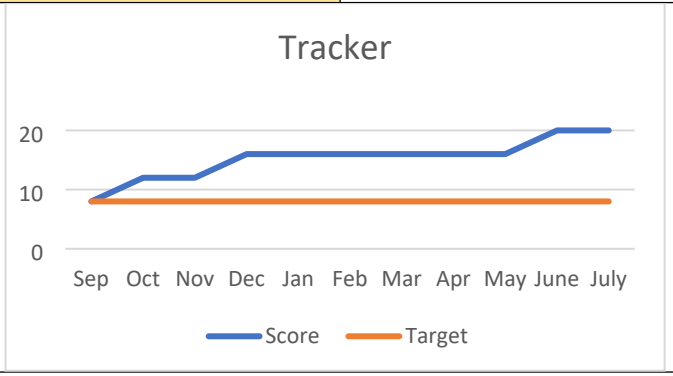
Culture within isolated departments	• Recruitment and retention premia policy • We Care programme • Onboarding and exit strategies/reporting • Annual Staff Survey • Learning and development programmes • Health and wellbeing initiatives, including P2P and Care First • Staff recognition - staff awards, 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	03/08/22	**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.	None Currently	Continued review	External review and reporting Vacancy Rates	None Currently	None Currently	

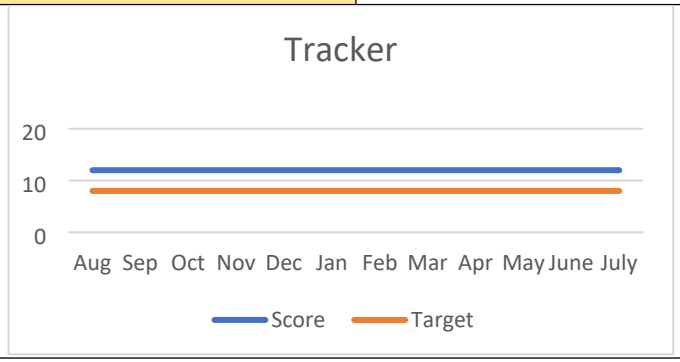
urology and trauma and orthopaedics Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply)	• Apprenticeships and work experience opportunities. • Exploration and use of new roles to help bridge particular 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	03/08/22	**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	

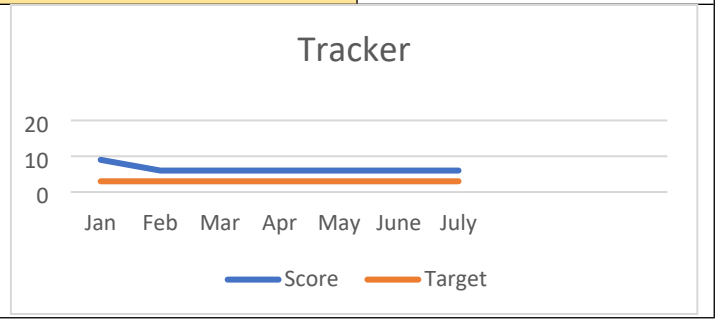
Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply) Large percentage of workforce predicted to retire over the next decade Large growth prediction for MK - outstripping supply Buoyant private 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	21/07/22	**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 length of stay for	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 Milton Keynes	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 recruitment and training needs).	Regular OUH / MKUH collaborative project group. Developing Thames Valley Provider Alliance.	Some elements outside Trust's direct control	Continued work with partners	

the admitted group is 2-3 days, whereas the experience for MK residents (super-spell) is 5-6 days.	(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.	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 during the COVID-19 pandemic

Strategic Objective 8: Employing the Best People

Strategic Risk	If the Trust does not maintain stocks of Personal Protective Equipment (PPE) and continue implementing the enhanced infection control measures it will be unable to maintain a safe working environment during the COVID-19 pandemic						**Strategic Objective**	Employing the Best People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff	At target level – no tracker	
Executive Lead	Director of Workforce	**Consequence**	4	4	**Risk Appetite**	Avoid		
Date of Assessment		**Likelihood**	2	2	**Risk Treatment Strategy**	Treat		
Date of Review	03/08/22	**Risk Rating**	8	8				

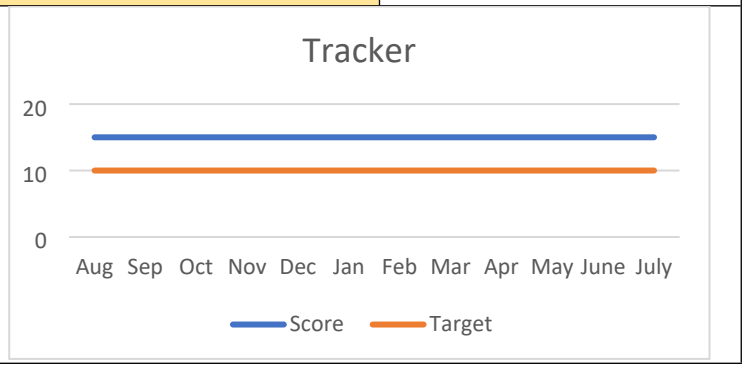
Cause	Controls	Gaps in Controls	Action	Sources of Assurance	Gaps in Assurance	Action	Assurance Rating
Ability to maintain a safe working environment during the Covid-19 pandemic due to a lack of equipment, including PPE, or inadequate staffing numbers	• Incident command structure in place • Oversight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

	immediate response through Gold/ Silver • National and regional response teams in place • Workforce and Workplace Risk Assessments completed and any necessary equipment or working adjustments implemented. • Staff COVID-19 Self-Test and vaccine offer to all MKUH workers			Staff Vaccine Uptake Report			

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

Strategic Objective 8: Employing the Best People

Strategic Risk	If the Trust does not implement and progress staff health and wellbeing initiatives, there is the risk of staff burning out during or due to the COVID-19 pandemic				**Strategic Objective**	Employing the Best People
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Staff
Executive Lead	Director of Workforce	**Consequence**	5	5	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	3	2	**Risk Treatment Strategy**	Treat
Date of Review	03/08/22	**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 20
Public Board 08 September 2022

Meeting of the Audit Committee held on 6 June 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- The Committee approved the internal Audit Contract Award and the Internal Audit Charter
- The Committee approved write-offs for £57k
- The Committee approved the Data Security and Protection Toolkit Report 2021/22

Summary of matters considered at the meeting:

- The Committee noted the External Audit Contract Award to Grant Thornton
- The Committee noted the Internal Audit Contract Award to RSM
- The Counter Fraud Report was noted by the Committee and included the annual report and workplan, and reviews on rostering and procurement and contract management
- The Committee noted the losses and special payments, waivers and salary overpayments.
- The health and safety report and response to the ESR Service Audit report were noted by the Committee

Milton Keynes University Hospital NHS Foundation Trust

Agenda item 20
Public Board 08 September 2022

Meeting of the Finance and Investment Committee held on 05 July 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

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

Summary of matters considered at the meeting:

- Regarding the Trust's performance, the Committee noted the continuing challenges of patient flow, relating to staffing constraints in community social care settings.
- The Committee noted the financial position for Month 2 (May 2022) which was £0.25m below plan, due to lower than budgeted clinical income relating to elective recovery activity.
- Regarding the Trust's efficiency programme, the Committee noted the latest position of £4m savings against the target of £12m for 2022/23, and next steps.
- The Committee was informed of the conditions associated with the additional £1.5bn funding to NHS bodies and how these would relate to the Trust.

Agenda item 20
Public Board 08 September 2022

Meeting of the Finance and Investment Committee held on 02 August 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- The Committee **approved** the proposal for a new payroll provider for the Trust

Summary of matters considered at the meeting:

- The Committee noted the operational performance report for Month 3 and the continuing impact of COVID related infection control measures

- The Committee noted that the Trust was £250k behind plan for the first quarter, due to lower than budgeted clinical income from elective recovery activity

- Regarding the Maple Centre, the Committee noted that the building was due to be operational by the end of October 2022

- The Committee noted the update on the Financial Efficiency – Better Value Programme

- The Committee noted the turbulence around the Trust's underlying financial position, and awaited the publication of NHSE's medium-term system funding arrangements

- The Committee noted the developments around the Trust's relationship with Sensyne Health.

Agenda item 20
Public Board 08 September 2022

Extraordinary Meeting of the Quality & Clinical Risk Committee held on 6 June 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- The Committee approved the draft Quality Report for 2021/22.

Summary of matters considered at the meeting:

The Committee noted the huge amount of work undertaken regarding falls prevention and in addressing pressure damage.

Regarding safeguarding, the Committee noted the Trust's partnership with Thames Valley Police and the local authority to reduce violence and exploitation of vulnerable patients

The Committee noted a sustained period of high activity and acuity intensified by staffing challenges specifically within paediatric services.

The Committee noted the ongoing work on practices in the Department of Critical Care regarding HM Coroner's Preventing Future Death report on silencing monitoring alarms within that department.

With regard to the introduction of the new risk management and incident reporting system, Radar, the Committee noted the ongoing collaboration with Trust staff, Radar and NHS Improvement to address the issues raised in connection with the system and also the Patient Safety Event form being piloted.

The Committee noted the Mortality Report covering the period March 2021 to February 2022.

Milton Keynes University Hospital NHS Foundation Trust

Agenda item 20
Public Board 08 September 2022

Meeting of the Charitable Funds Committee held on 28 April 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- The Committee approved the merging of proposed fund accounts

Summary of matters considered at the meeting:

- Regarding the Meaningful Activities Coordinator, the Committee noted the high levels of activity undertaken in a short period of time.

- The Committee noted the Arts for Health MK Activity Plan for 2022-2024

Agenda item 20
Public Board 07.07.22

Meeting of the Trust Executive Committee held on 13 July 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- The Committee approved the following business cases:
  - White House Park Endoscopy Community Diagnostic Service (subject to Commissioner support)
  - Spacelabs Integration with eCARE
  - Two Air Handling Unit Replacements
  - Cath Lab PCI Equipment (subject to Commissioner approval)
  - Welling Software Solution's extension.

Summary of matters considered at the meeting:

- The Committee noted the proposed new governance arrangements due to be implemented later in the year

- Adjustments to the Continuity of Carer model within Midwifery, made necessary as a result of establishment issues, were noted by the Committee

- The Committee noted the following updates and reports
  - The operational performance, workforce and finance reports for Month 2 (May 2022)
  - The complaints and PALS (patient advice and liaison service) report for Q4
  - The risk management escalation report
  - The divisional highlights, concerns and updates from within their areas

Milton Keynes University Hospital NHS Foundation Trust

Agenda item 20
Public Board 08 September 2022

Meeting of the Trust Executive Committee held on 10 August 2022

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

- The Committee approved the following business case subject to minor clarifications:
    - Breast Development works and installation of 3rd mammography Machine
    - Testing of the electrical structure for 20% of the site
    - Wayfinding update and refresh

- The Committee approved the following documents
    - Sickle Cell Disease in Pregnancy Guideline
    - People who choose to have care outside of guidance Standard Operating Procedure (SOP)
    - Maternity Triage SOP
    - Variable Rate Guideline
    - Discharge of Adults Young People (on adult wards) from Hospital Policy
    - Supporting Patient Choices to Avoid Long Hospital Stays
    - Violence and Unacceptable Behaviour Prevention Strategy
    - Optimal Cord Management for All New-borns
    - Re-Banding Policy
    - Streaming SOP

Summary of matters considered at the meeting:

- The Committee noted the following reports and updates:
    - The update on the Radar incident and risk management tool introduced in November 2021
    - The health and safety report and progress in tackling violence and abuse
    - The Capital Programme Board update
    - The operational performance, workforce and finance reports for Month 3
    - The annual complaints and PALS (patient advice and liaison service) report and the patient and family experience annual report

- The Committee noted the divisional highlights, concerns and updates

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	**Board of Directors**	**Date: 8 September 2022**
Report title:	**Use of Trust Seal**	**Agenda item: 21**
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:

29 July 2022

Grant agreement between MK Council and MKUH to fund Pathway Unit (Maple Centre) construction (£9m)

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 Workforce 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
	Declaration of Interests 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

	Pressure Damage update
	Maternity Update
	Emergency Preparedness, Resilience and Response Annual Report
November	Infection Prevention and Control Annual Report
	Annual Complaints Report
	Annual Patient Experience Report
	CNST Maternity Incentive Scheme and Board Assurance Framework Sign Off
	Maternity Update
	Guardian of Safe Working Hours Annual Report
	Maternity Patient Survey 2022 interim report *(Action No. 2*)
	Update on quality priorities (electives, diagnostics, emergency care and outpatients)
	Freedom to Speak Up Guardian Report *(twice yearly reporting recommended by internal auditors)*