Bundle Trust Board Meeting in Public 3 November 2022

1.1 10:00 - Agenda
- 1. DRAFT Agenda Board Meeting in Public - 03.11.22 v3.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
- 4. Minutes Trust Board Meeting in Public 08.09.22 draft AD.docx

5 10:15 - Matters Arising
- 5. Board Action Log 14.09.22.xlsx

6 10:15 - Chair's report
- 6.1 MKUH Coversheet Jan 2022.docx
- 6.2 Report to Board Nov.docx

7 10:20 - Chief Executive's Report

8 10:30 - Feedback from Maternity Assurance Group
- 8. Draft MAG Minutes 22092022_IR_MD.docx

9 10:40 - Serious Incident and Learning Report
- 9.2 PDF response.pdf
- 9.1 SI report Q2 2022 - 2023.docx

11 10:50 - Complaints and Patient Advice and Liaison Service (PALS) Annual Report
- 11. Annual Complaints and PALS Report 2021 to 2022.docx

12 10:55 - Complaints and Patient Advice and Liaison Service (PALS) Quarterly Report
- 12. Q1 2022 to 2023 Complaints and PALS report.doc

13 11:00 - Patient and Family Experience Quarterly Report
- 13. Q1 22-23 Patient Experience report.docx

14 11:05 - Accountability and Support for Theatre Productivity
- 15. Clinical effectiveness Theatres_letter_Sept22.pdf

15 11:15 - Performance Report
- 15.1 2022-23 Executive Summary M06 Coversheet.docx
- 15.2 2022-23 Executive Summary M06.docx
- 15.3 2022-23 Board Scorecard M06.pdf

16 11:25 - Update on Quality Priorities 2022-23

17 11:35 - Finance Report
- 17. Financial performance report (month 6).docx

18 11:45 - Workforce Report
- 18. Workforce Report M6 2022.docx

19 11:55 - Freedom to Speak Up Guardian Report
- 23 20221025 FTSU 6 month report 2022.docx

20 12:05 - Significant Risk Register
- 20.1 Trust Board - Significant Risk Register Report 26th October 2022.docx
- 20.2 Significant Risk Register - as at 26th October 2022.pdf

21 12:15 - Summary Reports
- 21.1 Audit Committee 18.07.22 Summary Report approved.docx
- 21.2 Finance and Investment Committee Summary Report 06.09.22 approved.docx
- 21.3 Charitable Funds Committee 15.09.22 Board Summary Report approved.docx
- 21.4 TEC 14.09.22 Board Committee Summary approved.docx

22 12:20 - Terms of Reference for Board Sub-Committees

22.1 Audit Committee ToR November 2022 Draft v 2.docx

22.2 Charitable Funds Committee Terms of Reference November 2022 - Draft v 2.docx

22.3 FIC Terms of Reference November 2022 - Draft v 2.docx

22.4 QCRC Terms of Reference November 2022 - Draft v 2.docx

22.5 RemCom Terms of Reference Sept 22.docx

22.6 Workforce and Development Assurance Committee ToR - Draft v 2.docx

23 12:25 - Forward Agenda Planner

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

24 12:30 - Questions from Members of the Public

25 12:30 - Resolution to Exclude the Press and Public

The chair to request the Board pass the following resolution to exclude the press and public and move into private session to consider private business:
"That representatives of the press and members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted."

26 12:30 - Date of Next Meeting

Agenda for the Board of Directors' Meeting in Public

Meeting to be held at 10:00 am on Thursday 03 November 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 08 September 2022	Approve	Chair	Attached
5		Matters Arising	Note	Chair	Attached
Chair and Chief Executive Updates					
6	10:15	Chair's Report	Information	Chair	To follow
7	10:25	Chief Executive's Report - Overview of Activity and Developments	Receive and Discuss	Chief Executive	Verbal
Patient Safety					
8	10:35	Feedback from Maternity Assurance Group	Receive and Discuss	Medical Director / Director of Patient Care and Chief Nurse / Maternity Safety Champion	Attached
9	10:45	Serious Incident and Learning Report	Receive and Discuss	Director of Corporate Affairs/ Medical Director	Attached
Patient Experience					

Item No.	Timing	Title	Purpose	Lead	Paper
11	10:50	Complaints and Patient Advice and Liaison Service (PALS) Annual Report	Receive and Discuss	Director of Corporate Affairs	Attached
12	10:55	Complaints and Patient Advice and Liaison Service (PALS) Quarterly Report	Receive and Discuss	Director of Corporate Affairs	Attached
13	11:00	Patient and Family Experience Quarterly Report	Receive and Discuss	Director of Corporate Affairs	Attached
Clinical Effectiveness					
14	11:05	Accountability and Support for Theatre Productivity	Receive and Discuss	Director of Operations	Attached
Performance					
15	11:15	Performance Report	Receive and Discuss	Chief Operations Officer	Attached
16	11:20	Update on Quality Priorities for 2022-23	Receive and Discuss	Director of Corporate Affairs	Verbal
11:30 – Break (10 mins)					
Finance					
17	11:40	Finance Report	Receive and Discuss	Director of Finance	Attached
Workforce					
18	11:50	Workforce Report	Receive and Discuss	Director of Workforce	Attached
19	12:00	Freedom to Speak Up Guardian Report (half-yearly)	Receive and Discuss	Freedom to Speak Up Guardian	Attached
Assurance and Statutory Items					
20	12:10	Significant Risk Register	Receive and Discuss	Director of Corporate Affairs	Attached
21	12:15	(Summary Reports) Board Committees • Audit Committee 18/07/22 • Finance & Investment Committee 06/09/22	Assurance and Information	Chairs of Board Committees	Attached

Item No.	Timing	Title	Purpose	Lead	Paper
		• Quality & Clinical Risk Committee 20/09/22 • Charitable Funds Committee 15/09/2022 • Trust Executive Committee 14/09/22			
22	12:20	Terms of Reference for Board Sub-Committees • Audit Committee • Charitable Funds Committee • Finance & Investment Committee • Quality & Clinical Risk Committee • Remuneration Committee • Workforce & Development Assurance Committee	For approval	Director of Corporate Affairs	Attached
Administration and Closing					
23	12:25	Forward Agenda Planner	Information	Chair	Attached
24		Questions from Members of the Public	Receive and Respond	Chair	Verbal
25		Motion To Close The Meeting	Receive	Chair	Verbal
26		Resolution to Exclude the Press and Public The Chair to request the Board pass the following resolution to exclude the press and public and /move into private session to consider	Approve	Chair	

Item No.	Timing	Title	Purpose	Lead	Paper
		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.”			
12.30		Close			
Next Meeting in Public: Thursday, 12 January 2023					

BOARD OF DIRECTORS MEETING

Minutes of the Trust Board of Directors Meeting in Public held on Thursday, 8 September 2022 at 10.00 hours via Teams

Present:

Alison Davis	Chair	(AD)
Professor Joe Harrison (left at 12:00)	Chief Executive	(JH)
Heidi Travis	Non-Executive Director	(HT)
Haider Husain	Non-Executive Director	(HH)
Gary Marven	Non-Executive Director	(GM)
Bev Messinger	Non-Executive Director	(BM)
Dr Ian Reckless	Medical Director & Deputy Chief Executive	(IR)
Danielle Petch	Director of Workforce	(DP)
Nicky Burns-Muir	Director of Patient Care and Chief Nurse (outgoing)	(NBM)
Yvonne Christley	Director of Patient Care and Chief Nurse	(YC)
John Blakesley	Deputy Chief Executive	(JB)

In Attendance:

Kate Jarman	Director of Corporate Affairs	(KJ)
Daphne Thomas	Deputy Director of Finance	(DT)
Kwame Mensa-Bonsu	Trust Secretary	(KMB)
Julia Price (Minutes)	Senior Corporate Governance Office	(JP)
Emma Codrington (Item 3)	Associate Chief Nurse	(EC)

1 Welcome and Apologies

1.1 AD welcomed all present to the meeting, including the Chief Nurse Fellows, YC as the new Chief Nurse and Director of patient Care and DT who was representing the Director of Finance. There were apologies from:

Terry Whittle, Director of Finance, who was represented by Daphne Thomas.
Luke James, Non-Executive Director
Emma Livesley, Director of Operations

2 Declarations of interest

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

3 Patient Story

3.1 NBM introduced Emma Codrington, in her new role as Associate Chief Nurse. EC described how she had recently met with a patient who had had an unpleasant experience as an inpatient following an ankle dislocation. Whilst the patient described her initial experience of coming into hospital by ambulance into the Emergency Department as 'second to none', she had felt compelled to write to JH as a result of her experience on an inpatient ward. She described this as 'the most horrendous time of her life'. She also stated in her letter that she was not sure why she was writing as she did not expect that her letter would make any difference.

3.2 EC described changes to the complaints process to make it more of a human interaction where the team would now review a complaint and where necessary intervene immediately, requesting divisional chief nurses to contact the complainant as an initial step. In this instance, EC met with the patient who described issues around communication, privacy and dignity, surgery delays, unanswered call bells, support for patients at mealtimes and the manner and attitude of staff towards patients. Although changes were made in practice in response to this complaint, EC realised that feeding this information

back to those involved in this patient's care would not have the same impact as the patient's description had had on her. As a result, EC arranged for the patient to be filmed later this month discussing her experience as she felt this would be more powerful in improving patient care across the organisation. EC advised that appreciative inquiry would be used in the session to support teams.

3.3 EC highlighted how loyal the patient was to the organisation, describing many positive aspects of her care, and also her sense of guilt and sadness over feeling compelled to complain. EC wanted to ensure that the patient was aware of how beneficial her complaint had been to the organisation and that it had made a difference.

3.4 NBM explained that there was general dissatisfaction over the content of complaint responses and the chief nurses and head of midwifery were seeking better ways of feeding back to patients and staff, encouraging early interventions to avoid the formal complaint route.

3.5 In response to a question from GM, EC explained that there were often generic themes such as support for patients at mealtimes but often, people would contact the organisation because they did not know or did not fully understand why something had occurred. Regarding issues with call bells, EC advised that in some areas of the hospital, the response times for call bells could be measured, but in the case study, that was not possible.

3.6 AD highlighted the importance of being open as an organisation when things did not go well and she thanked EC for bringing this to the Board's attention.

4 Minutes of the Trust Board Meeting in Public held on 7 July 2022

4.1 The minutes of the Trust Board Meeting in Public held on 7 July 2022 were reviewed and **approved** by the Board with minor amendments to Paragraphs 9.7-9.9 which IR would discuss with KMB.

5 Matters Arising

5.1 The due actions on the log were reviewed as follows.

Action 7 – Other organisations approach towards appraisals
Closed

Action 12 – Review of content of performance data
JH advised that the Executives had been working with the Divisions to produce a more balanced score card to reconcile activity, finance and performance indications. The revised report would be tested at Board Seminar before use at the next public Board meeting. Open

Action 13 – Amendment to Risk 101
Closed

Action 14 – Replicating maternity engagement exercise
KJ advised that work was ongoing to develop a means to replicate the maternity engagement exercise for both specific issues and more generically. The final model would be reviewed at the Workforce and Development Assurance Board. Closed

There were no other matters arising.

6 Chair's Report

6.1 AD advised that two new associate non-executive directors would commence in post this month, one of whom, Dr Dev Ahuja would be attending the Trust Board Meeting in Private later in the day. She further advised that Dr Luke James would be stepping down from his role as Non-Executive Director at the end

of the month. AD would be discussing the non-executive vacancies with colleagues and Lead Governor, Babs Lisgarten, shortly.

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

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

7.1 JH advised that the Trust had received Government funding of £190k as part of the New Hospital Programme to conduct ground surveys for the new Women and Children's Hospital.

7.2 He expected media coverage and a high level of concern by the workforce over the increase in pension contributions which would coincide with the NHS pay award of 4.5%. DP had highlighted the issues both regionally and nationally and ensured that affected staff had been contacted.

Action: DP to circulate a paper to the Board on this issue

7.3 JH advised that alongside the community kitchen, the organisation was collecting unwanted school uniforms for use by children of members of staff. Other means to support staff were being sought in response to increasing financial pressures.

7.4 Event in the Tent would be taking place over 3 days from 20 September and one of the speakers, on 21 September, would be the national Freedom To Speak Up Guardian. The sessions would be streamed and recorded.

Action: KJ to circulate the details of this year's Event in the Tent to the Board

7.5 IR reported that the Health Service Journal (HSJ), the foremost arbiter of the quality of patient safety projects in the country, would be holding their Patient Safety Awards in Manchester in the forthcoming week for which there were huge numbers of applications every year and the Trust had been shortlisted for two categories:

- The patient safety pilot on safe reviews which was led by the Patient Safety Specialists investigating critical incidents involving teams, patients and families; and
- The human factors courses led by the Clinical Skills and Simulating Training Team in the Academic Centre.

7.6 The Maple Centre would be handed over to the Trust at the end of the month and JB invited Board members to visit the new building after the Board Seminar in October. The business case for the Radiotherapy Centre would be discussed in Part 2 of the Board meeting and it was hoped that work could begin before the end of the financial year.

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

8 Patient and Family Experience Report Annual Report

8.1 KJ presented the report which had previously been shared at Quality & Clinical Risk Committee. She highlighted the positive impact of the new electronic patient experience platform in obtaining patient feedback. All staff could access and interrogate the data. There was a large programme of work around improving the management of complaints. NBM explained that people were reluctant to raise their concerns during their inpatient stay and to address this, patient experience volunteers would be introduced.

8.2 JH highlighted the huge improvement in Friends and Family Test responses last year increasing from 3000 in the first quarter to 16,000 by Q4. AD asked if the Trust aspired to a percentage of patients accessing services they would like to hear from and JH explained that many patients access several different services and there was no desire to bombard them with requests to complete the test. Patients may be put off if asked too frequently. The target areas were the Emergency Department, Outpatients and electives.

8.3 HT requested a greater focus on ethnic minorities to enhance the richness of data.

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

9 Feedback from Maternity Assurance Group (MAG)

9.1 IR reminded the Board of the Ockenden review and the formation of the Maternity Assurance Group (MAG), chaired by the Non- Executive maternity safety champion, to provide assurance to the Board of the Trust's maternity services. The information reviewed and discussed was available to any board member and approved meeting minutes would be included in the public board papers. The Group had held an inaugural meeting, chaired by Luke James, and the Board was asked to approve the terms of reference.

9.2 IR advised that MAG reviewed evidence in relation to CNST (Clinical Negligence Scheme for Trusts) where the Trust was compliant with the ten CNST safety actions with the exceptions of:

- The requirement for labour ward coordinators to be supernumerary. Work was ongoing to fully understand the data definitions and resolve this.
- The requirement for pregnant mothers of potential pre-term babies to be given two doses of steroids in mitigation of lung problems in premature babies. IR explained that acute trusts (including MKUH) struggle to meet this 'second dose' requirement as some such mothers would transfer to tertiary centres in anticipation of delivery. Work was ongoing.

IR advised that the Board would be required to undertake a self-declaration regarding these ten CNST safety actions in December.

9.3 MAG reviewed a detailed staffing report and noted the key issues and gaps which included the impact of Birthrate Plus modelling (May 2022), vacancies against establishment and the impact of new guidance on neonatal medical staff. The Birthrate Plus report considered the acuity and comorbidities of women labouring in that particular month. IR advised that this exercise was last undertaken in 2018 and the workforce had been developed based on the results. There had also been an uplift in establishment after the publication of the Ockenden Report. Following a repeat of the exercise in May, the requirement for a further small increase of around 5% (equating to around six midwives) was suggested. This report and any ensuing business case would be reviewed via internal trust groups and processes in the first instance.

9.4 MAG noted the adoption of the Perinatal Quality Surveillance Model in monitoring the safety of maternity and neonatal services. The Group also reviewed information relating to compliance with the Saving Babies' Lives Care Bundle.

9.5 IR reminded the Board of the 84 safety actions from the recommendations in the final Ockenden Report (the 84 arose from breaking down the smaller number of high level recommendations into their constituent parts). There were four areas of non-compliance that were discussed at the MAG:

- Training for labour ward coordinators. There was no nationally recognised training available although an internal development programme, running over the last few months, had been well received.

- A dedicated patient safety champion for maternity. IR explained that trusts had adopted different approaches to introducing patient safety specialists when the generic role was introduced, including 'rebadging' existing roles. MKUH had introduced two dedicated specialists and they were a new and much valued resource, now incorporating a group of patient safety partners into the team. The Ockenden Report recommended a patient safety specialist specific to maternity. As the Board lead for safety, IR's view was that having a siloed / separate safety specialist in Maternity was not the right approach. Since the current specialists both had maternity backgrounds, one being a midwife and the other an obstetric anaesthetist, it could be argued that the recommendation was met. IR clarified that the two specialists reported directly to him operating within a work plan supported by the Patient

Safety Committee. His vision was for the team to grow to 4 or 5 people over time, and the team could of course incorporate a programme of proactive work in maternity services agreed with Clinical Service Unit leads. JH believed it feasible for the Trust to recognise that the role of patient safety specialist as required by the national team was fulfilled by the patient safety specialists currently in post. He felt it would be appropriate to state that the Trust was able to encompass the requirement within the current structure and skillset. However, should either of the current team members leave the role, the situation would have to be reviewed by the Board. HT queried why the nationally recommended approach was not felt to be appropriate and IR expressed the view that the recommendation had not been well thought through, adding that the Trust had progressed the patient safety role much further than most organisations. He acknowledged that there would likely be a way of describing what the Trust was doing to meet the recommendation, although the wording of the recommendation and any implementation notes produced subsequently by NHS England or others would need to be reviewed. He highlighted to the Board the very positive impact the team was having through their fresh eyes approach and clinical credibility, which enabled them to work impartially with teams during difficult and challenging situations. KJ added that the risk of Maternity becoming very siloed and externally managed was significant given that the Board remained accountable for the service. AD felt that more information was required from the national team, identifying what was so uniquely different within maternity as to require a dedicated person.

- A high-dependency trained midwife available 24/7. The process to put this in place was underway.

- A formal audit programme in respect of intrauterine transfers out of the unit. Plans to put this in place were in hand.

9.6 MAG reviewed the maternity improvement plan developed by the service and the local maternity neonatal service (LMNS) which was part of the Integrated Care System. The Group was satisfied that the plan aligned well with the Trust objectives and strategy.

9.7 IR reminded the Board of the Continuity of Carer model and the Trust's decision in May to suspend three of the six teams delivering this care. Following the end of the formal consultation period in August, the decision was made to bring the remaining three teams back into the traditional model of care. Regional and national teams were fully aware of the process in reaching this decision. Support from the MKUH midwifery team was in essence unanimous – even the strongest advocates of the model recognised that in the current context reversion to traditional was appropriate. Nationally, full implementation of the Continuity of Carer model was still expected to be accomplished by March 2024 (previously March 2023) and a Board discussion would need to take place on when to re-introduce the model. It was agreed that the Workforce and Development Assurance Committee would take a measured view on the percentage of establishment required before consideration could be given to the reintroduction of the Continuity of Carer model.

Action: Workforce and Development Assurance Committee to advise the Board when establishment figures within maternity had reached an appropriate level to reintroduce the Continuity of Carer model

9.8 HH asked whether MAG would have access to data on ethnicity to track the outcomes of women from ethnic minorities. IR stated that MAG would clearly take an interest in this area, and noted that unwarranted variation was one of the major benefits of the Continuity of Carer model (geographical roll-out in line with demographic markers of poor maternity outcomes). The Trust would work with the LMNS and BLMK ICS to gain a better understanding of outcomes geographically, and to monitor / intervene with respect to unwarranted variation

9.9 Given the detailed nature of the information required by the region and nationally, KJ was looking to ensure that any public information, made available on the website, was in an easy-to-understand format.

9.10 In response to a question from HT, IR advised that where some organisations were only confident of 40% compliance with the Ockenden recommendations when these had been published, this Trust was

able to demonstrate compliance of around 75% as a baseline – and was expecting to meet the vast majority in due course.

The Board **noted** the feedback from the Maternity Assurance Group and **approved** the Terms of Reference

10 Serious Incident and Learning Report

10.1 Taking the report as read, KJ highlighted the significant violent and aggressive event that took place on one of the wards and she reminded the Board of the Trust's continued focus to address the issues through the Violence and Unacceptable Behaviour Prevention Steering Group.

10.2 Noting the continuing trend in deep tissue injuries and pressure ulcers, KJ advised that the Trust was looking to work in different ways to avoid all injuries of this nature.

10.3 An appreciative inquiry festival had been held in the summer to help staff develop a deeper understanding of harm and peer review quality visits to wards and clinical areas had been re-established post pandemic. These were providing rich feedback.

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

11 Mortality Update

11.1 IR reminded the Board of the complex systems to review mortality and noted that reported numerical mortality rates were within the expected range. He explained that an inpatient could have several consultant episodes as diagnostic tests were undertaken and as they moved between wards. The number of episodes had increased since the implementation of the electronic patient record system, and this could adversely impact mortality statistics which took account of the first two episodes of care.

11.2 In response to a question from HH regarding the number of relatives directed to the Patient Advice and Liaison Service (PALS), IR explained that historically the Bereavement Team would have discussed a patient's death with relatives but now bereaved relatives were routinely contacted by a medical examiner and sometimes concerns from past episodes of care over a number of years could be raised. These were subsequently referred to PALS.

11.3 The Board **noted** the Mortality Update

12 Workforce Report

12.1 DP highlighted key points from the report.

- The recruitment team were very busy with much interest being shown in jobs advertised
- The majority of newly recruited international nurses were now taking and passing the Objective Structured Clinical Examinations (OSCEs) and progressing onto the wards as registered nurses.
- The payroll contract was due for renewal and following a procurement exercise, a new provider had been selected. The contract value was £1.5m based on a 3+1+1 year contract at £300k per year.
- Plans for the flu and Covid vaccine for staff were in hand and would be administered in the Academic Centre from October to November, and, as previous years, staff would be encouraged to complete the staff survey at the same time. The vaccines would be offered to staff from partner organisations working on site.
- The Trust had signed up to the East of England's anti-racism pledge.
- Freedom to Speak Up learning recently became nationally available and the completion rate here to date was 65% with a target of 100/%.
- The Health Education England self-assessment was included in the Board pack for approval.

12.2 HT highlighted the statutory mandatory training compliance of 95%. She asked whether the number of nurse vacancies currently at 160 was expected to reduce in view of the international recruitment campaign with 125 nurses in the pipeline. DP confirmed that as these nurses completed their OSCEs, the number of vacancies would reduce. She was looking at options to address further increases in establishment. In response to a question from GM, DP explained that the international nurses were recruited on a reduced banding until completing their OSCE when they would progress to registered nurse banding. The Board noted the significant improvement to the nursing vacancy factor.

12.3 HH asked whether the Board should be concerned over the steady increase in the turnover leaver rate and DP explained that this was a national trend and was thought to be due to staff waiting for the end of the pandemic before seeking a change. She added that the organisation was an outlier in terms of its ability to fill vacancies where other organisations were struggling.

Action: Workforce & Assurance Development Committee to review exit information.

12.4 JH informed the Board that the Trust had received several notifications of balloted strike action from different unions on the back of the cost of living crisis.

The Board **noted** the Workforce Report, the payroll contract renewal and **approved** the Health Education England self-assessment.

13 Violence and Aggression Programme Update

13.1 KJ advised that the paper provided a quarterly snapshot of reported incidents and advised that the actual number of incidents was likely to be higher as, despite encouragement, it was a known area of under-reporting, particularly to the police. There had been an increase in severity of violence with some very serious assaults against staff members which were obviously traumatic and distressing. This had resulted in greater use of body-worn cameras. The actions and interventions led by the Violence and Unacceptable Behaviour Steering Group were summarised in the report and included increased training, a poster campaign and a Victim's Charter aimed at supporting victims of assaults, violence and aggression and encouraging victims to report incidents to the police. Bespoke training in the Emergency Department was planned, together with a review of the environment.

Action: KJ to circulate the Victim's Charter to the Board

Action: KJ to advise the Board on the figures for violence and aggression from the previous quarter

13.2 GM asked whether the trust involved experts in addressing the issues and KJ advised that this would be considered particularly in the Emergency Department in terms of security and the environment. Health partners were supporting work on some wards regarding de-escalation and distraction techniques and developing the skills of health care support workers in supporting patients with dementia.

13.3 IR highlighted the distress incidents of violence and aggression caused not only for staff but also for patients witnessing such behaviour. The management of violent individuals and those considered likely to be violent was a significant activity for staff.

Action: KJ to raise with the Violence and Unacceptable Behaviour Steering Group the provision of opportunities for patients who have witnessed violent events to talk through their experience.

13.4 KJ expressed the hope that reporting levels would increase significantly as this would indicate that people were comfortable in reporting and did not feel that violence and aggression was to be accepted as part of their working day.

13.5 In response to a question from HH over the provision of a dedicated on-site police presence, JB explained that the Trust would opt to have a police presence but recruitment issues within the police

force meant that this was not possible. Therefore, there was a vacancy for a Police Community Support Officer (PCSO) that the Trust aspired to fill. He added that the number of substantive security posts had increased, and the Security Team excelled at de-escalation, backed up by a good track record. The Team was valued by staff. However, he acknowledged that it took time for them to reach areas where incidents were taking place.

The Board **noted** the Violence and Aggression Programme Update.

14 Performance Report Month 4

14.1 JB presented the report on behalf of EL and highlighted the following:

- Similar to most acute trusts, emergency care continued to be challenging although compared to peers, the organisation continued to perform well.
- The number of stranded and super stranded patients remained high due to external partners' issues with recruitment, particularly within therapies and social care.
- Diagnostic performance was improving steadily month on month but JB reported that equipment failures, where at one point both MRIs were out of service at the same time, had been challenging.
- There had been an MRSA infection, breaching the zero-tolerance threshold for 2022-23.
- Midwifery recruitment impacted midwife to birth ratios. IR advised that bank cover was not covered within this metric.

14.2 AD asked how the reporting streams were pulled together and JH advised that internally every month the divisional triumvirates met with the executive team to review and discuss issues and he recognised the need to evidence that level of scrutiny to Board. HT added it would be helpful to understand some of the detail around, for example, referral to treatment waiting lists, the main focus areas for the executive team over the coming months and where patients were most at risk.

Action: JH to consider a means of providing CSU level assurance to the Board

Action: A subjective executive assessment for Board Seminar on risks within the organisation alongside the data points associated with the performance metrics

The Board **noted** the Performance Report for Month 4

15 Finance Report Month 4

15.1 DT highlighted the following from the report which took account of the first four months of the year to 31 July 2022.

- The deficit position of £5.4m was adverse to plan by £1.6m mainly as a result of receiving lower than planned elective recovery funding (ERF). The hospital's total allocation of ERF was £7.25m for the year but only 25% of this had been recognised to date as the activity targets had not been met. Nevertheless, the Trust had performed well from an activity perspective compared to peers. ERF guidance had been evolving and it was believed that the first six months of funding was guaranteed but there had been no formal notification of this.
- Costs were broadly in line with plan, slightly above on Pay and Non-Pay by less than 0.5%.
- Inflation pressures were not as high as had been expected but remained a serious risk which was being closely monitored.
- The £6m efficiency savings identified in the report had since increased to £8m with a target of £12m.
- The capital programme was on target.
- The cash balance was £46m which was slightly better than plan.

Despite the deficit position at Month 4, a break-even year end position was being forecast based on efficiency savings and receipt of ERF.

15.2 GM pointed out that the organisation was overspent on staff in month and year to date but was not meeting activity targets. DT explained that activity levels were 100% but in order to achieve ERF they needed to reach 104% and that non-elective pressures were consuming resources.

15.3 HT as Chair of Finance & Investment Committee, advised that whilst activity levels were consistently at 100% here, levels at other Trusts within the East of England were thought to be around 60-70% and greater clarity on how ERF would be used to best support the system was awaited.

15.5 Considering the current energy crisis, GM asked if the report reflected energy costs and it was explained that the Trust had a guaranteed price up to September when a change in tariff was expected. However, it was acknowledged that the contingency for this may not be sufficient. JB advised that the NHS, as a whole, negotiated with energy companies for best price, adding that 15% of the Trust's energy was generated through solar power.

The Board **noted** the Finance Report for Month 4

16 Research and Development Annual Report

16.1 IR reminded the Board that the Research and Development Strategy had been approved by the Board at the meeting in May. He explained that around 80-85% of income was related to trials within the national portfolio with the remainder coming from original work. The organisation was better than most at recruiting for research and development projects. However, Covid had had a huge impact on research activity as the team supported the clinical workforce and Covid specific trials.

16.2 IR warned that the Thames Valley Clinical Research Network would be more impacted than most by proposed adjustments to the areas encompassed and IR advised that objections to this proposal had been raised.

16.3 HH was pleased to note the variety of research areas and queried whether health inequalities were included. IR explained that while he was aware of the focus on this topic within BLMK, participation for the Trust was dependent on whether it was included in the national portfolio. AD would raise this issue with the Independent Chair of BLMK ICS.

Action: AD to discuss research and development for health inequalities with the Independent Chair of BLMK ICS

The Board **noted** the Research and Development Annual Report.

17 Emergency Preparedness, Resilience and Response (EPRR) Annual Report

17.1 KJ presented this item on behalf of EL and explained that the Trust had been working within the EPRR framework for most of the previous two years as a result of the pandemic. In addition, the heatwave plan had been executed over the summer. The organisation had also participated in regional and national exercises. HH added that he was assured of the Trust's emergency preparedness following a meeting with the Trust's Emergency Planning Officer.

The Board **approved** the Emergency Preparedness, Resilience and Response Annual Report

18 Significant Risk Register

18.1 KJ advised that the corporate and divisional risks were reviewed monthly and were available on the website for public scrutiny.

18.2 HT queried why Risk 366 (unattended items causing restrictions in hospital corridors) had increased and KJ explained that a weekly assessment of the whole site had indicated this to be an increasing problem. She advised that it was likely to reduce shortly in view of ongoing work to address the issue.

18.3 BM asked whether the scoring was affected when risks were overdue a review and KJ explained that it was not but that an escalation process to encourage a review would be pursued.

18.4 Regarding Risk 248 (IT network failure), HH asked whether the implementation scheduled for February 2022 had taken place. JB explained that this was a vast piece of ongoing work that was due to complete by the end of December 2022.

The Board **noted** the significant risk register

19 Board Assurance Framework

19.1 KJ advised that the Board Seminar in October would focus on the format of the Board Assurance Framework to make it a more dynamic document, reflecting the organisation's most significant risks.

The Board **noted** the updates on the Board Assurance Framework

20.1 Summary Report for the Audit Committee – 6 June 2022

The Board **noted** the report.

20.2 Summary Report for the Finance and Investment Committee Meeting – 5 July 2022

The Board **noted** the report.

20.3 Summary Report for the Finance and Investment Committee Meeting – 2 August 2022

The Board **noted** the report.

20.4 Summary Report for the Quality and Clinical Risk Committee – 6 June 2022

The Board **noted** the report.

20.5 Summary Report for the Charitable Funds Committee – 28 April 2022

The Board **noted** the report.

20.6 Summary Report Trust Executive Committee Meeting – 13 July 2022

The Board **noted** the report.

20.7 Summary Report Trust Executive Committee Meeting – 10 August 2022

The Board **noted** the report.

21 Use of Trust Seal

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

22 Forward Agenda Planner

22.1 It was pointed out that some items scheduled for this meeting were not on the agenda:

- The Annual Digital Review had been deferred due to annual leave and JB encouraged those present to advise what information they would like to see included;
- The Messenger Review would be discussed at Workforce and Development Assurance Committee before coming to Board; and
- The Objectives would be discussed at the October Board Seminar and presented at the next Board meeting.

Action: KMB to amend the Forward Agenda Planner and include the Green Agenda

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

23 Questions from Members of the Public

23.1 There were no questions from the public.

24 Any Other Business

24.1 Whilst the quality of the papers was appreciated, the lateness of some of the papers was questioned and it was explained that this was due to annual leave.

25 The meeting closed at 12:22

Updated : 17/10/22

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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	IR	03-Nov-22	A review of the maternity risks will be included in the report on the results of 2022 Maternity Survey. The report will be submitted to the Board in January or March 2023 when the embargo on the 2022 Maternity Survey results is lifted.	Open
10	05-May-22	19.3	Board Assurance Framework	Greater scrutiny of the BAF to be given at sub-committee meetings	Sub-committee chairs	03-Nov-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	12-Jan-22	08/09/22 - The revised report would be tested at Board Seminar before use at the next public Board meeting	Open
17	08-Sep-22	13.1	Violence and Aggression Programme Update	KJ to circulate the Victim's Charter	KJ	03-Nov-22		Open
18	08-Sep-22	13.1	Violence and Aggression Programme Update	KJ to advise the Board on the figures for violence and aggression from the previous quarter	KJ	03-Nov-22		Open
19	08-Sep-22	13.3	Violence and Aggression Programme Update	KJ to raise with the Violence and Unacceptable Behaviour Steering Group the provision of opportunities for patients who have witnessed violent events to talk through their experience	KJ	03-Nov-22		Open
20	08-Sep-22	16.3	Research and Development Annual Report	AD to discuss research and development for health inequalities with the Independent Chair of BLMK ICS	AD	03-Nov-22		Open
21	08-Sep-22	22	Forward Agenda Planner	KMB to amend the Planner as discussed and to include the Green Agenda	KMB	03-Nov-22	For discussion at Board in January 2023	Closing

Meeting Title	**Trust Board**	**Date: 07.11.2022**
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	An update for the Board on activity and points of interest including • New Associate Non Executive Directors • Appointment of new Governors • Discussion on Allyship as part of Black History month			
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Noting** [ ]	**For Review** [ ]

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

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

Chair's report 07.11.2022

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

1. Our new Associate Non-Executive Directors (NED) started with us in October; Devdeep Ahuja and Jason Sinclair. Welcome to them both.

2. The vacant NED post(s) have been advertised and interviews will take place on the 7th December

3. We have four new Governors to welcome this month:-
    - Philip Gage
    - Rose Grove
    - Baney Young
    - John Garner

    And congratulations to our Lead Governor, Babs Lisgarten on her reappointment

4. I am delighted to record that the Trust has now received its Silver Award, as part of the Armed Forces Covenant which acknowledges the organisation has demonstrated support for service personnel employed at MKUH.

5. There was a launch of the AccessAble website and app on the 19th October, for those who need information about the accessibility of the Trust when visiting the site. It is the culmination of several years work, with a lot of stakeholder input and will be constantly updated when things change in the organisation.
   The website is AccessAble.co.uk and the search will provide a link to the MKUH site.

6. I have chaired three Consultant Interview Panels, for Acute Physician, Respiratory Medicine and Cardiologist. I am pleased to report that appointments were made for all posts.

7. On October 5th the Integrated Care System held an event to receive the views of people with lived experience of health inequalities and relevant organisations working in the field of health inequalities. The intention is to identify areas to prioritise in BLMK and what needs to be put in place to address the challenges.

8. As part of the Black History Month in October, an open session on Allyship took place on the 27th using Teams and in person at the Tent by Eaglestone Restaurant; including Executive and Non- Executive Board members. There was a lot of interest, discussion and feedback which will be taken forward at the Board development session in December focusing on allyship and actions to prioritise.

Maternity Assurance Group (MAG)

Meeting Date:	22nd September 2022	**Meeting Time:**	08:00 – 09:00
Location:	Microsoft Teams		

Present:	**Name**	**Job title**	**Initials**
	Alison Davis (Chair)	Chairman and Non-Executive Director	AD
	Dr Ian Reckless	Medical Director and Maternity Safety Champion	IR
	Yvonne Christley	Chief Nurse	YC

In attendance:	Melissa Davis, Head of Midwifery, Paediatric and Gynaecological Nursing (MD) Dr Nandini Gupta, Clinical Director Obstetrics and Gynaecology (NG) Katie Selby, Maternity Governance and Quality Lead (KS) Dr Vicky Alner, Divisional Director, Women's and Children's (VA) Emma Mitchener, Deputy Head of Maternity (EM)
Apologies:	Kate Jarman, Director of Corporate Affairs Katy Philpott, Associate Director of Operations, Women's and Children's
Minute Taker:	Nicky Peddle – PA to Medical Director

Item	**Minute**	**Action**
1.	**Welcome and Introductions**	
	Introductions were made. Apologies received from Vicky Alner, Katy Philpott.	
2.	**Minutes of the last meeting**	
	The minutes of the meeting held on 25th August were accepted as an accurate record.	
3.	**Action log and matters arising**	
	Action 1 ToR approved at Board. Action closed. **Action 2** Clarify – BirthratePlus advocated a further uplift in establishment in following May 2022 exercise. Business case for this to be progressed through usual Trust mechanisms. VA to report back to MAG on progress in January 2023. **Action 3** 3a – Alison Davis (Trust Chair) has taken on the role of maternity NED safety champion. This will be reviewed in six months following recruitment of other NEDs. Action closed. 3b – Agenda item. Action closed.	

	Action 4 IR and MD to further discuss. Update MAG in November. **Action 5** Sits with Workforce Committee - update via Danielle Petch in January 2023. **Action 6** Agenda item. Action closed. **Action 7** Agenda item. Action closed.	
3.	**ToR**	
	Approved at Board.	
4.	**Feedback from Board**	
	• IR confirmed that the Board discussed all areas escalated by MAG. Members of Board were assured by the work of this group and the level of detail provided. • The Board were advised that AD has replaced Luke James as interim Maternity Safety Champion. • MD advised that Wendy Matthews, Regional Chief Midwife, has setup a forum for Maternity NEDs which will provide an opportunity for discussion around the safety and quality elements within the various units, and allow NEDs to check and challenge from a Board level perspective.	
5.	**Digital Survey (page 59)**	
	The MKUH maternity digital strategy has been approved at the Exec Directors meeting on the 9th September 2022 and was due for the required LMNS approval at the LMNS Strategic Board meeting on the 14th September 2022. Due to recent events, the LMNS Strategic Board meeting was cancelled, and the policy is now going to ICB on 30th September for sign off. IR commented that although the objectives are solid and sensible, there are concerns about achieving them in a meaningful time frame, particularly connectivity and bidirectional flow of information from women to record and vice versa. MD confirmed that the digital strategy is linked to several different maternity transformation workstreams of which personalisation is one of the highest areas. The aim is that service users will have access to their notes on a digital platform, and both the service user and the clinical staff member will be able to write on the notes, providing bidirectional flow. Providing women with the opportunity to visit any maternity unit in the country with all information available on one platform, and to review notes outside of appointments supporting informed choice.	
6.	**Recruitment and Retention GAP**	
	Agenda item carried forward to next meeting, pending further information from the national team.	
7.	**Perinatal Quality Surveillance Model**	
	The Perinatal Quality Surveillance Model has been implemented into maternity services to ensure that Board has oversight of safety and quality metrics.	

	MD provided a verbal overview of all areas reportable for compliance, this was supported by the submission of the information pack to MAG. The following additional comments were highlighted and discussed: • HSIB (slide 22) - IR expressed concern about the length of time to close action plans after the incident. MD advised that the Ockenden requirement is to demonstrate that actions have been into place within 6 months. It was agreed to contemplate the implementation of an overarching service improvement plan for longer terms actions. IR also requested the addition of a column for noting the date reports are finalised by HSIB. A discussion took place regarding the engagement of families in the HSIB process. MD advised that it is pivotal to have the input of families, in terms of their experience of informed choice and care planning and confirmed that some improvements have been made as a direct result. • Monthly Maternity Serious Incident report (slides 55-57) – INC-4718 confirmed as an SI. • Training (slides 35-36) - MAG notes challenges in achieving required training levels (PROMPT, Gap/Grow etc…) in general, and specifically amongst medical staff. A brief report to be presented in October on the requirement (and its origin), the consequences of failing to achieve the target, appraisal of options for improvement, clinical risks related. • Midwifery safe staffing (slides 44-51) – ○ MAG seeks a better understanding of the terminology / methodology used in the staffing report driven through the BirthRatePlus App. A one-page introduction / glossary to the report may be sufficient. ○ Whilst MAG (and Trust Board) review bi-annual staffing reports (the content of which is driven externally), MAG needs to be seeing detailed internal figures in respect of midwifery staffing (establishment advocated by benchmarking, budgeted establishment, gaps against establishment, leavers / turnover, changes in skill mix and experience consequent to turnover, plans to close gaps articulated). MAG seeks these figures at our next meeting. These figures need to be validated by the HR team and Danielle Petch will be invited to attend. • Risk management update (slide 31): MAG notes high level concerns about ultrasound capacity. MAG requires a detailed update on the position including capacity, demand, demand management, DNA, clinical risk, and mitigation etc.	NG MD MD KP
8.	**Ockenden and CNST**	
	MD provided a verbal overview (slides 39-43). The following additional comments were highlighted and discussed: • Ockenden 1 Immediate and essential actions update: ○ Action 1 - Full SI reports to Trust Board. Summary of findings and actions already submitted to Board. Trust position to be agreed and signed off, to be discussed further outside this meeting. ○ Action 2 – change to green following ADs appointment.	

9.	**Any other business**	
	• IR - MAG seeks a better understanding of plans for improved IT connectivity in the community (the issue, the options for resolution / improvement, and anticipated timelines).	John Blakesley
	Date of Next Meeting	
	20th October 2022 @ 08:00-09:00 via MS Teams	

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Mr Tom Osborne
HM Senior Coroner
HM Coroner's Office
Civic Offices
1 Saxon Gate East
Central Milton Keynes
MK9 3EJ

By email: coroners.office@milton-keynes.gov.uk

12 July 2022

Dear Mr Osborne

I am writing to formally respond to the Regulation 28 report to prevent future deaths you made following the conclusion of the inquest into the death of Sangeerth Girirathan on 6 May 2022.

You also wrote to me on 19 May 2022 on two matters raised during this inquest, but which did not form part of the Regulation 28 report; namely the disclosure of notes in a paginated and indexed format; and the storage of data on monitoring units in the hospital, particularly the ICU. I will address these matters within this letter.

Regulation 28 Report

The Regulation 28 report reads as follows: *During the inquest it became apparent that in the ICU the alarms that are operating on the monitors had been disengaged. This resulted in the staff not being alerted when the patient's saturations fell below an acceptable level and he went into cardiac arrest. My understanding is that if a patient is being monitored at all then it is essential that the alarms remain operational. I believe that all staff should be reminded of the need for the alarms to be active so that future deaths in similar circumstances do not arise*

Response

There is no national guidance regarding frequency of observations on ICU and patients vary from those who are acutely unwell to those who are well and waiting for a ward bed and on occasions direct discharge home. Observations (frequency and type) are decided by ongoing dynamic risk assessments from the nurse looking after the patient with input from the medical team as required.

Alarm fatigue is a recognised detrimental consequence of intensive, continuous monitoring. As part of the wider learning from this incident, the importance of proportionate and appropriate use of alarms and alarm limits will be emphasised to all critical care staff. A reference is included at ***Appendix 1***.

All registered nurses and consultant intensivists have been communicated to regarding the recommendations contained within the Regulation 28 report. The communication has reiterated that nursing staff must position themselves to have visibility of the monitor and when monitoring is deemed appropriate, the audible alarms set should reflect and augment the parameters monitored. If monitoring - intermittent or continuous but more important for the continuous - is deemed necessary then the alarms will not be disabled but parameters - highs and lows - may be altered to alert us a different points for different patients to avoid 'overuse' of the audible alarms.

The senior nursing team and consultant intensivists are doing point prevalence surveys to support and education staff as to safe and effective monitoring.

The ability to store data on monitoring devices following an incident that may have caused harm

Response
The ICU has a monitoring system provided by Spacelabs. There are several options to retain information/data from this monitoring system. Some of these options are longer term and require input from IT and all methods have risks associated with them that might result in failure to capture the appropriate data.

In the short term, all registered nurses, medical trainees, and consultant intensivists have been informed that in clinical situations where death may have been prevented or an incident may have resulted in serious harm, that the monitor should be quarantined and data preserved. As an interim solution, monitor data should be transferred into the monitor modules, uploaded into a Spacelabs transport monitor and preserved until the clinical engineering team has access to that monitor to download the data. The patient should not be unlinked from the monitor (i.e. 'discharged' or disassociated from the monitor) unless absolutely necessary (in the case of the monitor being required urgently for another patient). Registered nurses have received refresher training and have been competency assessed to ensure they can transfer data as above.

In the medium term, with training there is also an opportunity to draw across additional observations that have not yet been saved to eCare. In a situation where harm or death has occurred and the patient has not been discharged from the monitor, additional time points

can be added to assessments that will pull through observations at that time point. The downside to this will be that observations will not be corroborated in real time and some readings may be artefactual if monitoring is not correctly attached at the time (dampened arterial line trace, sats probe that is incorrectly positioned etc) leading to inaccurate data.

In the longer term, Spacelabs Intesys Clinical Suite held in the central station should be able to store 72 hours of data for a patient who has been on a monitor in ICU (or elsewhere in the hospital) and has since been discharged from that monitor. 72 hours of data can be accessed from the moment a patient is discharged. However, the amount of data available reduces over that time frame as it's not designed as a data repository. A business case is being produced to draw up a contract between Spacelabs and IT to further consider this option.

An action plan detailing ongoing work is included at ***Appendix 2***.

Pagination and Indexing of Notes for Court Disclosure

Response
There is a meeting between your team and the MKUH Director of Corporate Affairs, Kate Jarman, and Head of Clinical Governance and Risk, Tina Worth, on 19 July to discuss potential options and agree next steps to ensure disclosures to the Court are made appropriately, coherently and accessibly.

I trust that this response is satisfactory and as always, please do contact me if you would like any further information or assurance on any of the areas above.

Yours sincerely,

Joe Harrison

Joe Harrison
Chief Executive Officer

Appendix 1 Reference: Patient Monitoring Alarms in an Intensive Care Unit: Observational Study With Do-It-Yourself Instructions

Monitoring Editor: Gunther Eysenbach

Reviewed by Mohammed Sayed and Katarina Braune

Akira-Sebastian Poncette, MD,1,2 Maximilian Markus Wunderlich, MSc,2 Claudia Spies, MD, PhD,1 Patrick Heeren, MSc,1,2 Gerald Vorderwülbecke, MD,1 Eduardo Salgado, MD,1,2 Marc Kastrup, MD, PhD,1 Markus A Feufel, MSc, PhD,3 and Felix Balzer, MD, MSc, PhDcorresponding author1,2

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Felix Balzer, Institute of Medical Informatics, Charité – Universitätsmedizin Berlin, Corporate Member of Freie Universität Berlin, Humboldt-Universität zu Berlin, and Berlin Institute of Health, Charitéplatz 1, Berlin, 10117, Germany, Phone: 49 30450 ext 651166, Email: ed.etirahc@rezlab.xilef.

Abstract

Background

As one of the most essential technical components of the intensive care unit (ICU), continuous monitoring of patients' vital parameters has significantly improved patient safety by alerting staff through an alarm when a parameter deviates from the normal range. However, the vast number of alarms regularly overwhelms staff and may induce alarm fatigue, a condition recently exacerbated by COVID-19 and potentially endangering patients.

Objective

This study focused on providing a complete and repeatable analysis of the alarm data of an ICU's patient monitoring system. We aimed to develop do-it-yourself (DIY) instructions for technically versed ICU staff to analyze their monitoring data themselves, which is an essential element for developing efficient and effective alarm optimization strategies.

Methods

This observational study was conducted using alarm log data extracted from the patient monitoring system of a 21-bed surgical ICU in 2019. DIY instructions were iteratively developed in informal interdisciplinary team meetings. The data analysis was grounded in a framework consisting of 5 dimensions, each with specific metrics: alarm load (eg, alarms per bed per day, alarm flood conditions, alarm per device and per criticality), avoidable alarms, (eg, the number of technical alarms), responsiveness and alarm handling (eg alarm duration), sensing (eg, usage of the alarm pause function), and exposure (eg, alarms per room type). Results were visualized using the R package ggplot2 to provide detailed insights into the ICU's alarm situation.

Results

We developed 6 DIY instructions that should be followed iteratively step by step. Alarm load metrics should be (re)defined before alarm log data are collected and analyzed. Intuitive

visualizations of the alarm metrics should be created next and presented to staff in order to help identify patterns in the alarm data for designing and implementing effective alarm management interventions. We provide the script we used for the data preparation and an R-Markdown file to create comprehensive alarm reports. The alarm load in the respective ICU was quantified by 152.5 (SD 42.2) alarms per bed per day on average and alarm flood conditions with, on average, 69.55 (SD 31.12) per day that both occurred mostly in the morning shifts. Most alarms were issued by the ventilator, invasive blood pressure device, and electrocardiogram (ie, high and low blood pressure, high respiratory rate, low heart rate). The exposure to alarms per bed per day was higher in single rooms (26%, mean 172.9/137.2 alarms per day per bed).

Conclusions

Analyzing ICU alarm log data provides valuable insights into the current alarm situation. Our results call for alarm management interventions that effectively reduce the number of alarms in order to ensure patient safety and ICU staff's work satisfaction. We hope our DIY instructions encourage others to follow suit in analyzing and publishing their ICU alarm data.

Appendix 2: Action Plan

Improvement Objectives	Actions Taken	Start date	Additional Support required	Review Schedule	Outcome
To communicate to all staff the need to store data on monitoring devices following any incident that might have caused harm	Email all RNs Email all Consultant Intensivists	05/05/22	Consultant Intensivists to communicate to medical trainees	27/06/22 To evaluate at Intensive Care senior nursing, medical and AHP group	
All RNs to receive training and be assessed as competent on transferring data from monitor to module	Senior nursing team provided one to one training and competency assessment to all staff	08/05/22	Band 7s to facilitate process	27/06/22 To evaluate at Intensive Care senior nursing, medical and AHP group	All RNs to receive training and be assessed as competent on transferring data from monitor to module
Engage with Spacelabs to discuss effective data capture process	Advanced Nurse Practitioner (ANP) Intensive care to communicate with Spacelabs representative	18/05/22		25/05/22 Communication received from Spacelabs	The data capture process is complex but potentially is not robust in present format for clinical staff to manage 24/7. There is potential for alternative individual monitor solutions and/or central monitoring solutions which require further investigation.
Face to face meeting to review ICU Spacelabs central monitoring system capabilities	ANP to communicate with Spacelabs to arrange meeting	08/06/22		16/06/22 Face to face meeting arranged between Spacelabs and ICU ANP	
Engage with Spacelabs, IT and Clinical Engineering to define and agree a process to effectively data capture from	ANP- Intensive Care emailed representatives from all specialist departments and company to proceed to a	25/05/22	Add to medical equipment training for Spacelabs monitoring when confirmed.	21/06/22 Planned meeting with key representatives from identified departments	Business case pre-approved and priority funding agreed to ensure IT & Spacelabs can update the

Improvement Objectives	Actions Taken	Start date	Additional Support required	Review Schedule	Outcome
Spacelabs monitoring 24/7 in the event of a clinical incident	meeting for resolution			Confirmation of contracts signed and work commenced will be provided ASAP.	Spacelabs Intesys Clinical Suite (ICS) held in the central station to store 72hrs of any patient data who has been on a monitor in ICU or elsewhere in the trust and has since been discharged from that monitor. 72hrs of data can be accessed from the moment a pt is discharged. However, the amount of data available reduces over that time frame as it's not designed as a data repository.
All RNs to receive training and be assessed as competent on transferring data from monitor to module	Senior nursing team provided one to one, small group training ongoing training.	21/06/22	Add to medical equipment training for Spacelabs monitoring	Ongoing	In a situation where harm or death has occurred and the patient has not been discharged from the monitor then additional time points can be added to assessments that will pull through observations at that time point. Observations will not be corroborated in real time and some readings may be artifactual if

Improvement Objectives	Actions Taken	Start date	Additional Support required	Review Schedule	Outcome
					monitoring is not correctly attached at the time (dampened arterial line trace, sats probe that is incorrectly positioned etc) leading to inaccurate data.
Ensure that nursing staff must position themselves to have visibility of the monitor and when monitoring is deemed appropriate, audible alarms set should reflect and augment the parameters monitored.	Matron has communicated this to all RNs	26/04/22	Band 7s have communicated this message via the 'safety huddle' which is communicated at every nursing hand over.	09/06/22 Evaluated, minuted and reiterated at senior nurses meeting	Continue to reiterate the message to all staff, face to face, safety huddle, role modelling and direct support to ensure compliance.
Ensure that if monitoring is deemed appropriate, audible alarms set should reflect and augment the parameters monitored.	Band 7 has communicated to Consultant Intensivist Leads, Band 7 & 8 RNs to support this process and ensure that this is being followed when attending patients and during ward rounds.	16/05/22		27/06/22 To evaluate at Intensive Care senior nursing, medical and AHP group	

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Board of Directors	Date: 20 September 2022
Report title:	Incident and Learning Report	Agenda item: 9
Lead directors **Report author** **Sponsor(s)**	Ian Reckless Kate Jarman Tina Worth	Medical Director Director of Corporate Affairs Head of Risk and Clinical Governance
FoI status:	Public document	

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

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

Report history	Quality and Clinical Risk Committee
Next steps	Quarterly reporting detailing analysis and trends and relevant learning from SI investigations
Appendices	Appendix 1 - SI log for Quarter 2

Quarterly review July to September 2022 (Q2)

Executive summary

This report summarises the position from a Trust perspective in relation to serious incidents (SIs) and any concerns raised by HM Coroner. This report details SI and inquest activity throughout the second quarter of the financial year (including noted trends, learning and concerns).

There were 128 SIs on the live log as of 8 September 2022.

There were 28 SIs in total this quarter (up to 8 September) reported on STEIS.

The 28 SIs can be broken down by month reported as follows. This is higher than the previous month and may increase as the month progresses.

- July - 13
- August –15
- September - 0

Definitions

Radar - Healthcare and risk management software systems for incident and adverse events reporting. *The Trust moved from Datix to this new system on 15th November 2021.*

Serious incident - Serious incidents/events are events in healthcare where there is the potential for learning or the consequences to patients, families, carers, staff or organisations are so significant that they warrant using additional resources to mount a comprehensive response.

'Never Events' - Serious Incidents that are 'serious largely preventable patient safety incidents that should not occur if the available preventative measure had been implemented by healthcare providers'.

'Being Open' - Being open is a set of principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident in which the patient was harmed. A culture of openness, honesty and transparency, includes apologising and explaining what happened to patients, carers and relatives.

Duty of Candour - The duty of candour requires all health and adult social care providers registered with CQC to be open with people when things go wrong.

STEIS - Strategic Executive Incident System (STEIS) is a single reporting structure which allows for management information to be shared across the country and for organisations to benchmark its performance against others.

Stop clock guidance (out with) - A stop clock request can be made to the CCG where there are circumstances that make a timely completion of the RCA investigation within the set time

frame per the commissioning contract difficult or not possible to comply with or where these are externally led investigation for example Healthcare Safety Investigation Branch (HSIB)

RIDDOR – Work related accidents and injuries. The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

Downgrade request – Where investigation has highlighted that the incident/event was unavoidable (e.g. hospital acquired pressure ulcer) or where the Trust's involvement did not have any correlation to the incident/event and was in line with best practice (e.g. child deaths in the Emergency Department), SIs can be downgraded and removed from the Trust's SI log

Trust's Serious Incident Review Group (SIRG) – The Trust's SI review group consisting of executive and senior staff who ensure a systematic, holistic, multi-disciplinary and proactive approach to the management of SIs and who hold divisions to account for non-compliance.

Root Cause Analysis (RCA) – A problem solving investigation process designed to identify the contributory factors and ultimate root cause of an incident and facilitate appropriate actions based on the evident learning. The Trust uses standard templates for RCA investigations.

HSIB - Healthcare Safety Investigation Branch

Regulation 28 report/Preventing Future Death report – The Coroners and Justice Act 2009, places a statutory duty on coroners to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be undertaken to prevent future deaths.

Serious Incident Reporting Process and Timeframes

All potential serious incidents are reviewed at Executive level and by the CEO before being reported on STEIS. The Trust then manages the SI investigations through the event module on Radar. SIs currently have an internal 20-day deadline for draft RCA reports to be completed and presented at the SIRG. Once approved by SIRG the RCAs are submitted to the Clinical Commissioning Group (CCG) for review by day 45. Any breaches in submission may incur a financial penalty. If the CCG has any questions concerning the RCA reports or require more information this is managed through the Risk Management Team. RCA reports are only closed on STEIS and Radar once the CCG feel assured appropriate learning is in place and evidence has been submitted to support the completion of the RCA action plans from two randomly chosen SIs.

The Trust uses internet software called Radar to register and track all SIs including the attaching of all associated evidence documentation. Radar also enables reports to be generated by location, incident/event type and date etc. to help with analytical review and deep dives. Radar also enables automatic communications requesting/following up reports.

SIRG meetings

SIRG was introduced to ensure that there was a corporate, senior robust process for the approval of SIs, with Trust wide sharing and learning, deep dives of noted trends and multi-disciplinary approval of RCA and action plans. The group has representation from the divisions and is chaired weekly by the Associate Medical Director, Medical Director, Chief Nurse or Director of Corporate Affairs (the Associate Medical Director is the default chair – although all Directors may be in attendance). In a no blame environment, staff are invited to present their draft RCAs and take any questions from the group before approval is given or request for representation later. All moderate incidents from the preceding week are also discussed to determine if they meet SI criteria &/or require further investigation. SIRG has very much seen a significant improvement in the quality of RCAs and the analysis of incidents, with smarter and achievable action plans to allow follow through of the learning and evidence that it has been completed and/or embedded.

The Risk Management Team subsequently track submission of the required RCA action plan evidence within the due date (5 working days of the agreed due date) with breaches reported on the weekly SI live log spreadsheet and divisions held to account for noncompliance.

SIRG also reviews all incidents/events reported on the Radar system the preceding week with a grading of moderate or above, to consider if the grading is appropriate and/or further information is required to determine an SI. By taking this approach all incidents that are reported with a higher severity are collaboratively reviewed and discussed enabling cross specialty scrutiny. Trends are also assessed from an incident category perspective and contributory factors with recent assurances sought from relevant teams/specialties.

SIRG receives monthly reports on inquests, claims and SIs which focus on trend analysis and learning and any areas of concern for further review.

Clinical Governance Leads (CGLs)

CGLs work for the Risk Management Team with one allocated to work for each Division. Their role is to work collaboratively with RCA Leads in the investigation of incidents/events and to ensure that Divisions and Clinical Service Units (CSU) are kept informed of progress, key learning and trends and areas of noncompliance. Key learning is included in departmental newsletters, messages of the week, local training, governance and departmental meetings. The CGFs also ensure cross divisional learning from incidents/events that may be replicated in other areas.

Mortality and Morbidity (M&M) processes

The Trust has robust processes in place to ensure that all deaths are reviewed in line with the Department of Health and Social Care's (DHSC) national guidance on learning from deaths. As part of this process where deaths at M&M meetings are deemed to be avoidable and/or there were significant care/quality concerns and the death has not previously been reported as an incident on Datix, a retrospective incident/event report is logged enabling these deaths to be investigated as SIs through the RCA process. Particular attention is focused on any learning disability deaths in line with the national DHSC position.

Main Report

The new national Patient Safety Framework (PSIRF) was released in August outlining the new way forward for incident and serious incident investigations. The PSIRF supports organisations to harness their resources for patient safety investigation in the most effective way and introduces a range of national tools and templates to support learning and improvement. This will be a transitional process over the next 12 months but looks to bring in:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Proportionate response to patient safety incidents to maximise improvement, rather than repeatedly responding to incidents on the threshold of harm, from which learning would be limited
- Supportive oversight focused on strengthening response system functioning and improvement

This is a significant change with a focus very much on the system rather than the person and has a variety of tools and techniques for investigation rather than just root cause analysis/72hr reports.

Recognising that organisations have finite resources for patient safety incident response, PSIRF supports organisations to use their incident response resources to maximise improvement, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited. Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care (that is, those meeting the Learning from Deaths criteria for investigation) all require a PSII to learn and improve. Some incident types will also require specific reporting and/or review processes to be followed.

Incident response activity going forwards may include investigation of an individual incident where contributory factors are not well understood, or a thematic review of past learning responses to inform the development of a safety improvement plan. After action reviews will also be adopted where local investigation is appropriate and patient safety incident investigation (PSII) reports where more analysis is required to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive and the drafting of safety improvement plans, with the move away from the term 'lessons learned'.

Serious Incidents Reported (June - 8 September 2022)

There have been 28 SIs reported so far this quarter. For details of all SIs please refer to appendix 1.

The top reported categories remain new pressure ulcers and medication incidents with a high recognition of the need to analyse these, re-assess previous actions for robustness and embedding and implement action plans to mitigate ongoing incidents. The Harm Improvement Group (HIG) has an overarching action plan and is planning an innovative and interactive session at event in the tent on harm from both pressures and falls. The thematic review undertaken for a previous cluster of deep tissue injuries (DTIs) on Ward 1 using the new SAFE approach saw staff proposing recommendations that will be tracked via HIG:

- Exploring the use of music and dance to encourage mobilisation.

- Exploring how we can we make it the 'norm' for patients to be sat out on a chair rather than in bed.
- Support from the Acute Assessment and Frailty Team (AAFT) to help with skin assessments and empowering patients and carers to help themselves.
- Doctors highlighting 'risk of pressure damage' in clerking like they do with falls.
- If the pop up for Waterlow score of >10 could automatically initiate the care plan rather than having to do it manually.
- Clearer more accessible information about the care plan for high-risk patients (time consuming to find on eCare and not everyone looks such as HCAs)

There has now been a trend of five DTIs being reported on Ward 23 across a 3 week period, which was recognised as concerning given the short space of time. Three have been reported as SIs. Early analysis has identified that for one of the cases the mattress was connected to a pump however the pump was not turned on and in discussion with different members of staff including nursing and therapy teams, not everyone is aware of the risk this poses.

An initial action plan has been collated pending a triangulated SAFE review approach rather than the standard RCA, in line with future patient safety framework.

Action:

- On the ward training sessions for beds and mattresses
- Publish QR codes for training video behind nurses' station and on ward
- Continue Top to Toe Rounds including senior nurse 3 times a week review of any patients with skin damage
- Allocated time to escalate and review anyone high risk of pressure damage
- Review of documentation and pressure prevention methods
- Daily Mattress checks to include pump on the correct setting, pump attached and on, clarity if patient requires a pump and is a Dolphin Mattress required
- Risk assessment of physical environment of Ward 23 and the implications this may have on care provided
- Review number of air mattresses and pumps for all beds so that when patients are admitted staff down grade rather than upgrade

Medication incidents remains a high reported SI. Following 3 CD related SIs and a number of near miss harm incidents on Ward 25 they have undertaken process review analysis which recognised the following concerns/risks:

- WOWs are bulky and can be difficult to manoeuvre
- Scanners often go offline/do not work
- No visible drug chart used when administering
- Not all packaging allows to scan (if packed down from pharmacy)
- Distance from WOW can affect scanning
- Layout of area means the CD cupboard can be a long way from the patient's room
- Interruption on route to administer
- Controlled drugs have to be manually identified before the round by nurses looking through every drug chart or have on handover.
- Drug WOW not tethered when in use due to absence of anchor points
- Risk to patients with regards Infection Control when taking the drug WOW into patients in isolation
- Risk to Information Governance with patient's details being left open on the screen when nurses go into the room.

- Medication is not always available either in the POD locker/Drug WOW/treatment room (time is spent trying to locate and may be forgotten after round)
- Medication not available is often left until the next drug round causing delay to treatment. It can be difficult to find stock from other wards due to the distance.

A collaborative approach with IT, Pharmacy and staff has seen an overarching action plan with the aim of ensuring safe CD administration and links in parallel with the work of the empathetic ward and how layout deficiencies influence practice. Actions since taken include:

- Laptop on wheels, including a scanner for ease of access into rooms
- Ward agreeing to pilot handheld scanners for scanning patients
- 'Lockdown' approach to drug rounds so staff are not disturbed
- Daily identification at the huddles of patients' CD needs with allocated nurses to administer these (buddy system)
- Colour coded keys matched to WOWs with separate CD keys

Scanning compliance has since seen an improvement and there have been no further reported incidents.

There is also a Trust medicine management safety working group looking at various aspects flagged during incident/SI investigations including error medicine reconciliation on admission and bespoke patient groups like those with Parkinson's disease, liking in with eCARE and how the system can be adapted for ease of prescribers/administrators and the use of alert flags.

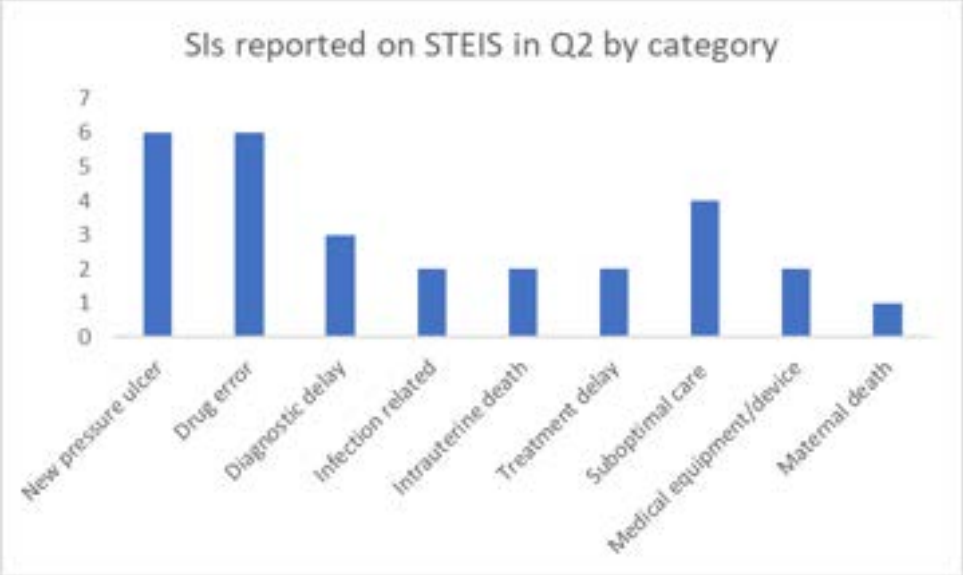

Chart 1 – SIs reported on STEIS in Quarter 2 (July to 8 September 2022) by category

SIRG has also seen an increase in MSSA bacteraemia healthcare associated incidents which Infection Prevention and Control (IPCT) see as concerning in the sense that appears to be little improvement in care despite a wealth of action points/plans/messages of the week being described. IPCT are arranging further training and have reiterated guidance on blood culture protocols/cannula insertion in line with best practice. The senior nursing team are also monitoring VIP score compliance on wards.

Chart 2 shows the trend analysis over 2021 – 2022 for the top reported categories.

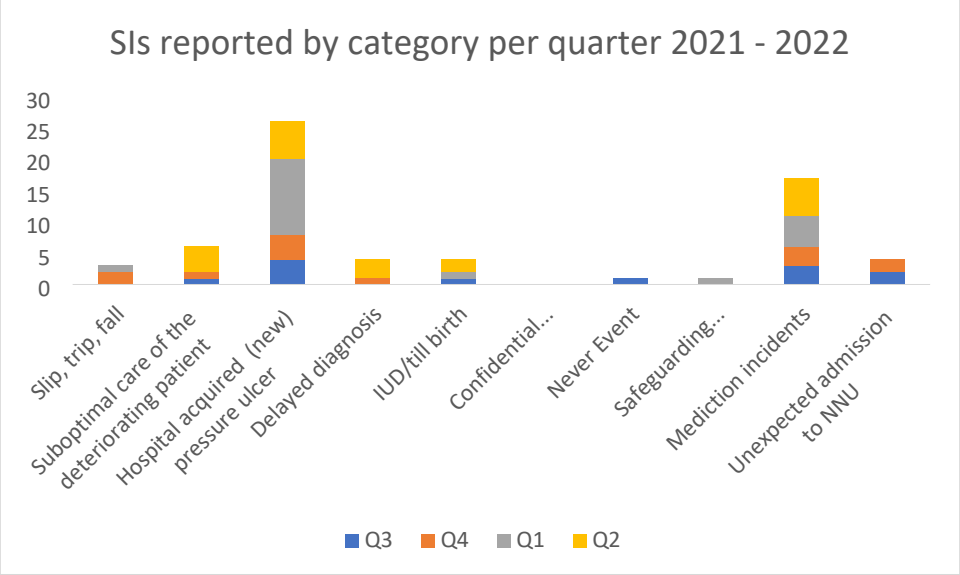

Chart 2 Top SIs by category and by quarter (Q3 October to December 2021, Q4 January to March 2022, Q1 April to 30 May 2022 andQ2 July to 8 September 2022)

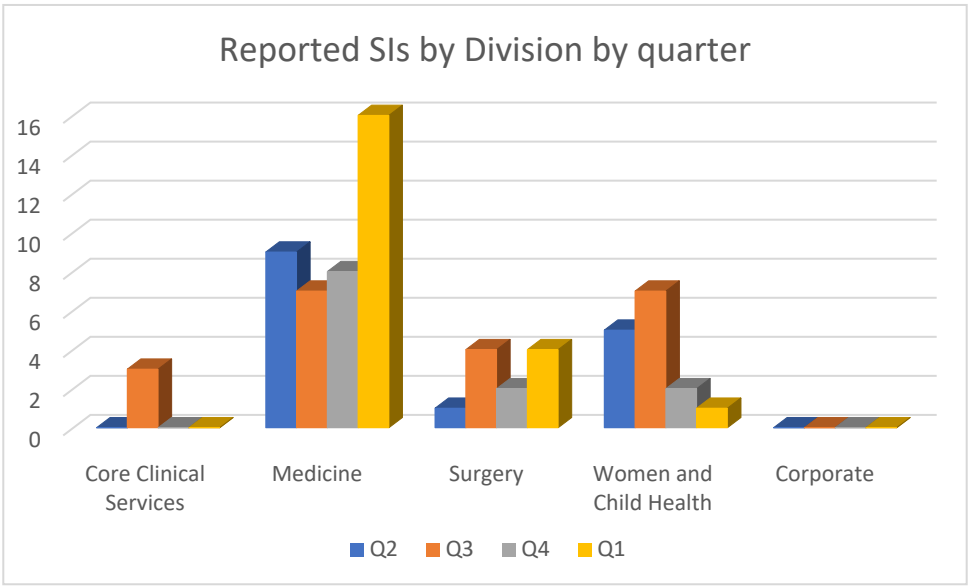

Chart 3 – SIs by Division per Quarter 2021 - 2022

From a responsible Clinical Service Unit (CSU) (as shown in chart 3) most of the SIs occurred across Medicine which is the same as previous months. Medicine is the largest CSU with the highest patient flow throughput.

Specific SI cases:

***2022/13892:* Medication error**

Root cause:

- Failure to follow the correct procedure for administering medications.
- Dr input on prescription
- Assumed patient would tolerate routine prescribing of opiates, Doses prescribed are not recommended by palliative care. Palliative care not consulted regarding doses
- No regular observation of blood picture, EGFR, or potassium to identify the need to switch opiate.
- Routine prescription for Naloxone, not considering patient as an individual and the impact of doses prescribed. Partial reversal using Naloxone is recommended in this scenario
- Contributary factors – prescription commenced on Friday, was then not flagged until Monday when majority of deterioration had occurred.

Recommendations:

- Medicines management review of Ward 25 drug administration process (note update in main report)
- Education planned for Opiate and Opioid prescribing in AKI + for naloxone prescribing and management in the cancer patient with AKI + understanding of AKI in the cancer patient
- Scanning compliance to be monitored monthly and shared with the team
- Staff involved to update their medicines management training.

2022/16309: **Delay in accessing care**

Root cause:

Delay in patient accessing emergency treatment.

Provisional recommendations:

- Update pathology standard operating procedure (SOP) for Identifying and Reporting Markedly Abnormal Laboratory Test Results
- SOP for acceptance of GP referrals via Medical Registrar
- Streaming Nurse Presence til 22:00 hours
- ED should create a triage working party with the remit of creating an SOP clarifying what is expected to be done to comply with guidelines, what steps should be taken to achieve them, how progress will be measured and how critical issues such as long delays for triage should be escalated.
- When the waiting times exceed agreed threshold, EPIC and NIC should consider sending extra staff (nurse or doctor) to triage and minors to ensure no sick patients are missed.

2022/13866: **Maternal death day five post-delivery**

The external appearance (scarlet fever), internal pathology and histopathology, microbiology all indicated a fulminant Group A Strep infection – the classical cause of

puerperal sepsis. Public health England (PHE) are investigating how and where the mother might have acquired the infection. This SI is being investigated by Healthcare Safety Investigation Branch (HSIB).

2022/17516: **MRSA reported in blood cultures**

Initial findings:

This is a multi-faceted case with many issues that could have contributed to the patient developing MRSA.

Initial recommendations:

- Development of teaching sessions for junior doctors and nursing staff
- Development of a Trust guideline on peripheral insertion and the care of patients with a cannula

2022/13887: **Medication incident where a patient was administered 1g of Paracetamol on the Day Surgery Unit (DSU) and a further 1g of Paracetamol her procedure in theatres.**

Initial recommendations:

There are a number of alerts in Powerchart around Paracetamol ensuring there is only one paracetamol prescription on the drug chart at any given time, alerting users if the patient has had a dose within 4 hours and counting number of doses in the previous 24-hour period. The issue is that this error (and others previously) happens when a dose is documented as given in Anaesthesia.

It remains important for anaesthetists to review the drug chart summary in eCARE before administering any further medications. The EPMA Lead Pharmacist is to put together a brief one-pager on how to set up your drug chart summary to make it quick and easy to check if the patient has received paracetamol or an antibiotic prior to arriving in theatres.

Regulation 28 report/PFD

INC-2553

The patient was transferred to Milton Keynes Hospital Intensive Care Unit (ICU) from the John Radcliffe Hospital after being admitted following a road traffic collision (RTC) on the 23/10/21. He had extensive polytrauma. On the 12/12/21 he was found not breathing and in cardiac arrest. The Tracheostomy inner tube was full of secretions. It was replaced and advanced life support was given but stopped given no reversible cause found or return of spontaneous circulation.

A letter was sent to the CEO regarding two points:

- “Data that is stored by the monitoring machines used within the hospital, in particular on the intensive care unit. I understand that the machines themselves are able to record data relating to the monitoring of the patient, but this data is then lost when

the machine is reallocated to another patient. In future we will require the recorded data to be saved or downloaded before the machine is reallocated so as to preserve that information for the use of the Court. We shall be grateful if this proposal can be considered by the hospital and a system put in place to ensure that this practice is implemented as soon as possible."

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

For Trust response please see Appendix 2. With further regard for eCARE records it has been clarified that if HM Coroner opens downloaded records using Adobe a table of contents appears which they will be able use to navigate the notes. We are also looking to arrange a demonstration session for the coroner's officers and HM Coroner on how eCARE looks electronically to better help them understand the views of records they receive and why information is duplicated, as part of the system's automatic pull through.

Duty of Candour (DOC)

The Trust is required to report compliance to the CCG for each quarter in relation to both elements of the ruling (initial discussion and formal written follow up) on all SIs.

In quarter 1 the Trust reported 0 breaches. Quarter 2 data is currently being validated.

Recommendations

The Quality and Clinical Risk Committee is asked to acknowledge this report and to make any recommendations for future monthly reporting.

Appendix 1 SI log for Quarter 2 2022 – 2023 (with 2 incidents from the end of Q1 – in green below)

SI reference no.	Category	Location/department/CSU
2022/11699	Unplanned admission to the Neonatal Unit (NNU)	Labour Ward
2022/11701	New pressure ulcer	Ward 19
2022/13811	Intrauterine death (IUD)	Labour Ward
2022/13866	Maternal death	Patient's home
2022/13885	Medication error	Ward 20
2022/13887	Medication error	Theatres
2022/13889	Treatment delay	Ophthalmology
2022/13892	Medication error	Ward 25
2022/13917	Treatment delay	Ophthalmology
2022/14996	Medication error & unexpected adult death (2 x separate incidents combined into 1 SI)	Ward 3
2022/14997	Medication error	Ward 1
2022/15638	Diagnostic delay	Radiology
2022/15640	Unexpected adult death	Ward 1
2022/15809	Medication error	Theatres
2022/16309	Unexpected adult death	Emergency Department (ED)
2022/16310	Intrauterine death (IUD)	Labour Ward
2022/16728	Suboptimal care deteriorating patient	ED
2022/16729	Hospital acquired infection	Ward 21
2022/17516	Hospital acquired infection	Ward 8

2022/17927	New pressure ulcer	Ward 20
2022/17929	New pressure ulcer	Ward 23
2022/17931	Unexpected adult death	Ambulatory Emergency Care Unit (AECU)
2022/17932	Violence and abuse	Ward 15
2022/18469	Delayed diagnosis	ED & Gynaecology
2022/18470	Medical device complication	Ward 5
2022/18471	Medical device complication	Intensive Care Unit (ICU)
2022/18472	New pressure ulcer	Ward 23
2022/18473	New pressure ulcer	Ward 1
2022/18474	New pressure ulcer	Ward 23
2022/18475	New pressure ulcer	Ward 23

Those in green were reported in the previous quarter after the previous QCRC report was presented.

Appendix 2:

120722 Letter to Coroner.docx PDF.pdf

SUBJECT Complaints Annual Report

DATE April 2021 to March 2022

REPORT BY Julie Goodman, Head of Patient and Family Experience

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1. Executive Summary

This is the complaints annual report for Milton Keynes University Hospital NHS Foundation Trust (MKUH) for the period 1 April 2021 to 31 March 2022. In this year there were:

- 100429 attendees to the Emergency Department
- 23828 elective admissions
- 31524 emergency admissions
- 404766 outpatient attendances
- 3724 babies delivered

The National Health Service Complaints (England) Regulations 2009 state that all Trusts must prepare an annual report on the handling and consideration of complaints. This report provides detail on the required inclusions and will be made public on the Trust's website and sent to the commissioners of the Trust.

National regulations are further supported by the publication of national reports including the Francis Report 2013, Clwyd and Hart Report 2013, Designing Good Together Parliamentary and Health Service Ombudsman (PHSO) 2013, and My Expectations for Raising Concerns and Complaints (PHSO) 2015. All reports highlight best practice in respect of dealing with concerns and complaints. Extensive analysis of the NHS England's toolkit - 'Assurance of Good Complaints Handling for Acute and Community Care - A toolkit for commissioners', has demonstrated that the Trust's complaints service and process is robust and accessible to our public.

Complaints are an important feedback tool and are a strong indicator of patient experience. The vision of the Trust is that we want all people using our services to be able to say, 'I feel confident to speak up and making my complaint was simple', 'I felt listened to and understood', and 'I felt that my complaint made a difference'.

2. Summary of NHS Complaints Procedures

In April 2009 the NHS Complaints Procedure was amended and the latest NHS (Complaints) Regulations came into force. The Local Authority Social Services and NHS Complaints (England) Regulations 2009 are a Statutory Instrument that all Trusts including Foundation Trusts have a duty to implement. Whilst the procedures are not prescriptive the regulations set out various obligations for NHS bodies in relation to the handling of complaints. Since 1st April 2009 there has been a single approach across Health and Adult Social Care in dealing with complaints. The regulations set out a two-stage complaint system:

Stage 1 Local resolution – working with the complainant to understand and resolve their concerns in a timely and proportionate way.

Stage 2 Referral to the Parliamentary and Health Service Ombudsman (PHSO) – if local resolution is not successful and complainants are dissatisfied with the way their complaint has been handled, they can refer their case to the Ombudsman for review.

National complaints legislation requires that concerns raised by the public are responded to personally and positively and that lessons are learnt by the local organisation. The local resolution stage focuses on the complainant and enabling organisations to tailor a flexible response that seeks to ensure all complainants receive a positive response to their complaint or concern. It places an emphasis on resolving complaints or concerns as fairly and as quickly as possible and ensuring that lessons are learned and shared to improve the experience of care.

The Parliamentary and Health Service Ombudsman is a free and independent service, set up by Parliament. Their role is to investigate complaints where individuals feel they have been treated unfairly or have received poor service from the NHS in England. If local resolution is not successful, the complainant can refer their case to the Ombudsman for review. The Ombudsman makes the final decisions regarding the complaints individuals make about the NHS.

3. MKUH Complaints Process

Systems and processes are in place within the Complaints and PALS teams to provide the Trust Board with assurance that:

- All complaints are well managed
- The learning from complaints is identified and used for improvement
- The complaints service is accessible, open, and transparent

Each complaint provides an opportunity for the Trust to learn and introduce improvements in areas that patients, carers, and relatives tell us are important to them when using our services. We understand that handling concerns and complaints effectively matters for people who use our services. Our patients deserve an

explanation when things go wrong, and they have a right to know what tangible changes have been made to prevent something similar happening to someone else.

Every complaint is triaged by a senior corporate nurse and the Head of Patient and Family Experience or his/her deputy. This is to ensure an appropriate investigation into the issues raised is undertaken and any potential safeguarding concerns are identified immediately and acted upon.

The remit of PALS is to provide advice and information and deal with informal complaints and to provide guidance on how to make a formal complaint, if requested. The team administrate the investigative process for any matters of concern that may have caused low or no harm and focus on resolving issues without the need for a formal process. If concerns are regarding current or treatment that has taken place very recently action should be taken to resolve the issues as soon as possible to ensure the person goes on to have a good experience. Not every complaint needs to be resolved by an in-depth investigation.

Complaints that are more complex and raise issues that may have caused serious or moderate harm require a formal investigation. These formal complaints are administrated by the Complaints team and an investigation is undertaken by the relevant senior clinical staff/manager.

The Complaints and PALS team aim to provide a person-centred approach to all comments, compliments, concerns, and complaints. The Trust actively encourage staff closest to the care and services being received to deal with concerns and problems as they arise. This is to ensure that issues are remedied quickly, and the Trust can be responsive to individual needs and circumstances to improve the experience of the patient. Such timely intervention can prevent an escalation of a complaint and achieve a more satisfactory outcome for all involved. The Trust encourages concerns and complaints and ensures that any lessons learnt are shared throughout the Trust and this information is used to inform service improvements for our patients and public.

When dealing with complaints, the principles, as laid down by the Parliamentary Health Service Ombudsman (PHSO), should be taken into consideration and adhered to. The principles are as follows:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

Most importantly, the Trust should put the complainant at the centre of process and ensure that the complaint is dealt with in the way the complainant wishes, wherever possible. The Trust should not decide on behalf of the complainant how the complaint will be processed, and the decision should be made in conjunction with the complainant.

4. Annual Complaint Figures

MKUH is organised into four core divisions, these are Surgical Services, Medical Services, Women and Children's Services, and Core Clinical Services. Each division is led by a triumvirate team which incorporates a Divisional Director, Chief Divisional Nurse, and an Associate Director of Operations, who are collectively supported by Corporate Services.

The complaint numbers during 2021/22 have been collated for each division and the number and type of complaints received has been closely monitored and analysed to identify themes and trends to inform future improvements moving forward.

A total of **1044 complaints** (formal and informal) were received by the Trust during 2021/22, as detailed on the chart below, this an increase from 2020/21 of 25.5% (n=832). The number of formal complaints totalled 161 and informal complaints 883.

	Q1 Apr - Jun 21	**Q2 Jul – Sep 21**	**Q3 Oct – Dec 21**	**Q4 Jan – Mar 22**	**TOTAL**
Complaint Numbers	264	250	260	270	1044 (n = 832 2020/21 **increase 25.5%**)

National complaint regulations state that any concern resolved within 24 hours does not have to be reported as a complaint. Resolving concerns and issues in a timely manner ensures that the patient/family can move on to have a better experience.

A key performance indicator (KPI) was assigned to the PALS team to achieve resolution of 30% of the concerns raised within 24 hours. This KPI was achieved in 2021/22 with a result of 34.8%. There was also an increase in the number of concerns resolved within 24 hours when compared to 2020/21 and the increase amounted to 158.5% (n= 352 - 2020/21 and 558 - 2021/22).

The information arising from concerns that are resolved within 24 hours is recorded on the Trust's event reporting database separately to complaints. This ensures that valuable information is retained and used to determine performance and learning across the divisions in relation to all feedback.

5. Responding to complaints

The following definitions are used to provide clarity about whether an issue of concern is handled in line with the NHS complaints procedure and to ensure that the Trust provides the most appropriate response.

Formal Complaint – A formal complaint can be defined as an expression of dissatisfaction with the service provided (or not provided) or the circumstances associated with its provision which requires an investigation and a formal response to promote resolution between the parties concerned.

Informal Complaint – An informal complaint can be defined as a matter of interest, importance or anxiety which can be resolved to the individual's satisfaction within a short period of time without the need for formal investigation and formal correspondence. Informal complaints are received by staff throughout the organisation. Where it has not been possible to resolve the complaint quickly (i.e., by the end of the next working day) and to the satisfaction of the person raising it, they will be asked if they would like their concern investigated as a formal complaint under the NHS Complaints Regulations (2009). All complaints whether resolved by the next working day or not are recorded and reported on and reviewed, collated, and analysed on a local basis.

It is important that complaints are handled in accordance with the needs of the individual case and investigated fairly and proportionately.

The Trust follows the Department of Health guidance and legislation (the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009) which outline the requirement to acknowledge all complaints within three working days. Under current legislation Trusts have six months in which to resolve a complaint to the satisfaction of the complainant providing a more flexible agreement with each complainant. MKUH aims to provide a response in as timely a manner as possible and work to an internal benchmark of 30 working days or 60 working days for complaints graded as Red (severe harm).

To ensure that people feel safe and supported to make a complaint, everyone is directed to additional information, advice, and advocacy support. Complainants are also signposted to the Parliamentary and Health Service Ombudsman (PHSO) (stage 2 of the NHS complaints process) where they remain dissatisfied with the results of the Trust's investigation and complaint handling.

All complaints are dealt with in line with the Trust's complaints policy which includes an initial triage process to ensure complaints are investigated at the appropriate level and in a timeframe considering the severity of harm. Each complainant is given the opportunity to speak directly to the Complaints or PALS team to discuss their complaint in further detail to ensure expectations can be met. This process ensures absolute clarity on the issues to be addressed and confirms what the complainant wants to achieve as an outcome from the process, along with how they would like to receive their response, in writing or a meeting with responsible medical staff, or both.

6. Complaints referred to the Parliamentary Health Service Ombudsman

During 2021/22, 11 cases were referred to the PHSO as follows.

Total cases referred to the PHSO	Number of cases awaiting investigation by the PHSO	Number of cases where recommendation(s) made	Number of cases where the PHSO deemed there was no case to answer
11	8	1 (Financial remedy of £300 for the distress caused as a result of experience in Women Services)	2

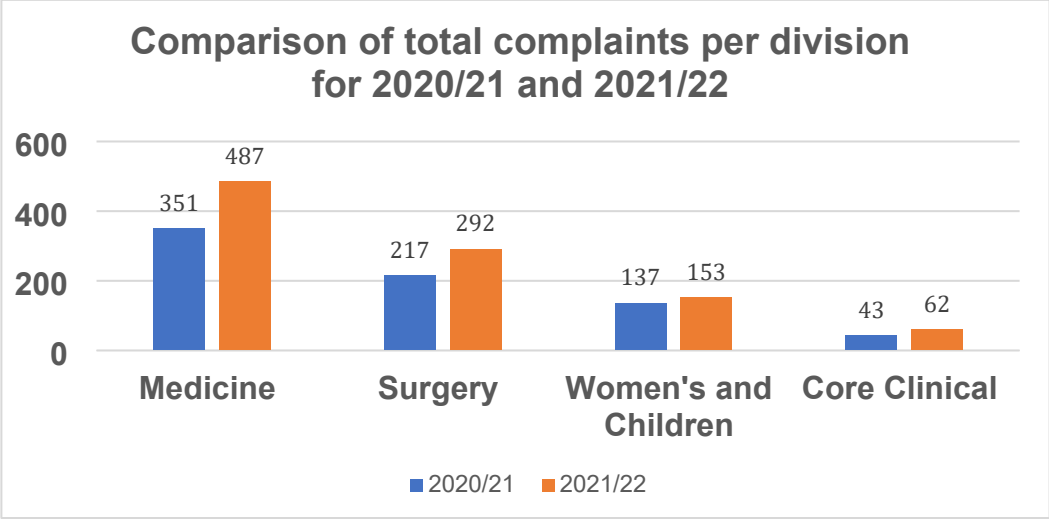
7. Complaint statistics

The 1044 complaints received in 2021/22 were represented across all divisions. Due to the changes to the organisational database in the middle of November 2021 (Datix to Radar), it has not been possible to provide some statistical information for the whole year. This is due to the dashboard and reporting facility of Radar still being under development and construction. It has been noted against each graph where a fully year's information is not available.

Complaints by division

The chart below compares the number of complaints received for the four main divisions for 2020/21 and 2021/22.

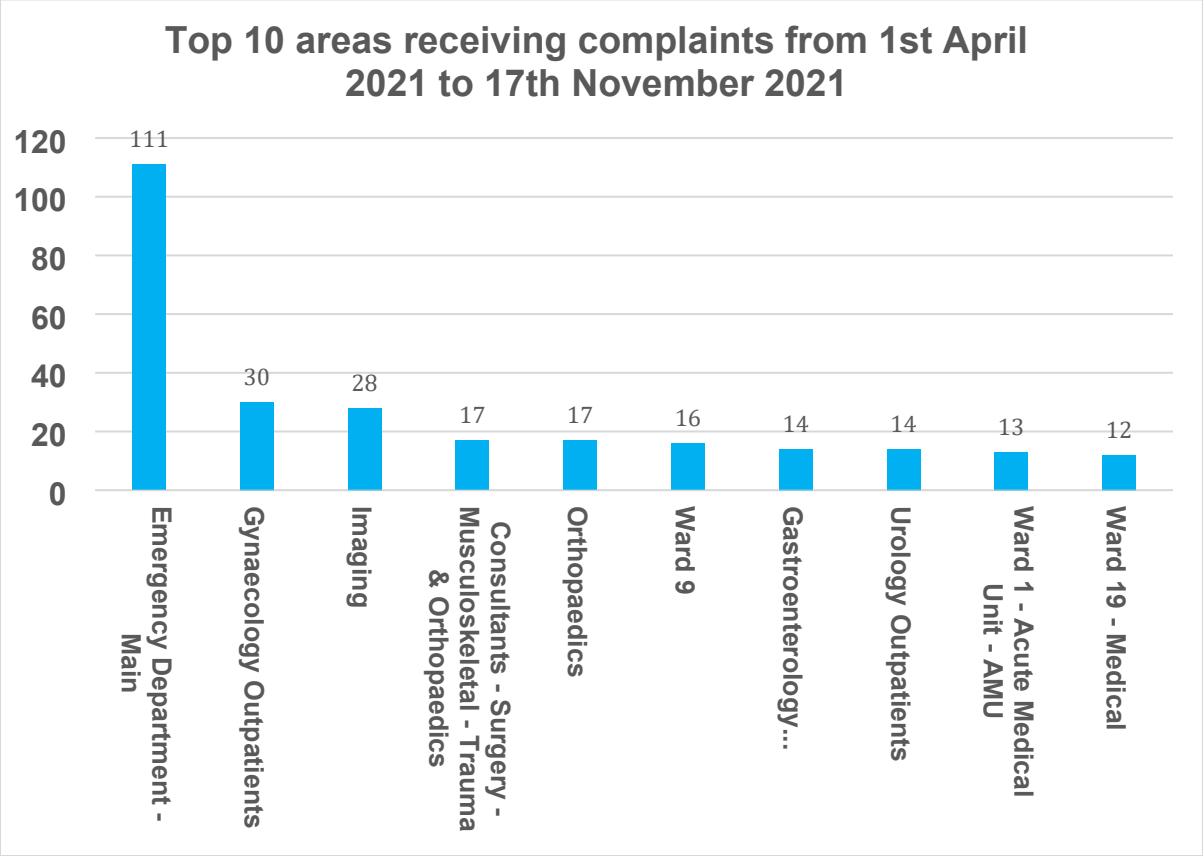
Chart 1 – Comparison of total number of complaints per division 2020/21 and 2021/22



8. Complaints by area

The chart below details the top 10 areas receiving complaints in 2021/22, **from 1st April 2021 to 17th November 2021 only.**

Chart 2 -Top 10 Complaint areas for all complaints 1st April 2021 to 17th November 2021



9. Responding

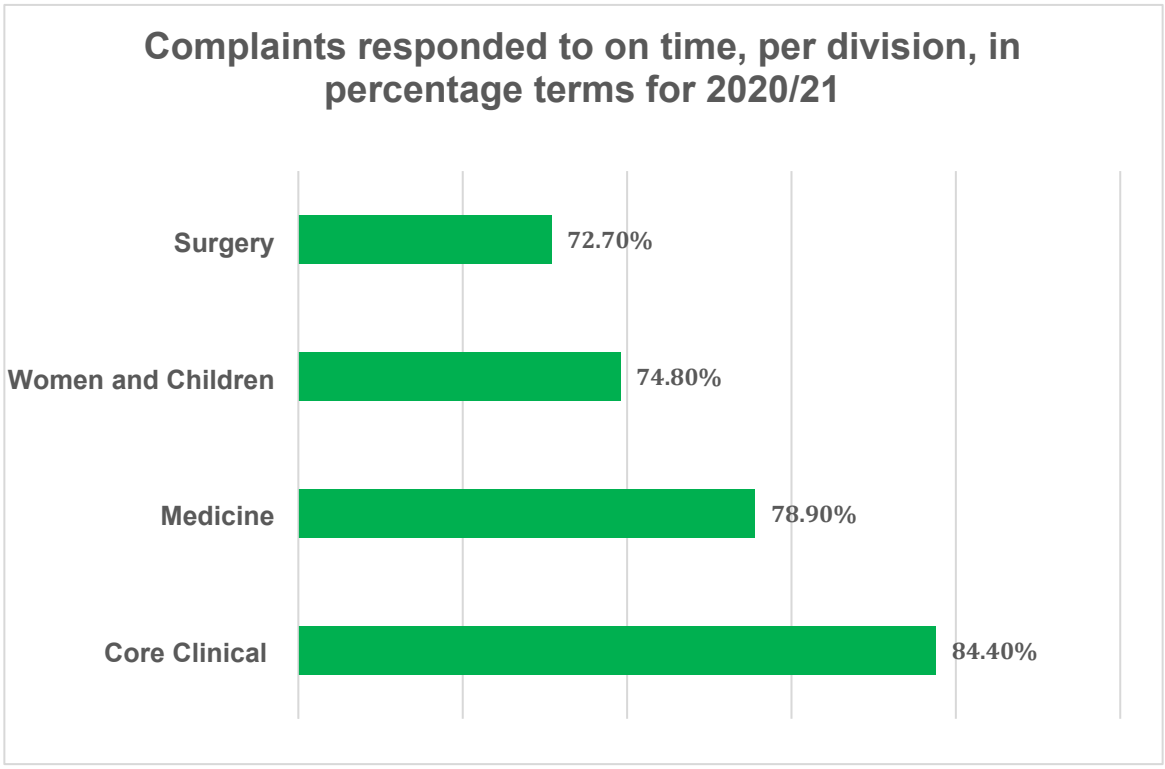
Each triaged category has agreed Trust timescales in which a response to the complainant should be made, as follows:

Green and Yellow (No and Low Harm):	15 Working Days
Amber (Moderate Harm):	30 Working Days
Red (Severe Harm):	60 Working Days

The chart below details the number of complaints responded to on time per division in percentage terms for 2021/22 This information is for **11 months only** as during

December 2021 this information could not be obtained from the new event reporting system, Radar.

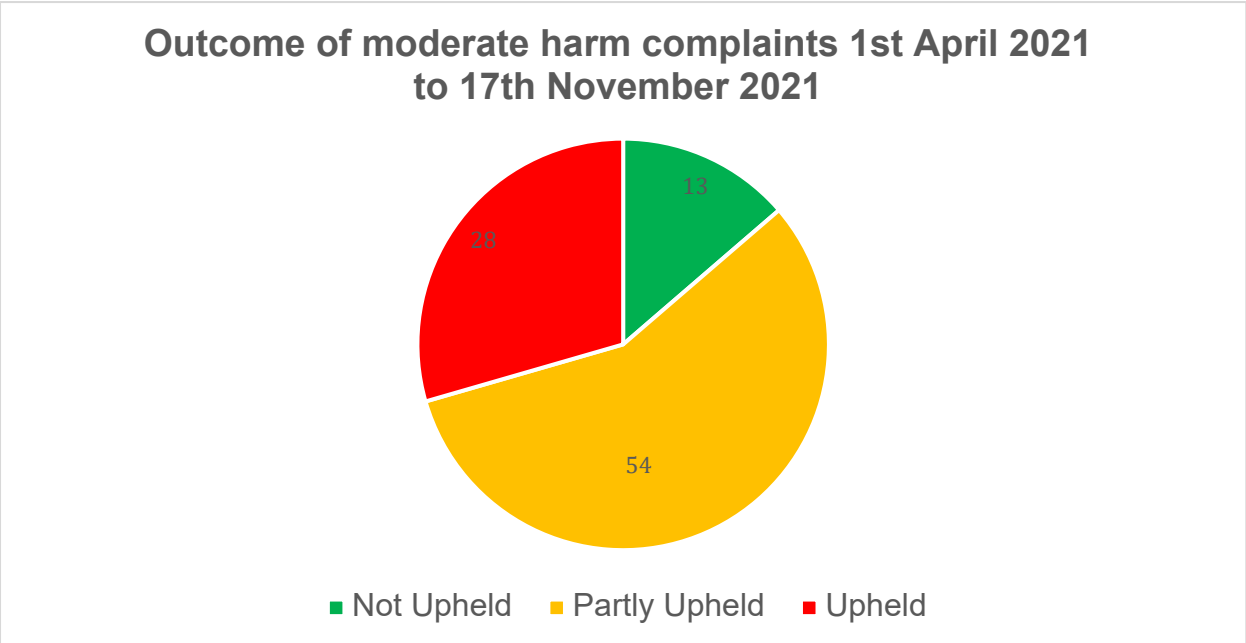
Chart 4 – Complaints responded to on time per division in percentage terms for 11 months of 2021/22



10. Complaints by outcome

Once a formal complaint investigation is complete, it can be determined whether the complaint is upheld in its entirety, partially upheld, or not upheld. The chart below shows the number of moderate harm (Amber) complaints upheld, partially upheld, or not upheld for the period **from 1st April 2021 to 17th November 2021.** During this period there were 95 Amber complaints.

Chart 5 - Moderate Harm Complaints Outcome 1st April 2021 to 17th November 2021



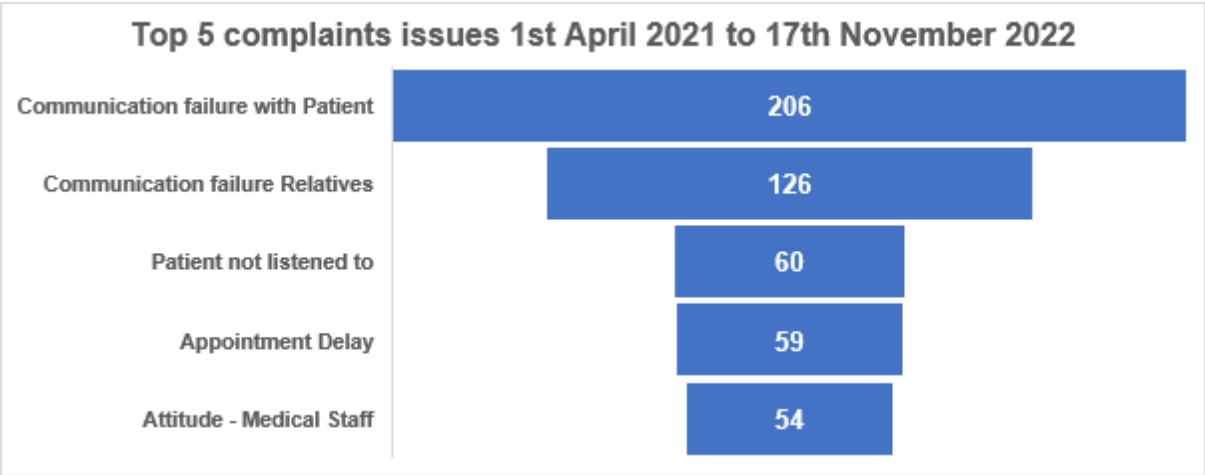
11. Category of Complaints

Complaints are recorded and categorised to help the organisation identify themes and trends and identify improvement actions in response to the findings.

Each issue reported in a complaint is logged onto the event reporting database, now Radar, using the category it pertains to. Some complaints have more than 1 issue and to ensure a true reflection of all issues encountered all issues are recorded.

The chart below gives a comparison of the top 5 issues raised in complaints **for the period from 1st April 2021 to 17th November 2021.**

Chart 6 – Comparison of top 5 complaint issues from 1st April 2021 to 17th November 2021



Communication and staff behaviour and attitude account for most complaints for 2021/22.

During a complaint investigation if issues of a serious nature come to light, the appropriate clinical leader for the Trust i.e., Chief Nurse or Medical Director are made aware, and their advice sought.

12. Internal monitoring

The numbers and issues raised in complaints are shared with the Board in quarterly Complaints and PALS reports.

Governance Groups are provided with a summary of complaints for each CSU by their Clinical Governance Lead. The summary encompasses details of complaints received by individual service.

13. Reopens

If a complainant remains unhappy with the response to their complaint, they are encouraged to return to the Trust with their outstanding issues. These files are reopened and further investigation, if required, takes place with the final resolution taking the form of a meeting with the complainant or a further written response. The re-opening of a file takes place to enable the Trust to understand why a complainant is unhappy with their initial complaint response and to ensure that any outstanding issues are dealt with in a timely manner and this performance can be measured.

The number of complaints that have been reopened for further investigation during the period form 1st April 2021 to 17th November 2021*, when 643 complaints were received, was 34 (5.29%)

*Radar is unable to provide this information currently.

14. PALS activity

The PALS team deal with calls from patients and the public requesting information, advice, or the need of signposting to a different organisation or department.

The number of contacts in this respect, for the year 2021/22, with a comparison for previous years, is shown below.

	2018/19	2019/20	2020/21	2021/22
Feedback	112	62	66	28
Information	1262	1134	735	563
Signposting	710	814	557	355
Total	2084	2010	1358	946

15. Lessons learned, and actions taken from complaints

The Trust values the opportunity that each complaint brings to learn and improve and recognises the importance of sharing the learning from complaints across the organisation for the benefit of our patients and their families and staff. We continue to strive to demonstrate the changes that have been made as a result of the learning from complaints and to sustain the changes for long term improvement.

The Trust acts on feedback to make improvements to its services wherever possible. Details of lessons learned, and actions taken, In summary are inputted on the Trusts' event reporting database. Every action mentioned in the response to the complainant is allocated for completion to the responsible member of staff.

There have been many actions for complaints this year across the CSU's including:

- **Dissemination of lessons learned/shared learning - by discussion at staff** meetings, one to one supervision for reflection and reiteration of correct practice to individuals or groups of staff and audit
- Processes/Procedures/Guidelines/Policy - amended/review or new
- Staff training, individual/group ongoing and training
- Patient information leaflets reviewed or new

In summary, the following actions have been taken as a result of feedback:

Communication with relatives - during the pandemic, wards allocated responsibility to a named individual to ensure relatives were kept updated on their loved ones. A guideline for all wards will be introduced in 2022/23 to ensure a uniform approach as to the standard and frequency of communication with relatives.

Nursing care - additional training was provided to nursing staff regarding monitoring fluid balance and improvement was monitored by the senior nursing team.

Women's Health - a new induction of labour process was implemented. For women who have undergone a surgical management of miscarriage, an information and support bag is given which includes a candle to acknowledge the loss of the pregnancy.

Delays in medication and diagnosis - process reviewed in the Cancer Centre to ensure medication is ready for collection in a timely manner. A missed diagnosis of an aortic dissection was discussed widely within the medical team and a guideline developed to help staff recognise the condition.

Learning disability patients - work is ongoing to review pathways for patients with a learning disability to ensure patients are treated in accordance with their needs and wishes.

Communication - pharmacy helpline information is now clearly displayed on discharge paperwork. The telephone system in Physiotherapy has been reviewed to ensure it is more robust.

16. Achievements

We care

During this year the dedicated email address @letterstolovedones where relatives and friends can send letters and photographs to their loved ones has remained available. Letters/photographs are laminated by the team and delivered to the ward areas. If the patient is unable to read their letter, ward and support staff read the letters to them. This service will continue to be available to patients and their families and enhancements made.

As required during times when restrictions were in place for visitors to the hospital, the relative's line was reintroduced to enable families to call for a general update on patients. This service was put in place due to the pressure on the ward areas and staff needing to concentrate wholly on the care of patients. The line was administrated by the PALS team with calls returned by the Governance team.

We collaborate

The Complaints and PALS team in collaboration with the Patient and Family Engagement team were finalists in the PENNA (Patient Experience Network National Awards) in September 2021 celebrating the services that were put in place for patients and their families during the pandemic. This was very well received and the team as a result were asked to present at a national NHS England event in October 2021.

PALS receive many calls from people who need to contact colleagues at other Trusts and organisations i.e., they wish to make a complaint about a GP, or they need to know how to obtain a copy of their health records. These callers are provided with the information they need on how this can be achieved. An analysis of calls is undertaken at the end of each quarter. Should there be a number of calls regarding a particular service the team ensures the Trust's internet pages are updated with details of how services can be accessed within the hospital and contact details are provided for other organisations. Moving forward collaborative work will be undertaken with other organisations to improve the patient's experience in respect of contact.

We communicate

The patient experience internet pages on the Trust's website, 'Tell Us About Your Care' detail the actions that have been taken as a result of feedback in a 'You Said, We Did' page.

Training sessions in respect of communication issues have been held with the medical teams in the Emergency Department. The training focuses on considering that each person is an individual and has individual needs and that communication styles must be adapted to meet the needs of the recipient with consideration of the impact their illness or condition was having on their life.

We contribute

The team offer a shadowing programme to staff as part of their development and may have expressed an interest in finding out more about the team. The person shadowing spends time with both teams and the Head of Patient and Family Experience to obtain a full picture regarding how feedback is collected and how it is acted upon. An activity booklet is provided to the member of staff which enables them to reflect on what they have learned so they can take this back to their workplace for sharing.

The Complaints and PALS team take part in the Trust's induction programme and leadership training. The team also support the Band 6 leadership programme and the Trust preceptorship programme, and any individual training required by staff that are new to the Trust or newly promoted into a senior post, to enable them to understand the complaints process and how to respond to complaints.

18. Conclusion

It is the responsibility of all staff to deal with any complaint or concern that is brought to their attention. If the member of staff is not able to deal with the issue, then they must escalate this to their manager. Patients and their families should never be discouraged from making a complaint and information on how to make a complaint is available on the Trust's internet site and in the complaints and PALS leaflets and through PALS and available on all ward areas/departments.

The complaints process used at MKUH is aligned to local policy and national regulations and guidance and, as such, all complaints are encouraged and dealt with in a timely manner with an appropriate response being given. The themes and trends from complaints are considered when setting the priorities for the Trust in relation to patient experience.

Meeting title	Trust Board	**Date:** 3 November 2022
Report title:	Trust wide report - Q1 2022/23 Complaints and PALS	**Agenda item:** 12
Lead director **Report author** **Sponsor(s)**	Kate Jarman Julie Goodman	Director of Corporate Affairs Head of Patient and Family Experience
FoI status:	Public document	

Report summary	This report provides a quarterly overview of complaints and feedback received through the Complaints and PALS teams and details some of the actions taken as a result of the feedback received.			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** [x]	**Decision** ☐
Recommendation	The Group is asked to note the contents of the report and make comment as required			

Strategic objectives links	Improving Patient Experience with a link to: • Improving Patient Safety • Improving Clinical Effectiveness • Delivering Key Targets
Board Assurance Framework links	Lack of learning from complaints and feedback is a key risk identified on the BAF
CQC outcome/ regulation links	This report relates to CQC: Regulation 16 – Acting on complaints Regulation 20 – Duty of candour Regulation 17 – Good governance
Identified risks and risk management actions	Lack of learning from complaints and feedback is a key risk identified on the BAF
Resource implications	None
Legal implications including equality and diversity assessment	None

Report history	Quarterly reports
Next steps	Quarterly reporting detailing analysis and trends and relevant learning from complaints
Appendices	

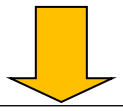
1. Introduction and purpose

This report details the Trust's overall position regarding the number of complaints received, the type of complaints and the performance in relation to responding to complaints on time during Q1 2022/23.

The overview from a Trust wide perspective is below followed by a summary of the individual performance of each division.

The purpose of the report is to highlight to the Trust Executive Board the feedback and concerns raised by patients and families that impact on the experience of their care at the Trust.

2. Overall Performance Summary

Measure	Q1 2022/23	Performance indicator	Q4 2021/22
Number of formal complaints	41 (15.2%)		38 (14.1%)
Number of informal complaints	228 (84.8%)		231(85.9%)
Total complaints received (formal and informal)	269		269
Percentage of total complaints responded to in timescales (reported 1 month in arrears)	Radar unable to provide this information presently		69.1% This decrease in performance was due to all clinical staff being fully engaged in clinical work due to Covid and capacity issues
*Number of complainants dissatisfied with the Trust's response (from previous quarter)	Radar unable to provide this information presently		Radar unable to provide this information

In accordance with national complaint regulations any complaint that is resolved within 24 hours of receipt is not required to be logged or reported by the Trust as a complaint. In Q1, 45.3% of PALS informal complaints were resolved within 24 hours against a KPI of 30%.

The information from informal complaints resolved in 24 hours is recorded on the Trust's complaints' database to enable the information to be analysed and triangulated with reportable complaints to identify improvement initiatives.

The issues highlighted within those complaints that were resolved in 24 hours were:

- Communication breakdown with patient
- Appointments – availability
- Breakdown in communication regarding appointments
- Appointment cancellations

Challenges

During Q1, there have been continued challenges with the use of Radar. The Complaints and PALS team continue to work with Radar to resolve these issues most of which are related to producing accurate reports.

In Q1, the PALS team have seen consistently experienced a higher number of callers to the service with the issues raised being more complex and time consuming. This is a trend that is being experienced nationally post Covid. Capacity is therefore an issue especially during periods of sickness or absence leave. The position regarding capacity is therefore being reviewed with the aim of easing those pressures across the summer months.

3. Activity

The Trust received 269 complaints in Q1, and this includes complaints received and managed through both the informal and formal route.

The top 3 issues raised in reportable complaints are as follows:

a) **Communication failure with patient**
b) **Inadequate information provided to patient**
c) **Communication failure with relatives/carers**

The lack of or inadequate communication with patients and their families continues to be the main issue raised in complaints. During this quarter the Trust's Matron group continued their collaborative work to develop guidance for all wards to assist them in improving communication as a whole with patients, families and carers.

4. Parliamentary Health Service Ombudsman (PHSO)

There have been no referrals to the PHSO during Q1 2022/23.

5. Audit

Internal Complaints Audit August 2021

The outstanding action from the internal audit regarding changing complaint response letters to be clear on the actions taken as a result of the complaint has been closed. Action plans detailing all actions taken are detailed on the first page of a complaint response in table form. This is to ensure that all complainants are clear on the changes that have been made as a result of their complaint.

Medical records audit

A requirement of the national complaint regulations is to ensure that complaint's communication is kept separate from medical records. Each quarter an audit is undertaken to gain assurance that details of complaints have not been placed in patient's medical records. Q1 audit confirmed that no complaint records had been filed in medical records.

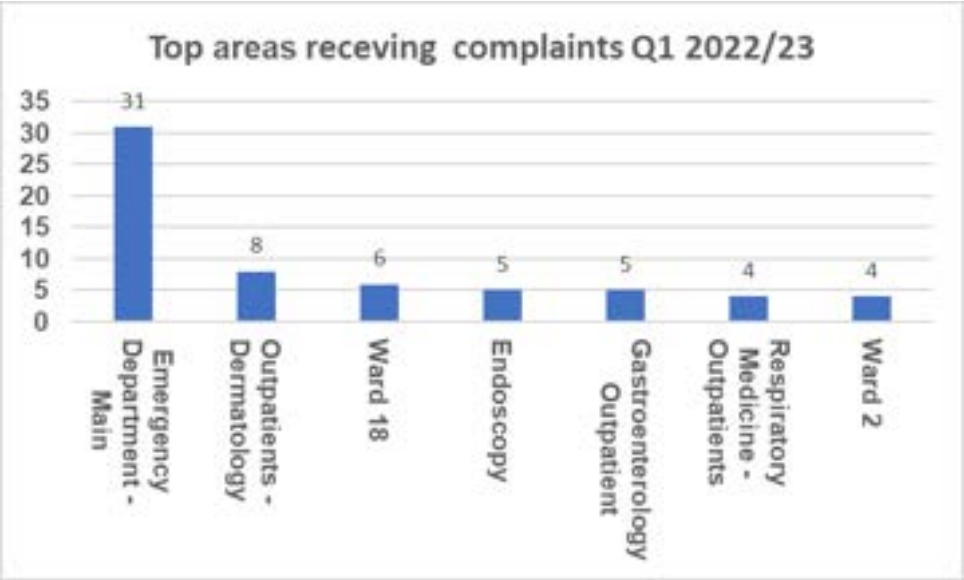
6. Divisional Reports

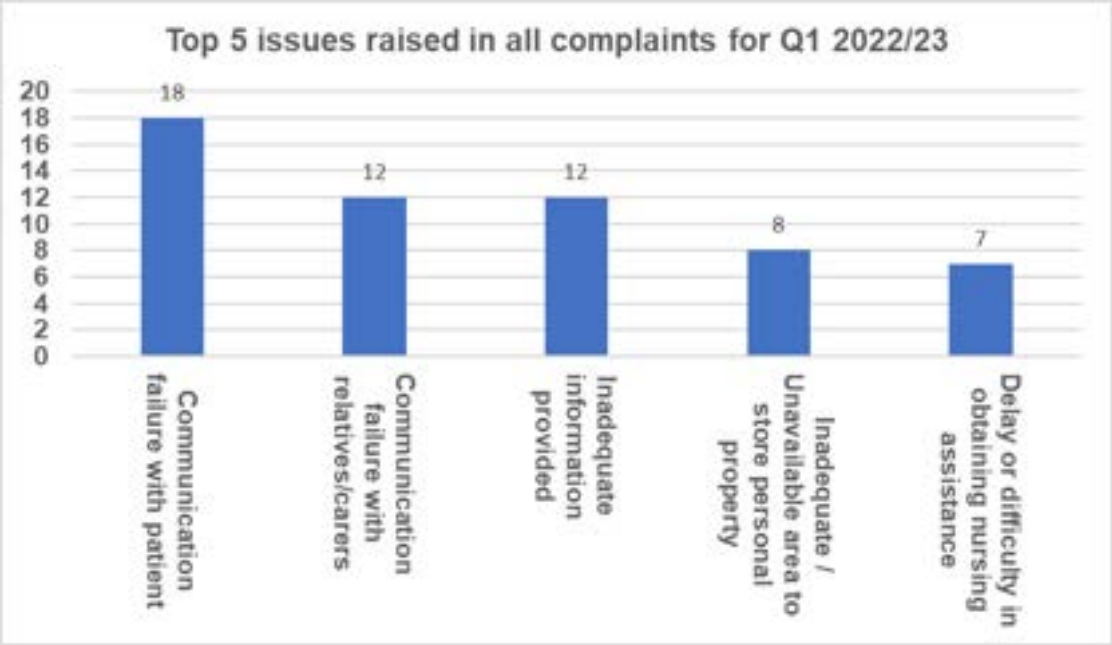
Medicine

Total number of complaints

In Q1 the division received 117 complaints in total, 13 (11.1%) formal complaints and 104 (88.9%) informal complaints.

Focus of Complaints





Improvements made following the receipt of complaints:

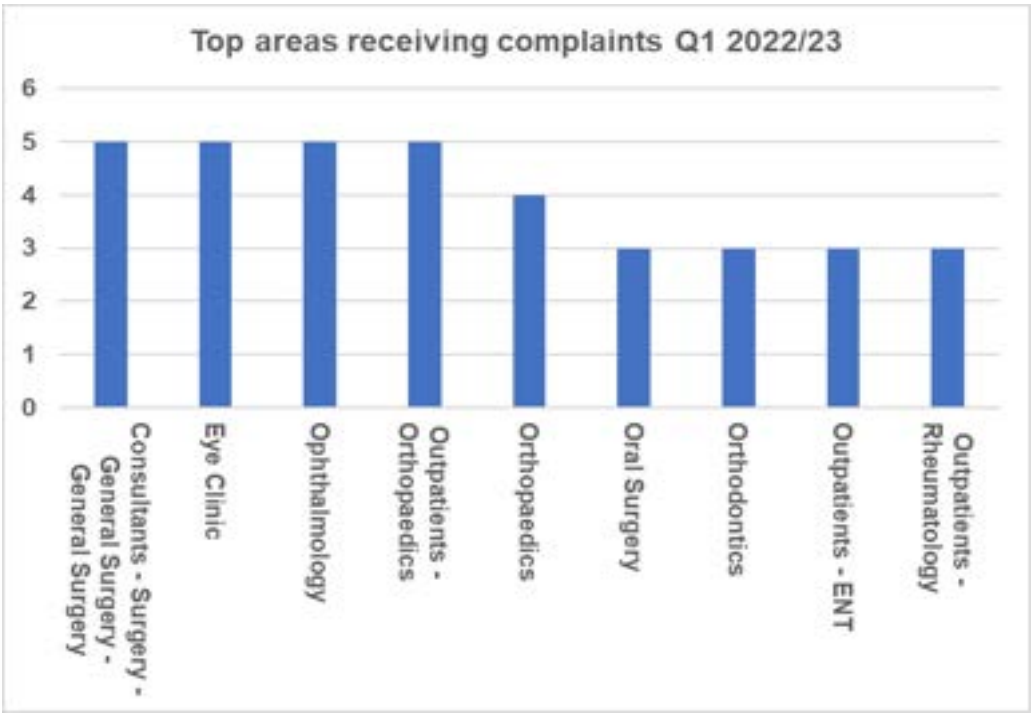
The complainant said:	The improvement was:
The Emergency Department (ED) did not follow the correct procedure when discharging a patient from their care. The patient had to return the ED to have their cannula removed as it had been left in situ.	The complaint was shared with the ED nursing team during handovers for shared learning. Staff were reminded that even when a patient is under the care of another medical team, the discharge process is the ED's responsibility and should be followed fully, especially regarding checking a cannula has been removed.
The patient was not sent copies of clinic letters and communications between the Dermatology team and the GP. The investigation showed that there was disparity amongst the team of clinicians regarding the practice of copying patients into correspondence.	The introduction of a standardised approach by all clinicians within the Dermatology team. All clinical communication will now be copied to the patient to avoid conflicting expectations.

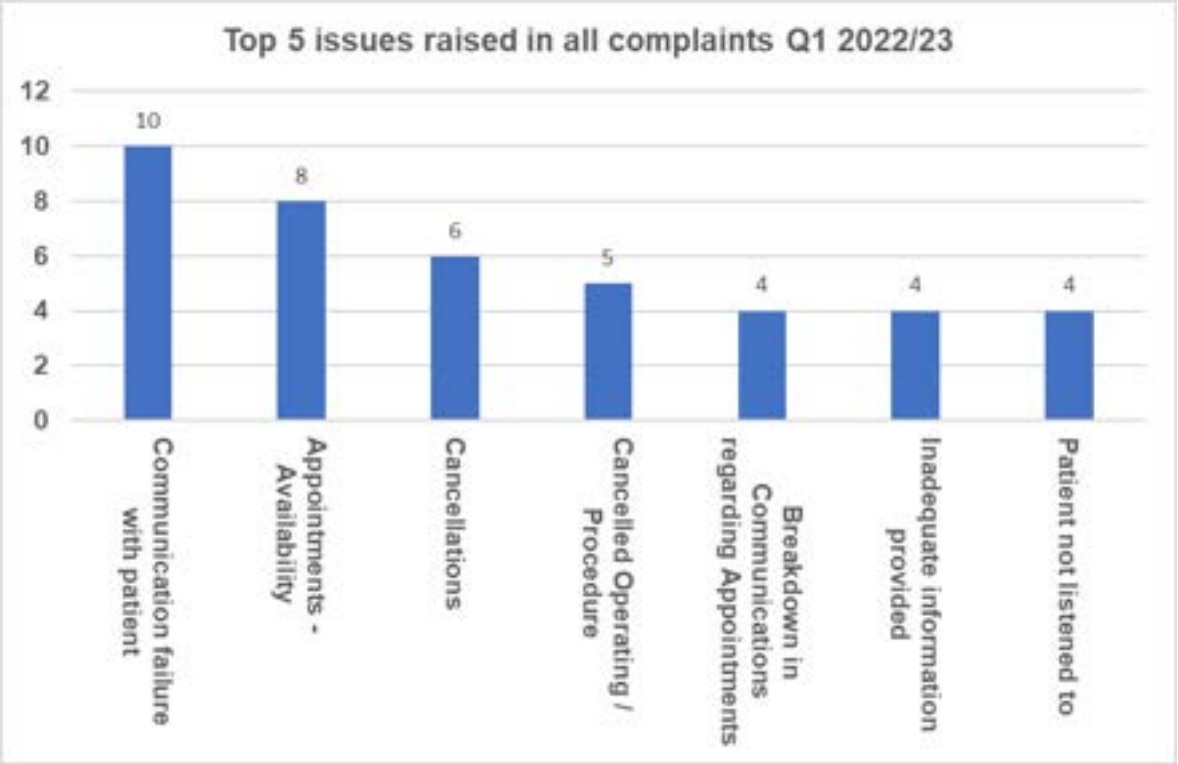
Surgery

Total number of complaints

In Q1 the division received 73 complaints in total, 11(15.1%) formal complaints and 62 (84.9%) informal complaints.

Focus of Complaints





Improvements made following the receipt of complaints:

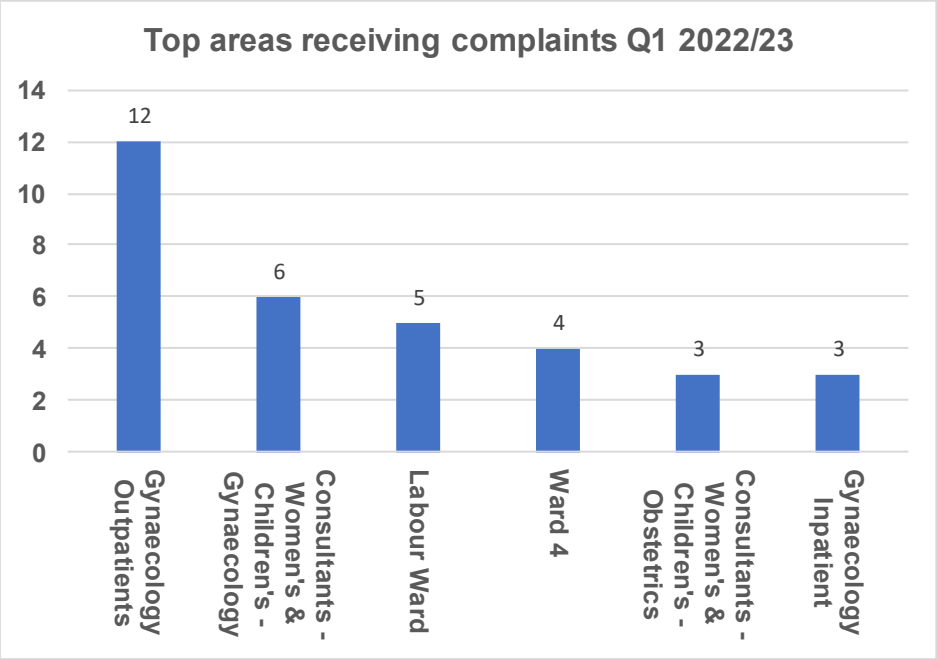
The complainant said:	The improvement was:
The patient was informed that they were not to use the trolley to lay down whilst waiting for surgery on the Day Surgery Unit (DSU). This caused the patient great distress, and they were left feeling uncomfortable.	It has been agreed, and reiterated to all staff in the DSU, that patients can rest on the trolley prior to surgery should they so wish.
The patient was concerned about delays in urgent clinical assistance being sought whilst in the recovery area following surgery. Investigation showed that the delays were happening specifically out of hours, or on audit afternoons when there is a reduced number of medical staff within the department.	The escalation process for requesting assistance from the on-call anaesthetist and/or or the surgeon has been reviewed and shared amongst the team, so that all staff are clear on how to summon urgent support at any time, if required.

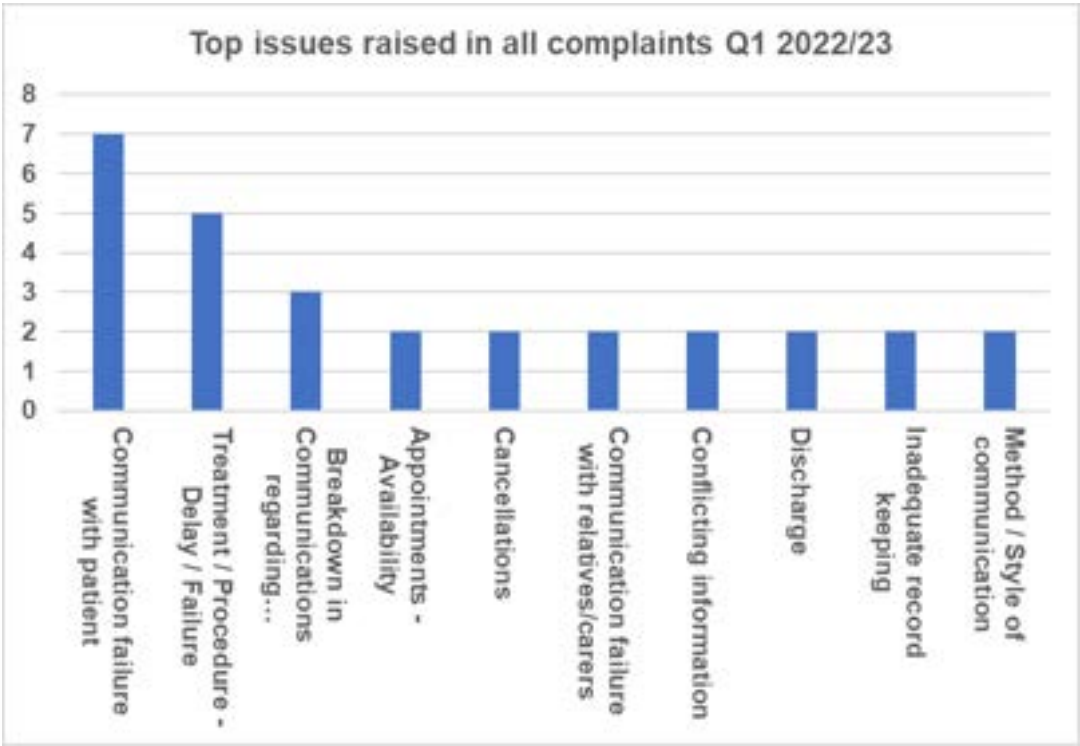
Women and Children's

Total number of complaints

In Q1 the division received 48 complaints in total, 15 (31.3%) formal complaints and 33 (68.7%) were informal complaints.

Focus of Complaints





Improvements made following the receipt of complaints:

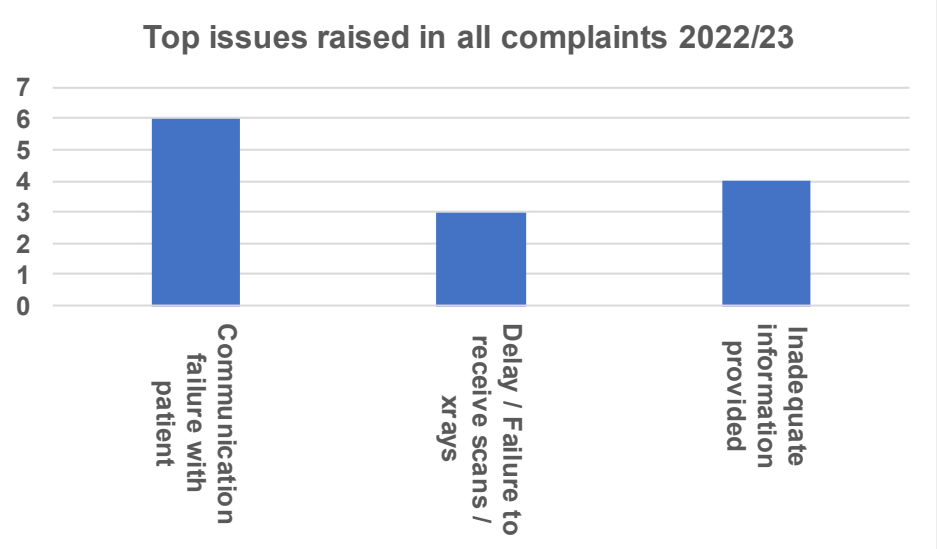
The complainant said:	The improvement was:
The patient was not given adequate information on how to access support and advice following a miscarriage.	The Maternity and Obstetric team agreed to review all of the department's information leaflets in co-production with the Maternity Voices Partnership.

Core Clinical Services

Total number of complaints

In Q1 the division received 25 complaints in total, all of which were informal complaints.

Focus of Complaints



Improvements made following the receipt of complaints:

The complainant said:	The improvement was:
The sonographer discussed a suspected diagnosis during an early pregnancy scan. This was prior to review by the Gynaecologist, which left the patient feeling that the team caring for her were not acting quickly enough.	The complaint was shared with the individual sonographer and the wider Imaging team, and it was reiterated that any communication regarding a diagnosis should only be shared with a patient when it is appropriate to do so and any necessary communication is undertaken appropriately and in the necessary manner.

7. Conclusion

The focus continues to be responding to complaints in a timely manner ensuring there is a thorough resolution of complaints. Challenges are being faced both locally and nationally with regard to the number and complexity of complaints. Public expectations, raised by the Covid pandemic, are not being met nationally regarding waiting times and availability of appointments and this is reflected in the number of complaints received locally regarding these issues.

On the 1st June 2022, a trial commenced regarding the divisions writing their own formal complaint responses. This was previously undertaken by the Complaints Office Manager. The trial is ongoing for a period of 3 months and to date is successful and ensures greater accountability and responsibility for the individual divisions.

During Q2 2022/23 the PALS team will continue to focus on resolving concerns within 24 hours. The Matron for Patient and Family Experience will continue to facilitate the team working more collaboratively with the clinical teams across the Trust.

Meeting title	Trust Executive Board	Date: 14th September 2022
Report title:	Trust wide report – Q1 2022/23 Patient and Family Experience Report	Agenda item: 13
Lead director **Report author** **Sponsor(s)**	Kate Jarman Julie Goodman	Director of Corporate Affairs Head of Patient and Family Experience
FoI status:	Public document	

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

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

Report history	Quarterly reports
Next steps	Quarterly reporting detailing analysis and trends in patient experience feedback

1. Introduction and purpose

This report details the Trust's overall position regarding patient and family experience feedback and engagement activity for Q1 2022/23.

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 and to recognise the work being undertaken by the Patient and Family Experience team. The aim is to identify areas of good practice and areas that require support to improve the patient and family experience.

2. Achievements of the Patient and Family Experience team

Patient Experience Week

During the week commencing 25th April 2022, the team celebrated Patient Experience Week. This was time to celebrate accomplishments, re-energise efforts, and recognise the ways in which staff, their kind words and their dedication, immeasurably improve the experience of our patients.

In the week leading up to Patient Experience Week, the team visited staff throughout the organisation to thank them for the difference they make to our patients and their families every day. With the support of the Communications Team a video recording was made in celebration of our staff. Link to the video is below:
https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fmkuhcloud.sharepoint.com%2F%3Av%3A%2Fs%2FCommunications%2FEefQT1xPyo9KlJUxGhYcbYUBG3CBodkVxSOihjad4VS_cw%3Fe%3D4%253akCuMXP%26at%3D9&data=05%7C01%7CLisa.Barnes%40mkuh.nhs.uk%7C6e4dc29ba9474db3572d08da26a3b851%7Ce96dd0a15d474a949e4a5c1056daa82c%7C0%7C0%7C637864781850375893%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=iSbnd%2FAYgiihHh2EefHxSSzrybwcOjhP4%2B9wZclsUAI%3D&reserved=0

The team held a stand outside the restaurant and in the main entrance to showcase ongoing projects and to get feedback from patients, families, and staff, to ensure inclusivity and engagement. The team spoke to staff and encouraged them to share their stories about the difference they have made to patient and family experience during the last year. A competition was also held to name the Patient Experience trolley. The trolley contains items to improve the experience of our patients and their families and includes information, activities, and personal items. The trolley will become a feature within the hospital once the Patient and Family Experience volunteers have been recruited in Quarter 2. The winning name was 'Buddy Trolley'.

The team were joined by a representative from Healthwatch and our non-executive directors for support. Healthwatch said that "it was fantastic to see genuine passion for strengthening the opportunities to share experiences".

Carers Week

The team helped celebrate Carers Week during the week commencing 6th June 2022. This was an opportunity to celebrate the role carers play in looking after their loved ones. An event held by Carers MK, in the community, was attended by the team to meet with carers, listen to their experiences and discuss forthcoming engagement work and opportunities.

During this week the team collaborated with the Trust's Catering Manager to celebrate our local carers, adults and children, by treating them to an afternoon tea. The Trust's Meaningful Activities Co-ordinator also attended and undertook some activities with the carers, including black out poetry and quilling. This was also an opportunity for the Catering Manager to showcase his concept of a patient and family tearoom in the hospital. To enable this concept to come to fruition a space is needed within the hospital where a permanent tearoom could be situated, and families could book a tea and bring their loved ones to give them some time away from the ward area. All attendees enjoyed their tea and supported the need for a tearoom and had some good suggestions for how the room should look.

Work with AI

The team continued their work with the AI team and participated in the Festival of Conversation and Curiosity. This festival explored those experiences and conversations that help us to learn what is important to people and what they value. During the festival, ways of working and being were explored, and tools and skills were introduced that can help facilitate these conversations, even when time is short. The team held a stand during the 'walk through wonderland' and the 'mastering the art of curiosity' event. The 'walk through wonderland' event was well attended, and all staff were treated to an ice cream van and free lunch.

This was also an opportunity to launch the online Patient and Family Experience Toolkit. This is an online selection of tools and resources to support staff and their teams to gather and learn from patient experience stories and is available on the MKUH intranet:
Patient and Family Experience Toolkit - MKUH - Intranet

The toolkit provides resources that offer practical ideas for:

- Capturing stories, experiences and perspectives from patients and families
- Exploring patient and family stories to maximise the potential for learning
- Using existing processes such as the Friends and Family Test and compliments to inform development and improvement work
- Engaging in reflective practice when responding to a patient or family concern

The PALS meeting room is now used to store and display information and advice in respect of the use of AI tools. Support can be given by request.

Continued work with Patient Experience Platform (PEP)

The team continue to collaborate with PEP Health to ensure staff are accessing the platform and reviewing and sharing the feedback received. This was promoted again during Patient Experience Week with the assistance of PEP Health.

During quarter 2 live training sessions will be held, similar to the Q&A sessions, with the PEP Health team to assist staff in being able to understand the feedback from their particular area. The sessions will be recorded for sharing purposes and the first session is planned for August 2022.

Matron for Patient and Family Experience update

The Matron for Patient and Family Experience has attended Appreciative Inquiry (AI) Action Learning Sets to develop her skills using the tools of AI, to be able to share effectively with other staff. During 'Patient Experience week' the 'AI Hub' was open, and staff were invited to familiarise themselves with the concept of AI and introduce some of the tools in their area.

Support was provided during the AI Summer Festival with the matron visiting clinical areas and using the Positive Practice posters to demonstrate and discuss good practice with staff.

Actively recruiting Volunteers

The Volunteers and Patient and Family Experience team, supported by Haider Hussain, Non-Executive Director, held a stand in main reception during Patient Experience week informing our patients and their families of the opportunities within the hospital to volunteer.

Over 50 volunteers have returned to the Trust following the pandemic.

During quarter 2, recruitment into volunteering roles will commence. The following roles will be available: -

ED support, dining companions, breast feeding peer support, activity buddies, patient experience and end of life.

The new post of Butterfly Volunteer coordinator, a role set up in partnership with the Anne Robson Charity, has been recruited into with the postholder attending dedicated training with the Anne Robson Trust, who will continue to support the development of this service at the hospital. During quarter 2 work will commence to recruit specific Butterfly volunteers.

Armed Forces Week

The Trust were represented at the Milton Keynes Armed Forces flag raising ceremony at the start of Armed Forces week. It was announced at this event that MKUH has been awarded the **Silver Award** in the Ministry of Defence Employer Recognition Scheme, which is an amazing achievement.

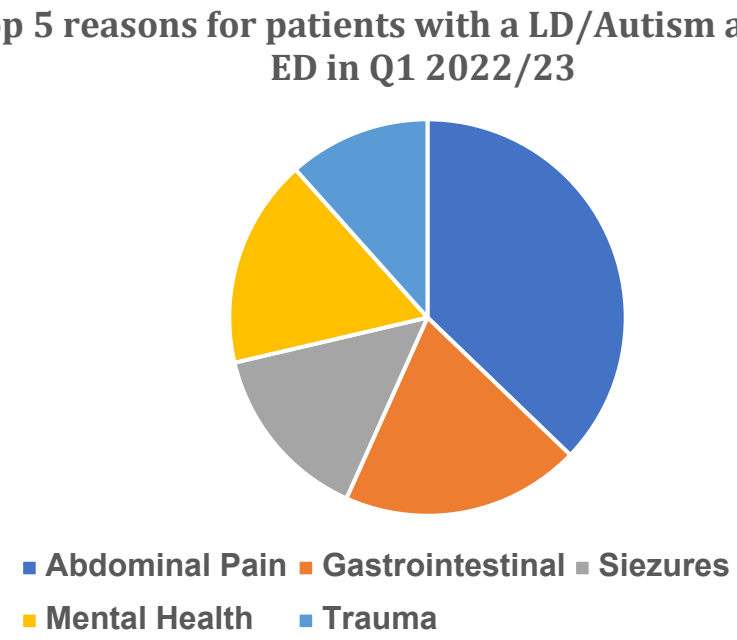
The CEO and the Chairperson along with a variety of hospital staff attended Reservists Day. Uniformed service personnel and cadet instructors were present to raise awareness with information stands in the courtyard to gain staff support and identify staff who have a link to the Armed Forces and would like to become involved with the AF staff network.

Learning Disability and or Autism

The Matron and the Learning Disability nurse have worked collaboratively with external stakeholders to improve the journey of our patients with a learning disability and/or autism. Engagement with those who have a learning disability and/or autism and their family and carers has taken place to understand what is important to them when they visit the hospital. Ongoing engagement work is planned to co-create bespoke pathways for individuals with complex needs who regularly attend hospital.

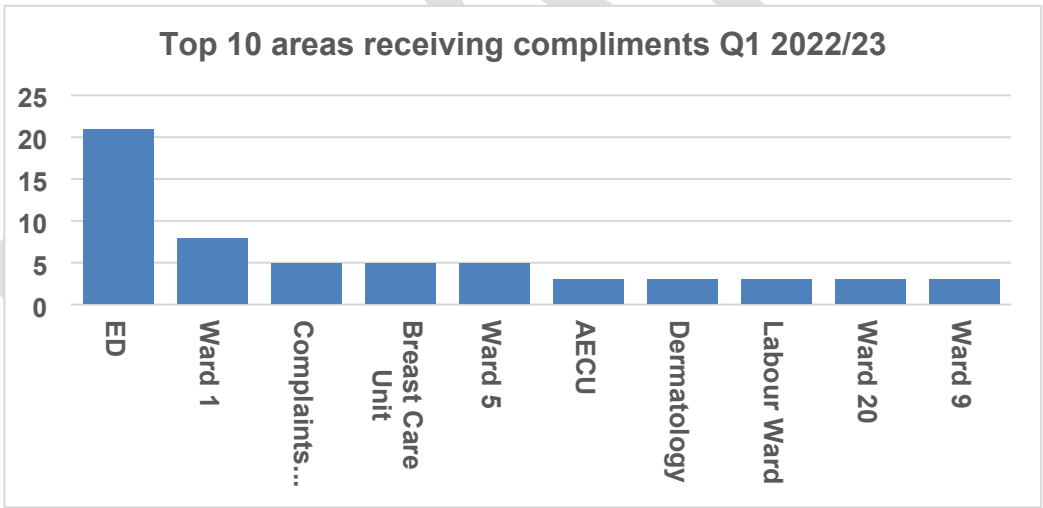
Summary of Learning Disability Admissions

Q1 2022/23	Overall admissions	Emergency Department admissions	Number of inpatient admissions	Number of outpatient admissions	Number of deaths	Cause of death
April	53	24	7	29	0	
May	46	19	5	26	0	
June	51	30	15	18	1	TBC



3. Compliments

During Q1, the Trust received 107 compliments via email, letter, review sites or telephone calls.



Compliment of the month

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

MONTH	INDIVIDUAL COMPLIMENT	TEAM COMPLIMENT
April 2022	**Lucy Peel – Physio** 'Lucy treated me with such kindness and compassion. She worked	**Ward 9** Thank you to all the Ward 9 midwives, nursery nurses, student midwives, cleaners

	with me to rebuild my shoulder after it was injured, and just went above and beyond.'	and every other staff that help the women at the most incredible yet vulnerable times of our lives. You're support made it so much easier.'
May 2022	**Thozama Cele – MRI** 'Thozama was calming, funny, reassuring and altogether extremely pleasant. I was panicking and I felt I was holding everyone up, but she was really kind and patient.'	**Ward 14** 'The family really appreciate all of you.' 'Thank you for your care support and communication.'
June 2022	**Natalie Houchin – Staff Nurse Ward 5** 'Throughout my time on the ward, her passion, care and dedication could be witnessed repeatedly from patient to patient to patient. I have never witnessed someone so dedicated and loving as Natalie within the NHS.'	**Ward 1** 'Amazing care under such extremely busy situations. Also, such a friendly professional approach and very supportive. Once again thank you for taking care of me whilst in your care.' 'My observations of Ward 1 staff in general were what a hardworking, empathetic and kind group they were. Nothing seemed too much trouble and they were very patient with visitors demands !!'

4. Patient Experience data

Friends and Family Test (FFT)

The team continue to receive a large number of FFT responses following the successful launch of the use of SMS text messaging in outpatients and the ED, for patients over 18 years. The figures have slowly decreased during Q1, although it must be acknowledged that there were a number of Bank Holidays during this period.

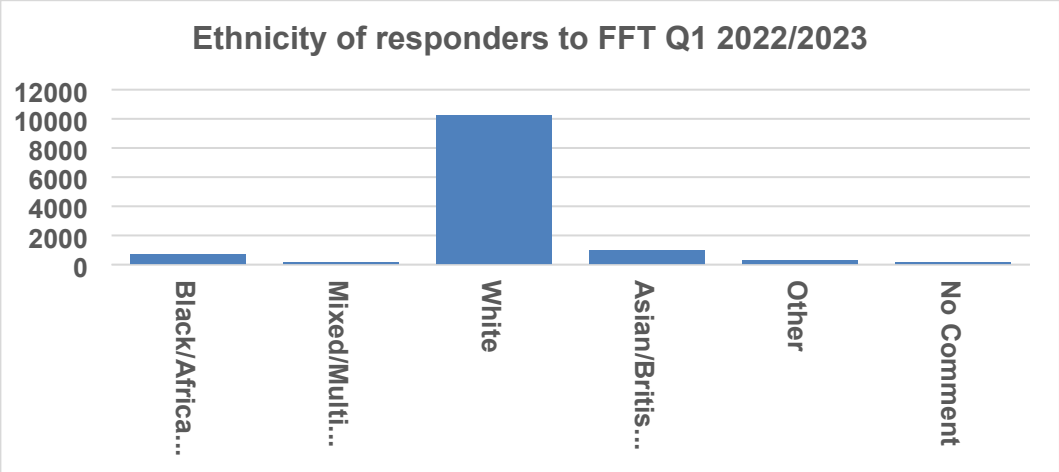
The table below details a comparison of the number of FFT responses received across the Trust for the last four quarters.

Quarter	Total number of responses
Q2 21/22	3600
Q3 21/22	16499
Q4 21/22	16059
Q1 22/23	12605

In Q1 2022/23, 90.75% of responses rated the Trust's services as very good or good.

FFT- Ethnicity

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

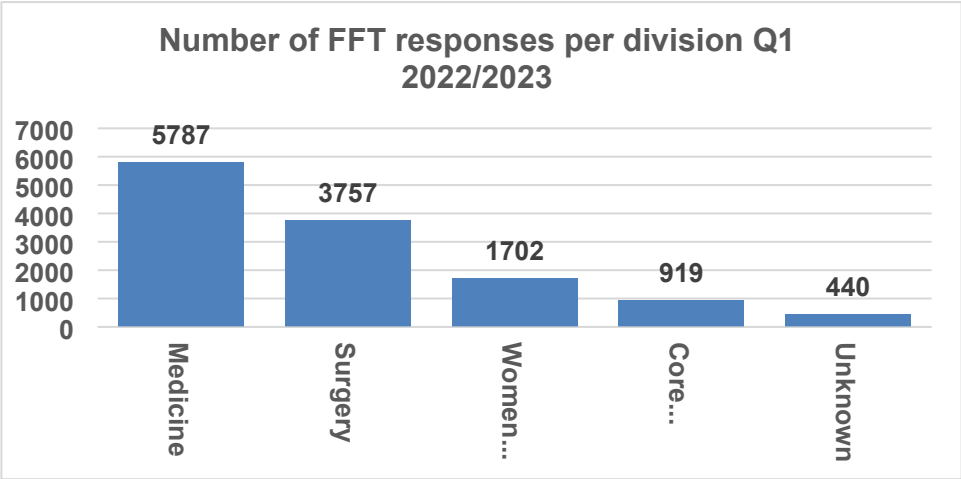


The focus for 2022/23 continues to be working with the Trust's Equality Diversity and Inclusion Lead to scope how the Trust can engage further with patients from ethnic minorities to obtain their valuable feedback. FFT inclusion resources are available from the team when required.

During quarter 2 2022/23, SMS text messaging will be avaibale to any patient who has been dicsharged from hosptial after an inpatient stay, over the age of 18 years.

Divisonal FFT responses

The chart below deails the number of FFT responses per divison for Q1 2022/23.



FFT and comments for social media and online review sites

During Q1, the overall rating for the Trust in relation to positive comments from FFT and comments left on Google review, the NHS website and Twitter, was 4.6* out of 5*.

Below is a screenshot from the PEP Health Trust dashboard for Q1 2022/23.

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

Critical Care, Neonatology, Endoscopy, Physiotherapy, and Respiratory Medicine

The top 5 services with the most comments are:

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

Each comment provided in free text form is themed by PEP health and given a star rating. Looking at the overall experience, 8535 comments ranked the service overall, on a ranking of 1 star to 5 stars, as 5 stars.

Surveys

National

The 2021 Adult Inpatient patient sample was extracted during December 2021. The survey field work took place during January to May 2022. The embargoed results from Picker, the contractor for the inpatient surveys, was received in June 2022 and the final report will be published by CQC in October 2022 with results being received after this time. During quarter 2 the divisions will work with the Patient and Family Experience team to put in place action plans to address the issues that have been identified though the survey.

The 2022 Maternity Survey patient sample took place in March 2022. The survey field work will take place during April to August 2022 with embargoed results being received in September 2022 and the final CQC report expected in January /February 2023.

During quarter 2, in September, the 2022 Urgent and Emergency Care Services survey will take place with the Picker results being expected April 2023 and the subsequent CQC report being avaible in September 2023.

5. Conclusion and upcoming events/future plans

There is much to celebrate during this quarter with the improvements that have been made regarding gaining valuable feedback from our patients and their families. The engagement with staff, patients, families, and outside agencies during both Patient Experience Week and Carers Week was positive in moving projects forward. The team continue to support staff to fully engage with the feedback they are receiving with the introduction of the online Patient Experience Toolkit and the ability to theme FFT and online comments by area and division, through the PEP Health platform. This will enhance learning and outcome from feedback across the Trust.

What to expect Quarter 2 2022/23

- The launch of the ward QR code - a unique QR code on bedside cupboards which will direct patients and their families through to a dedicated ward information page which will detail any information they may need to know i.e., visiting times, who's who from a uniform perspective, how to access snacks/drinks etc.
- The launch of the Patient Experience trolley. A trolley which will be taken round wards and facilitate a discussion with patients and families. The trolley will contain items such information, activities for patients, items they may need to improve their experience i.e., eye masks, ear plugs, personal items such as sanitary towels
- The launch of SMS messages to gain FFT feedback from inpatient areas

- Work with the Paediatric team to increase the amount of FFT responses received
- Plan to restart 15 Steps programme as circumstances allow
- Work with the team at PEP Health to coordinate quarterly drop-in sessions to allow staff to seek support and ask any questions around the dashboard
- The Learning Disability Nurse and the Meaningful Activities Co-ordinator joining the Patient Experience team greatly enhancing the team's ability to support patients and families
- Arranging engagement sessions with various groups to listen to patients and families and find out what they would like to see in the new women and children's hospital and surgical block i.e., how they would like it to feel, what could be considered to enable them to have a good experience i.e., decoration, smell, lighting etc.
- Working with the Obstetrics team on a survey following the implementation of the new ERP guidelines
- Working with the Communications team on an extension to letters to loved ones, an online greeting card system for the website
- Working with PEP Health to ensure compliments received into the Trust are available on the dashboard for staff to review and discuss with their teams
- Information in relation to all patient and family feedback received by the Patient and Family Experience team will be incorporated into the new Quality booklet, to be used as a quality tool on all wards, to ensure all areas are aware of the feedback they receive and celebrate /share that feedback or take forward learning and action as a result of negative feedback
- The webpages for patient and family experience to be enhanced by the addition of charity information directing patients and their families to where they may find support and assistance from charities and other organisations

Dear COO & CMO, September 2022

RE: Accountability & Support for Theatre Productivity

Further to the recent letter outlining the next steps for elective recovery, we are writing to ask for your support in improving the efficiency and productivity of our operating theatres, a core enabler to delivery. Understanding the data relating to the utilisation of our theatres is a key element in driving improvements. We have asked all trusts to return their theatre data at fortnightly intervals into the Model Health System. We now have 100% of trusts returning data, which is a fantastic achievement for which we want to thank you all.

The current theatre data (June 2022) shows that the amount of planned session time we actually use ("Capped Theatre Utilisation") remains at 72% nationally, down from 76% pre-Covid. The data also shows significant variation between ICBs, ranging from 49% to 86%. We have established a national Theatre programme aiming to support providers address many of the common challenges.

Whilst we continue to work with trusts to ensure their theatre returns are wholly accurate, it is clear that there are significant gains to be made within existing theatre sessions (i.e. those that are run and staffed) by eliminating this unwarranted variation. Looking specifically at the 29 'HVLC' pathways, in the month of May, an extra 41,000 procedures could have been carried out if utilisation had been 85% & the average number of cases performed in line with GIRFT standards.

There are already fantastic examples across the country of trusts and systems making excellent progress despite the current challenges, be it through innovation, configuration of services, or sometimes simply through excellent operational and clinical management, we can share these with you.

Achieving high levels of theatre productivity requires the adoption of a data-driven, clinically led pathway improvement approach. Through our work with providers across the broad spectrum of performance, it is clear that having strong senior executive oversight (clinical & operational) is a critical success factor.

As Medical Directors and Chief Operating Officers of your organisations we would request that you review the Senior Responsible Officer(s) and oversight arrangements in relation theatre productivity and strengthen these if necessary. Ideally, it should consist of a joined approach with a senior manager working "shoulder to shoulder" with a senior clinician, to succeed we need both groups working together. Every Trust Board should discuss theatre productivity, we suggest with the support of a Non-Executive Director to act as a sponsor. Further, the routine review of Model Health System theatre productivity data, as well as other key information such as day-case rates across Trusts, is critical to success and must be embedded.

We need an urgent significant step change in theatre utilisation, so we plan to alert system and regional leaders every month where trusts fall below 65% utilisation. The GIRFT team will provide improvement support if requested, in relation to improving data quality or by working directly with clinical and operational teams to implement the necessary changes. We'd be grateful if you could confirm your SROs for Theatres to us, so we can ensure we direct data and other materials accordingly.

We are here to support you, so please discuss with your regional team or directly with us via england.girft.hvlc@nhs.net. We are also looking forward to further discussions around these and other issues as we continue our periodic visits to each ICB.

Thank you once again for your leadership and support.

Yours sincerely

Professor Tim Briggs CBE FRCS
National Director of Clinical Improvement
Chair of GIRFT Programme

Miss Stella Vig
National Clinical Director for Elective Care

C.c.
Regional: Directors, Medical Directors, Clinical Leads
System: Senior Leadership Teams
Trust: Chair, Chief Executive, GIRFT Lead
NHSE: Vinod Diwakar, Sir David Sloman, Sir James Mackey, Dame Cally Palmer, Ian Eardley, Prof. Ramani Moonesinghe

Meeting Title	Trust Board	Date: 03 November 2022
Report Title	2022-23 Executive Summary M06	Agenda Item: 15
Lead Director	Name: John Blakesley	Title: Deputy CEO
Report Author	Name: Information Team	Title:

Key Highlights/ Summary	In September 2022:
	
	Emergency Department:
	- There were 8,135 ED attendances, below the monthly year to date average.
	- ED 4-hour performance remained consistent at just above 80%, exceeding both the national performance and the performance of most other trusts within its Peer Group.
	- 82.3% of ambulance handovers took less than 30 minutes, slightly worse than the 15-month average.
	
	Outpatient Transformation:
	- There were 32,510 outpatient attendances, an increase in comparison to September 2019.
	- 13.6% were attended virtually, the lowest percentage to date this financial year.
	- 7.2% of patients did not attend their appointment, a deterioration from August.
	
	Elective Recovery:
	- There were 2,447 elective spells, an increase in comparison to September 2019.
	- At the end of the month 37,828 patients were on an open RTT pathway. Of these:
	  o 2,218 patients were waiting over 52 weeks, almost doubling from April.
	  o 73 patients were waiting over 78 weeks, but none over 104 weeks.
	- At the end of the month 6,743 patients were waiting for a diagnostic test, a significant improvement compared to the end of May. Of these patients:
	  o 78.2% were waiting less than 6 weeks; an improvement in performance compared to August.
	
	Inpatients:
	- Overnight bed occupancy was 90.9%.
	- A significant number of beds were unavailable due to:
	  o 120 super stranded patients (length of stay 21 days or more).
	  o 58 DTOC patients (the highest value since records began in April 2016).
	  o 93 patients not meeting the criteria to reside.
	
	Human Resources:
	- Substantive staff turnover was 15.8%, the highest rate to date this financial year.
	- Staff vacancy rate and agency expenditure also exceeded their thresholds.
	- Appraisals (excluding doctors) and mandatory training completion rates were better than their targets. However, September completion rate for doctors was only 26.5%.
	
	Patient Safety:
	- Nine infections were reported and both MRSA and MSSA have breached their 2022-23 thresholds.
	- One Never Event was reported, classified as wrong site surgery.

Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Noting** ☐	**For Review** ☐

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

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

Trust Performance Summary: M6 (September 2022)

1.0 Summary

This report summarises performance in September 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)	344	0
4.6	Diagnostic Waits <6 weeks	90%	99%

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

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

ED performance remained consistent in September 2022 at 80.3% compared with 79.9% in August 2022. Further, MKUH performance exceeded both the national overall performance of 71.0% and the performance of most of the other trusts within its Peer Group (see Appendix 1).

The Trust's RTT Incomplete Pathways <18 weeks performance was 49.7% at the end of September 2022. The total volume of open pathways is now at 37,828, increasing from 36,206 in August 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.

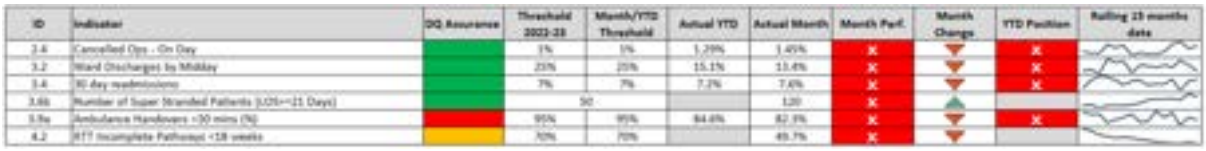
Cancer waiting times are reported quarterly, six weeks after the end of a calendar quarter. They are initially published as provisional data and later finalised in line with the NHSE revisions policy.

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



Cancelled Operations on the Day

In September 2022, there were 36 operations that were cancelled on the day for non-clinical reasons, representing 1.45% of all planned operations. The majority of the cancellation reasons were related to staffing issues and bed availability.

Readmissions

The Trust's 30-day emergency readmission rate increased from 7.4% in August 2022 to 7.6% in September 2022, representing a slight deterioration in performance.

Delayed Transfers of Care (DTOC)

The number of DTOC patients reported at midnight on the last Thursday of September 2022 was 58 patients: 50 in Medicine and eight in Surgery. This is the highest value since records began in April 2016. Following a similar pattern is the number of patients not meeting the criteria to reside, which reached its highest value this financial year. As of the last Thursday of September 2022, this number was 93 patients: 76 in Medicine, and 17 in Surgery.

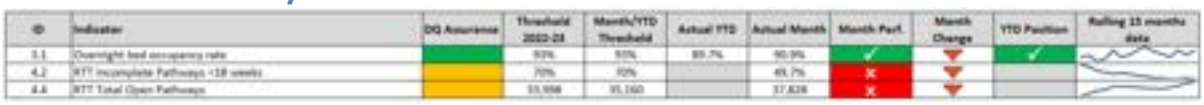
Length of Stay (Stranded and Super Stranded Patients)

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 120. This was an improvement in performance compared to 135 patients at the end of August 2022, however numbers remain high.

Ambulance Handovers

In September 2022, the percentage of ambulance handovers to the Emergency Department taking less than 30 minutes was 82.3%, a slight deterioration in performance compared to 84.4% in August 2022.

4.0 Elective Pathways



Overnight Bed Occupancy

Overnight bed occupancy was 90.9% in September 2022, increasing from 88.8% in August 2022.

RTT Incomplete Pathways

The Trust's RTT Incomplete Pathways <18 weeks at the end of September 2022 was 49.7% and the number of patients waiting over 52 weeks was 2,218 against a trajectory of 344. These patients were distributed across Surgery (1,960 patients), Women and Children (241) and Medicine (17).

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 September 2022, with a performance of 78.2%. This was a slight improvement compared to 76.7% at the end of August 2022.

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

5.0 Patient Safety

Infection Control

In September 2022, the following infections were reported:

Infection	Number of Infections	Division/ Ward
C.Diff	4	Medicine (Ward 3 and Ward 16 x2), Surgery (Ward 21a)
E-Coli	3	Medicine (Ward 17), Surgery (Ward 20 and Ward 23)
MSSA	1	Medicine (Ward 15)
Klebsiella Spp bacteraemia	1	Medicine (Ward 22)
MRSA bacteraemia	0	
P.aeruginosa bacteraemia	0	

Note:

- MRSA has breached its zero-tolerance threshold for 2022-23 with two occurrences.
- MSSA has breached its threshold of eight in 2022-23 with nine occurrences.

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.

July to September 2022 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	Jul-22	Aug-22	Sep-22
Homerton Healthcare NHS Foundation Trust	79.0%	86.3%	86.2%
Milton Keynes University Hospital NHS Foundation Trust	80.0%	79.9%	80.3%
Southport and Ormskirk Hospital NHS Trust	73.8%	73.7%	72.5%
Buckinghamshire Healthcare NHS Trust	72.1%	72.1%	69.7%
Northampton General Hospital NHS Trust	66.1%	66.6%	67.4%
North Middlesex University Hospital NHS Trust	62.3%	65.7%	66.9%
Barnsley Hospital NHS Foundation Trust	63.1%	71.9%	65.7%
Oxford University Hospitals NHS Foundation Trust	62.2%	64.5%	60.9%
Mid Cheshire Hospitals NHS Foundation Trust	58.0%	62.3%	60.6%
The Princess Alexandra Hospital NHS Trust	57.5%	54.0%	59.1%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	57.3%	59.1%	58.3%
The Hillingdon Hospitals NHS Foundation Trust	70.9%	57.4%	57.6%
Bedfordshire Hospitals NHS Foundation Trust	-	-	-
Kettering General 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) ★		99.8	99.8		103.1	✗	▲		
1.2	Mortality - (SHMI)		100.0	100.0		106.6	✗	▲		
1.3	Never Events		0	0	1	1	✗	▼	✗	
1.4	Clostridium Difficile		10	5	9	4	✗	▼	✗	
1.5	MRSA bacteraemia (avoidable)		0	0	2	0	✓	▬	✗	
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)					36		▼		
1.8	Incident Rate (per 1,000 bed days)		50	50	46.36	41.29	✗	▼	✗	
1.9	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▬	✓	
1.10	E-Coli		15	<8	13	3	✗	▲	✗	
1.11	MSSA		8	4	9	1	✗	▬	✗	
1.12	VTE Assessment		95%	95%	95.6%	97.2%	✓	▲	✓	
1.14	Klebsiella Spp bacteraemia		15	<8	6	1	✓	▼	✓	
1.15	P.aeruginosa bacteraemia		10	5	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%	95.5%	96.9%	✓	▲	✓	
2.4	Cancelled Ops - On Day		1%	1%	1.29%	1.45%	✗	▼	✗	
2.5	Over 75s Ward Moves at Night		1,500	750	796	145	✗	▼	✗	
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%	89.7%	90.9%	✓	▼	✓	
3.2	Ward Discharges by Midday		25%	25%	15.1%	13.4%	✗	▼	✗	
3.3	Weekend Discharges		63%	63%	62.7%	64.5%	✓	▼	✗	
3.4	30 day readmissions		7%	7%	7.2%	7.6%	✗	▼	✗	
3.5	Patients not meeting Criteria to Reside		TBC			93	Not Available	▼		
3.6a	Number of Stranded Patients (LOS>=7 Days)		184			258	✗	▲		
3.6b	Number of Super Stranded Patients (LOS>=21 Days)		50			120	✗	▲		
3.7	Delayed Transfers of Care		25			58	✗	▼		
3.8	Discharges from PDU (%)		12.5%	12.5%	9.5%	10.9%	✗	▲	✗	
3.9a	Ambulance Handovers <30 mins (%)		95%	95%	84.6%	82.3%	✗	▼	✗	
3.9b	Ambulance Handovers <60 mins (%)		100%	100%	97.7%	96.8%	✗	▼	✗	

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%	81.5%	80.3%	✗	▲	✗	
4.1b	Total time in ED no more than 8 hours (Admitted)		100%	100%	50.5%	43.4%	✗	▲	✗	
4.2	RTT Incomplete Pathways <18 weeks		70%	70%		49.7%	✗	▼		
4.4	RTT Total Open Pathways		33,998	35,160		37,828	✗	▼		
4.5a	RTT Patients waiting over 52 weeks (Total)		0	344		2218	✗	▼		
4.5b	RTT Patients waiting over 52 weeks (Non-admitted)		0	TBC		1760	Not Available	▼		
4.6	Diagnostic Waits <6 weeks		90%	90%		78.2%	✗	▲		
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		41,107	5,867	Not Available	▼	Not Available	
5.2	A&E Attendances		104,759	53,966	50,983	8,135	✓	▼	✓	
5.3	Elective Spells		25,821	13,143	12,650	2,447	✓	▲	✗	
5.4	Non-Elective Spells		34,421	17,317	14,251	2,489	✓	▼	✓	
5.5	OP Attendances / Procs (Total)		407,339	205,817	198,358	32,510	✗	▼	✗	
5.6	Outpatient DNA Rate		6%	6%	7.2%	7.2%	✗	▼	✗	
5.7	Virtual Outpatient Activity		25%	25%	16.7%	13.6%	✗	▼	✗	
5.8	Elective Spells (% of 2019/20 performance)		110%	110%	98.8%	102.3%	✗	▲	✗	
5.9	OP Attendances (% of 2019/20 performance)		104%	104%	102.9%	102.3%	✗	▼	✗	

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	167,260	170,892	30,662	✓	▲	✓	
7.2	Pay £'000		(208,343)	(106,026)	(110,612)	(20,747)	✗	▼	✗	
7.3	Non-pay £'000		(98,408)	(50,202)	(49,890)	(8,354)	✗	▼	✓	
7.4	Non-operating costs £'000		(25,412)	(14,789)	(14,487)	(1,632)	✓	▼	✓	
7.5	I&E Total £'000		(0)	(3,757)	(4,097)	(71)	✗	▼	✗	
7.6	Cash Balance £'000			41,835		44,074	✓	▼		
7.7	Savings Delivered £'000		12,049	3,425	3,425	834	✓	▲	✓	
7.8	Capital Expenditure £'000		(18,288)	(5,992)	(7,340)	(3,204)	✗	▼	✗	

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%		10.9%	✗	▼		
8.2	Agency Expenditure %		5.0%	5.0%	5.8%	5.1%	✗	▲	✗	
8.3	Staff Sickness % - Days Lost (Rolling 12 months) 🖉		5.5%	5.5%		5.5%	✓	▲		
8.4a	Appraisals (excluding doctors)		90%	90%		91.0%	✓	▲		
8.4b	Doctors due appraisal in the given month who have completed that appraisal by month end	TBC				26.5%		▼		
8.4c	Doctors who have completed appraisal since 01 April 2022	TBC				30.5%		▲		
8.5	Statutory Mandatory training		90%	90%		92.0%	✓	▼		
8.6	Substantive Staff Turnover		9.0%	9.0%		15.8%	✗	▼		
8.7	Percentage of employed consultants with (at least one) fully signed off (3-stage) job plan since 01 April 2021					84.8%		▲		

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		18	✗	▬		
O.2	Rebooked cancelled OPs - 28 day rule		90%	90%	95.7%	93.1%	✓	▼	✓	
O.4	Overdue Incidents >1 month		TBC	TBC		271	Not Available	▼		
O.5	Serious Incidents		75	<38	67	9	✗	▲	✗	

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

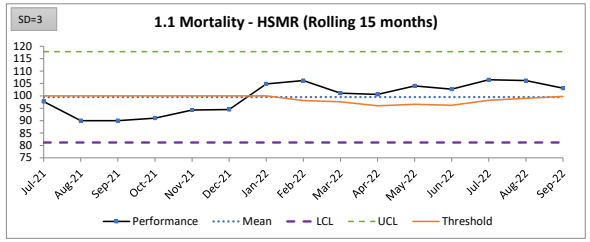
✓	Achieving YTD Target
	Within Agreed Tolerance*
✗	Not achieving YTD Target
✗	Annual Target breached

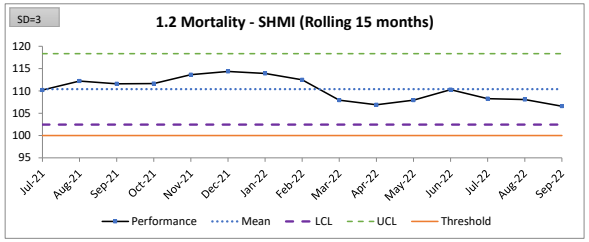
Data Quality Assurance Definitions

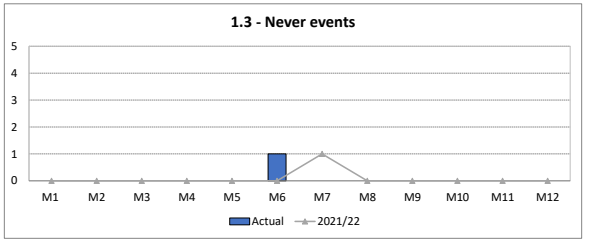
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory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

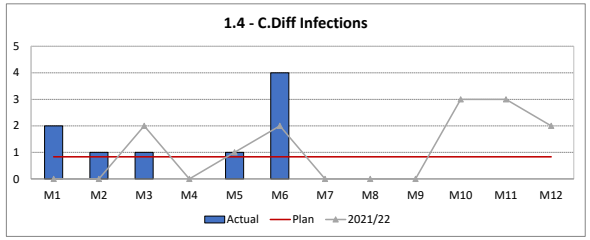
* Independently Audited – refers to an independent audit undertaken by either the Internal Auditor, External Auditors or the Data Quality Audit team.

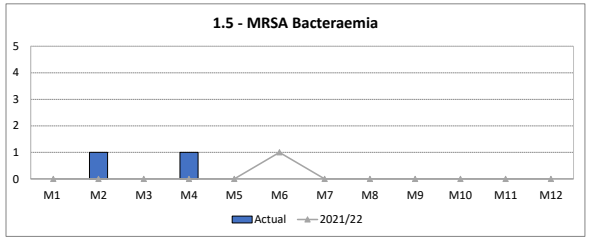
OBJECTIVE 1 - PATIENT SAFETY

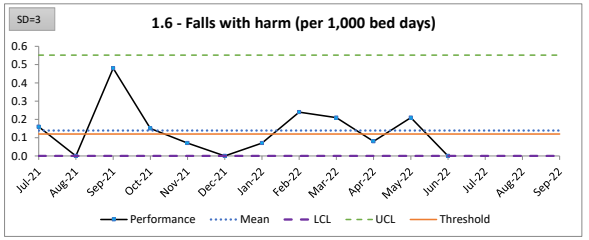


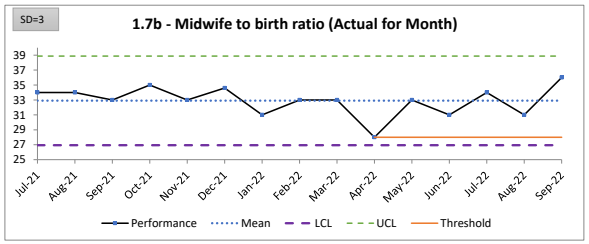


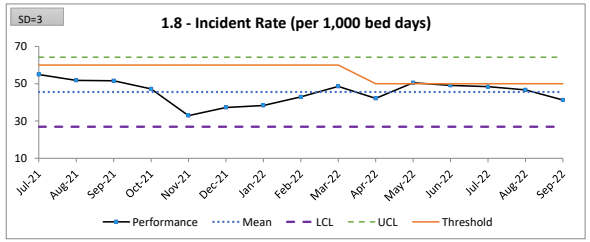


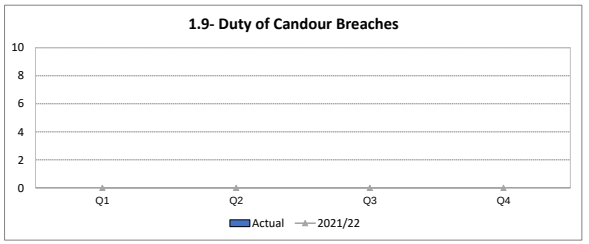


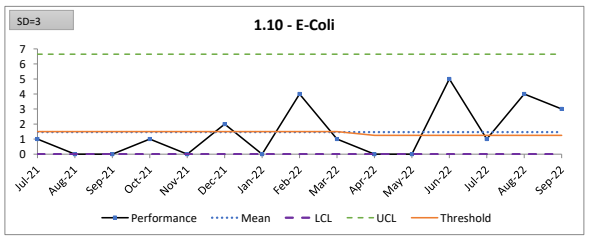


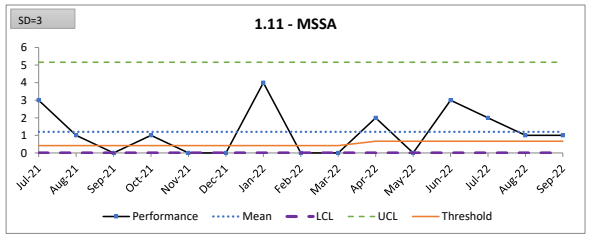


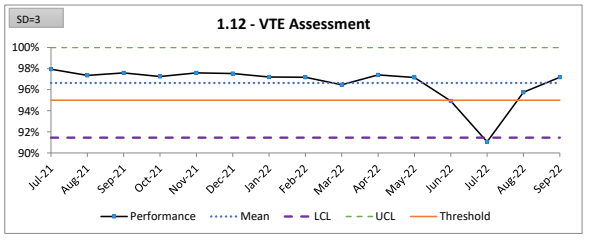


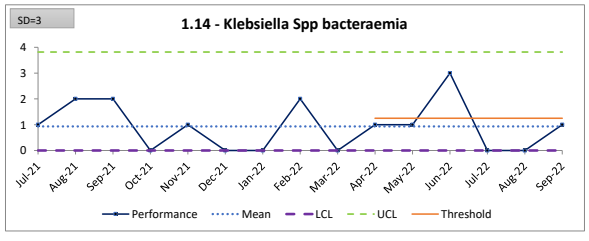


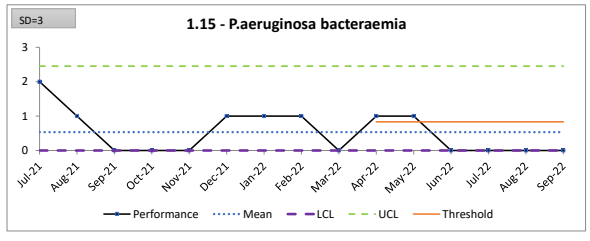












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- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
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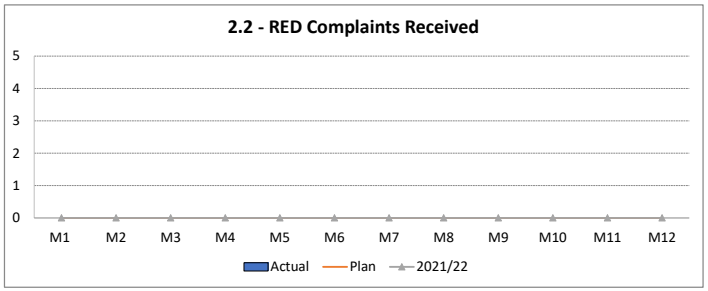
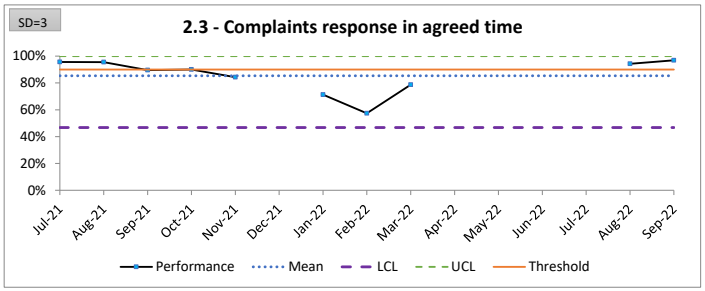
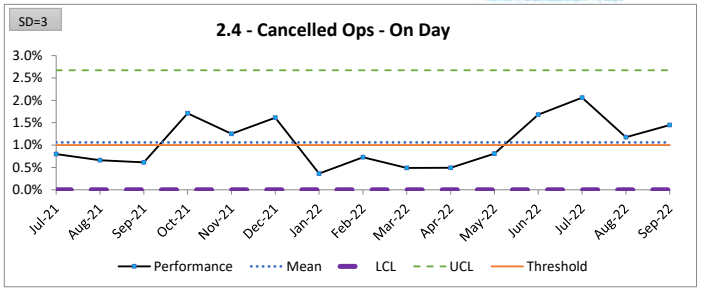
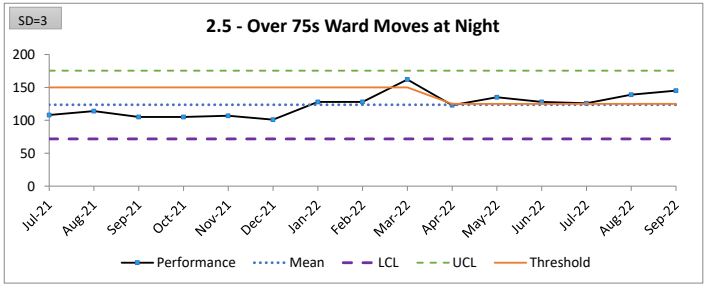
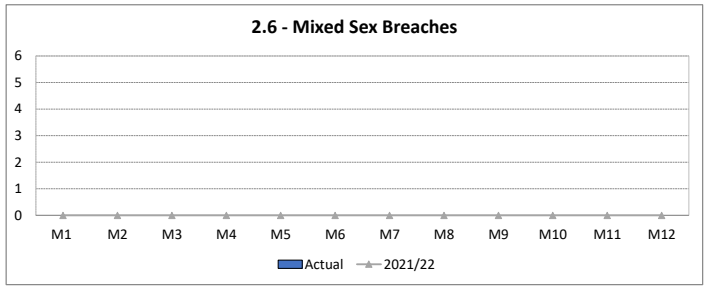
OBJECTIVE 2 - PATIENT EXPERIENCE











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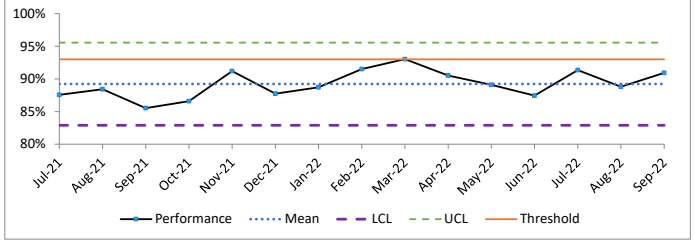
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

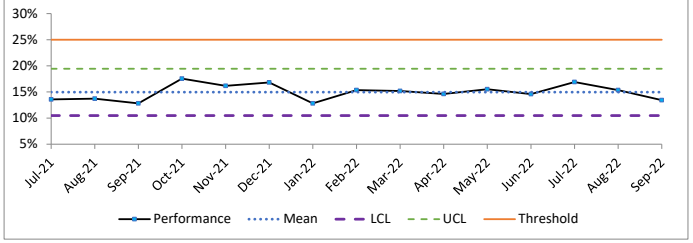
SD=3

3.1 - Overnight bed occupancy rate



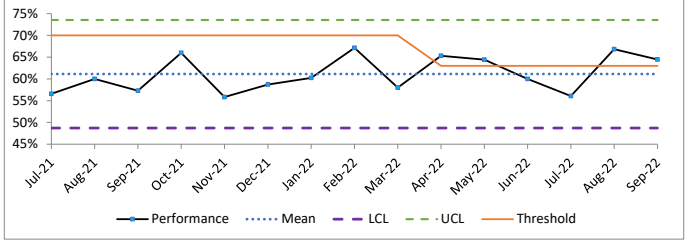
SD=3

3.2 - Ward Discharges by Midday



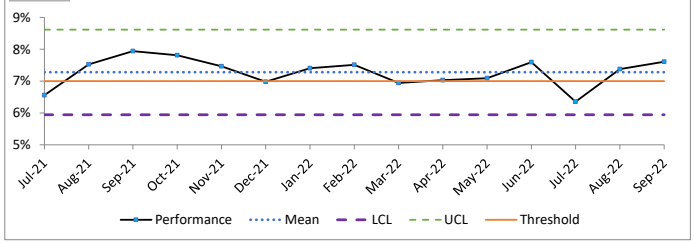
SD=3

3.3 - Weekend Discharges



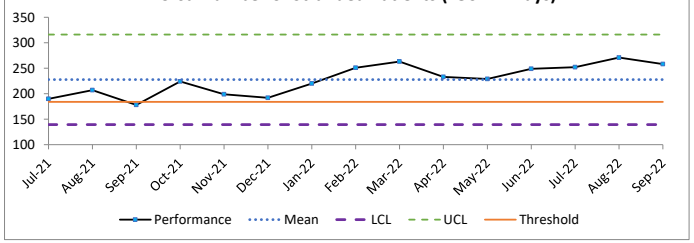
SD=3

3.4 - 30 Day Readmissions



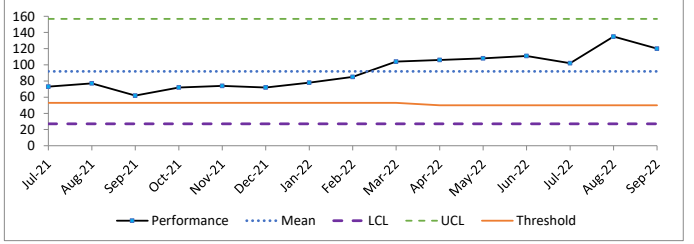
SD=3

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



SD=3

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



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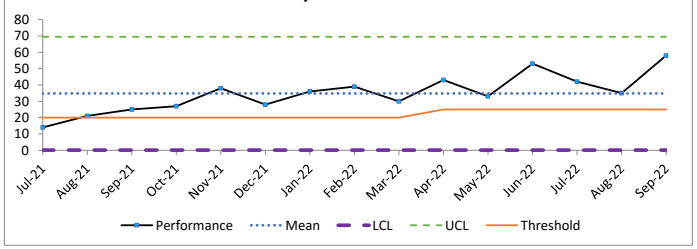
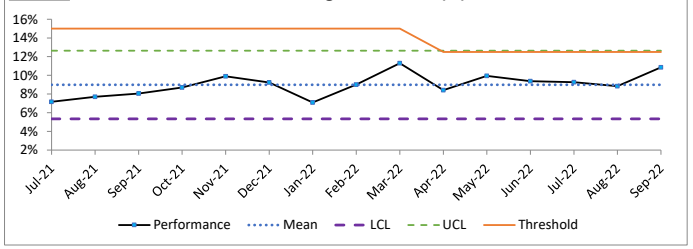
3.7 - Delayed Transfers of Care



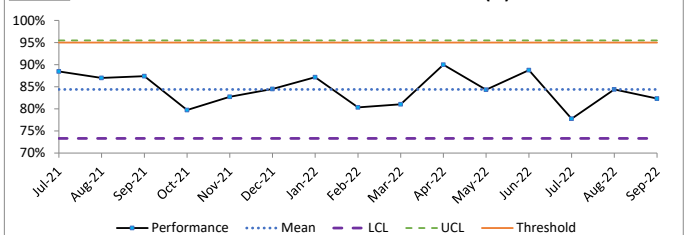
SD=3

3.8 - Discharges from PDU (%)



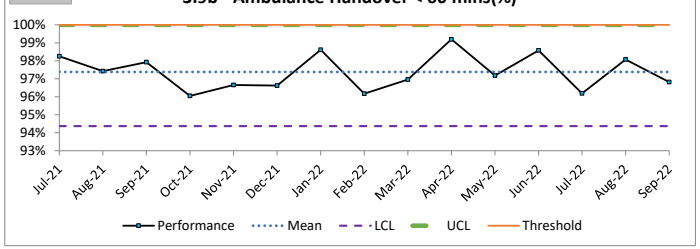
SD=3

3.9a - Ambulance Handover < 30 mins(%)



SD=3

3.9b - Ambulance Handover < 60 mins(%)



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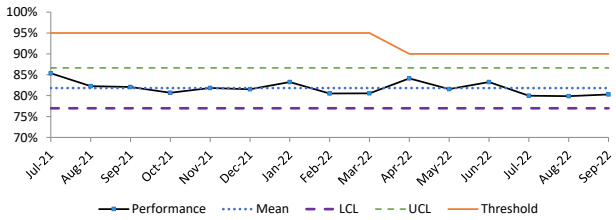
OBJECTIVE 4 - KEY TARGETS

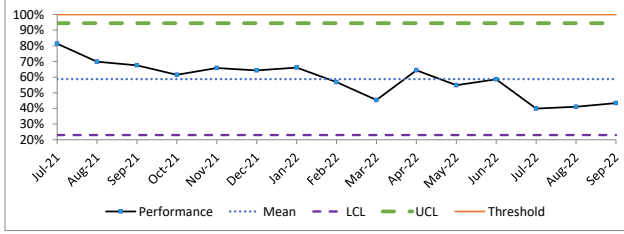
SD=3

4.1a - ED Hour Target (includes UCS)



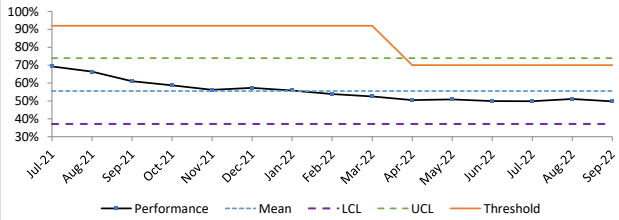
SD=3

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

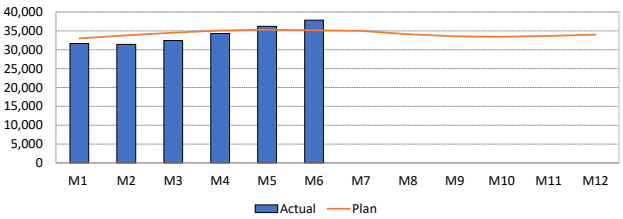


SD=3

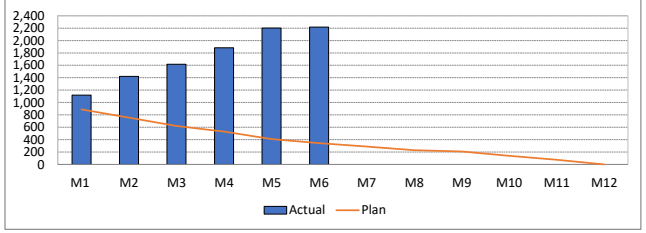
4.2 - RTT Incomplete Pathways <18 weeks



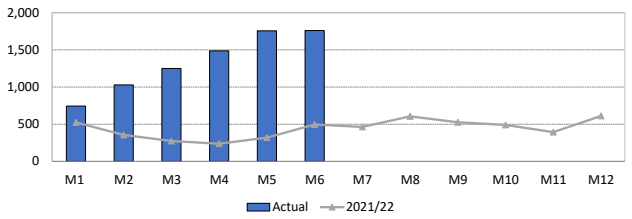
4.4 - RTT Total Open Pathways



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



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



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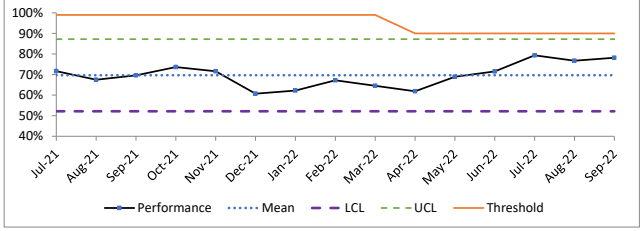
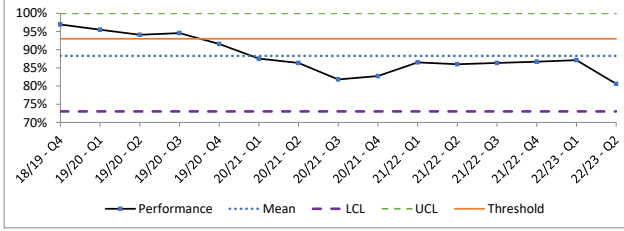
4.6 - Diagnostic Waits < 6 weeks



SD=3

4.7 - 2 Week Wait - Cancer



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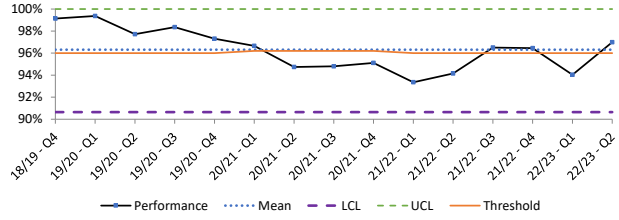
4.8 - 31 day diagnosis to treatment - Cancer



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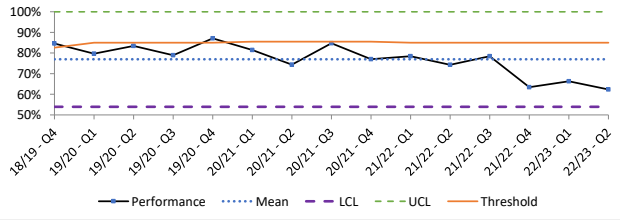
4.9 - 62 day standard - Cancer



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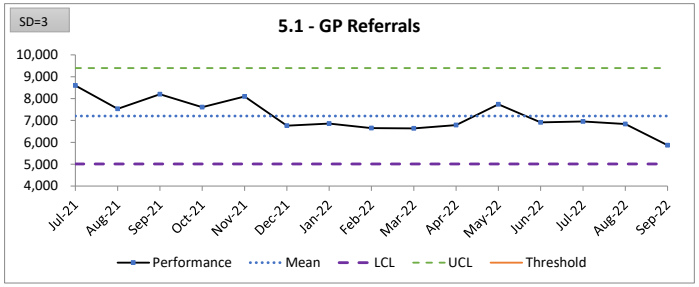
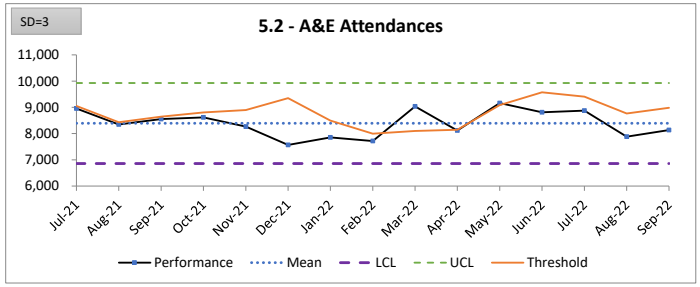
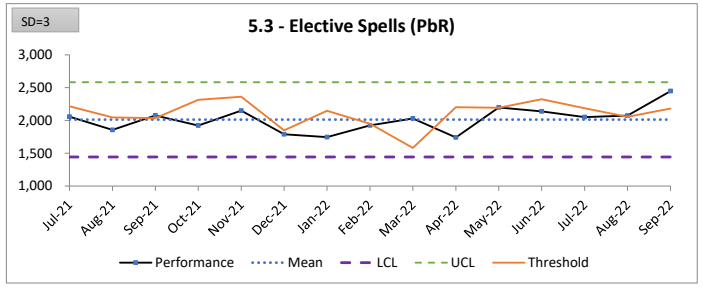
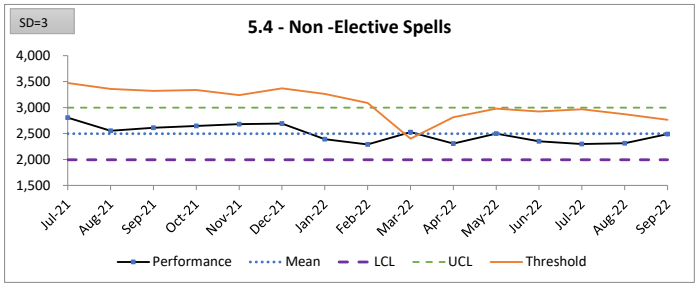
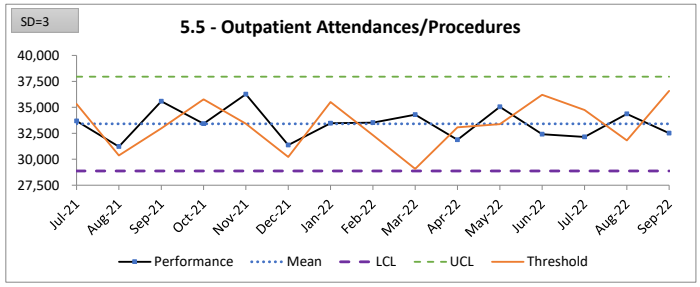
OBJECTIVE 5 - SUSTAINABILITY

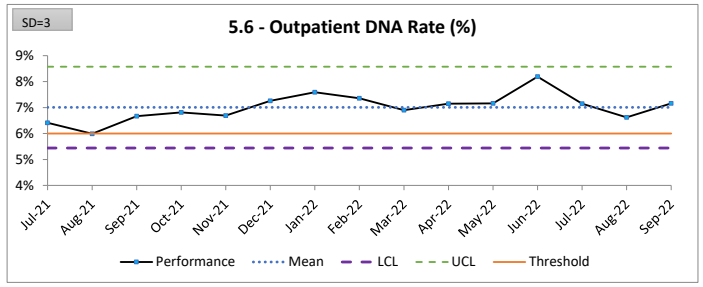












If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
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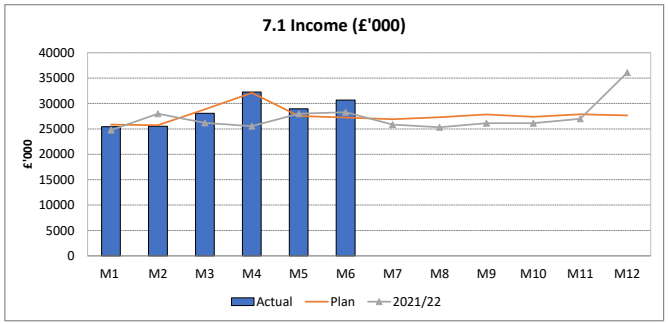
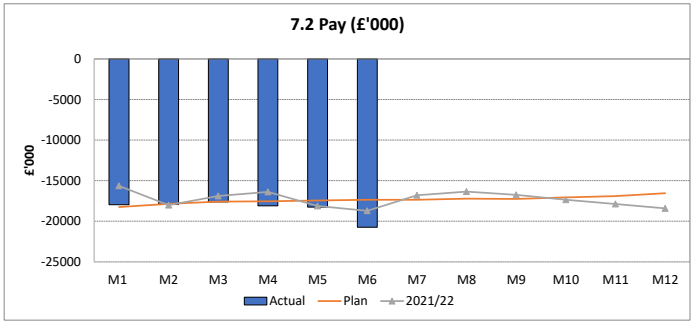
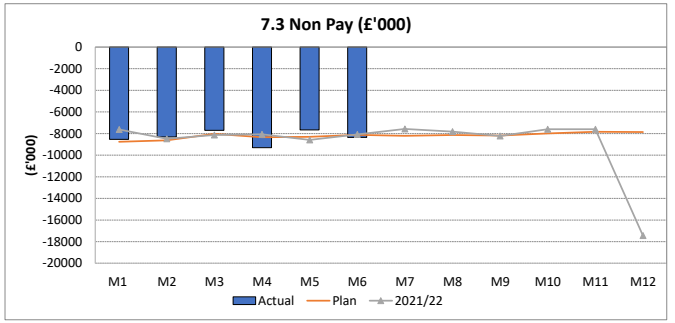
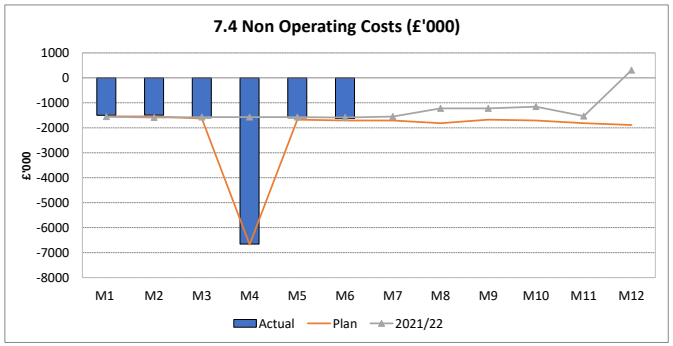
- Targets/Thresholds/NHSI Trajectories

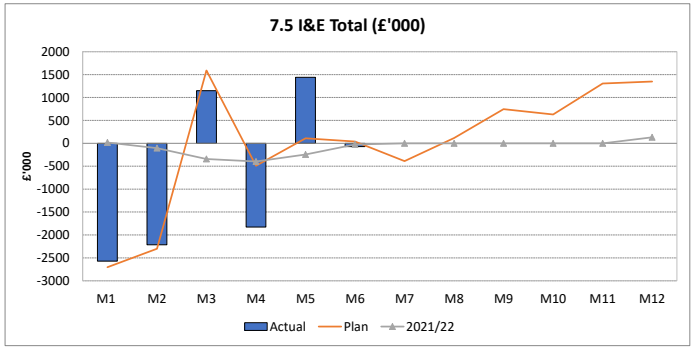
OBJECTIVE 7 - FINANCIAL PERFORMANCE

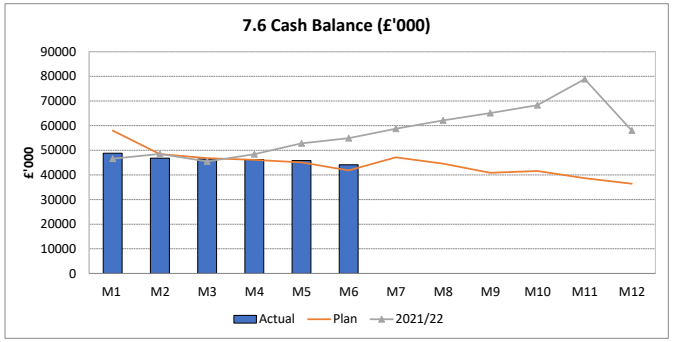


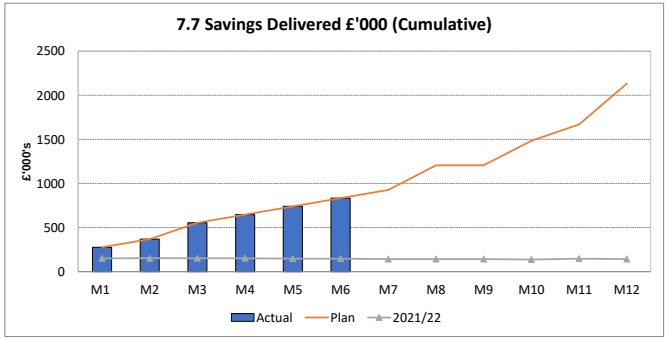


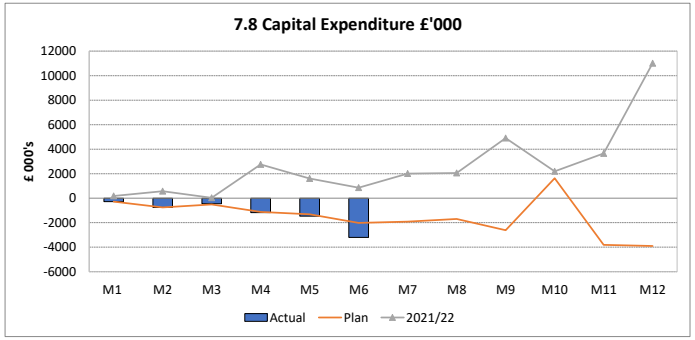




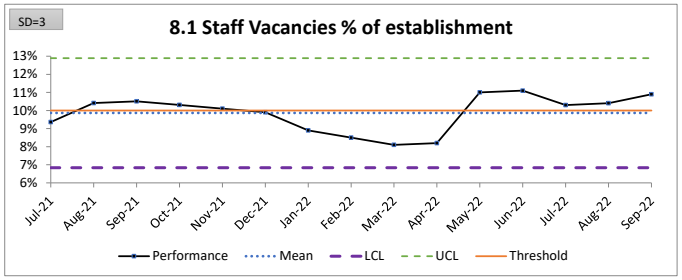


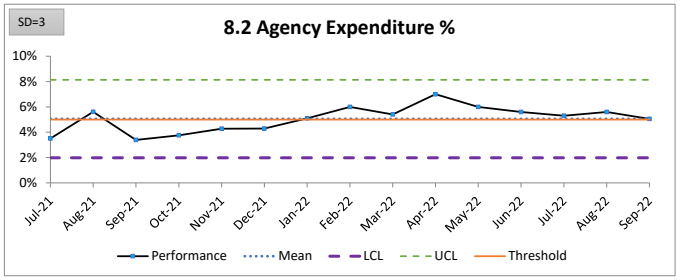


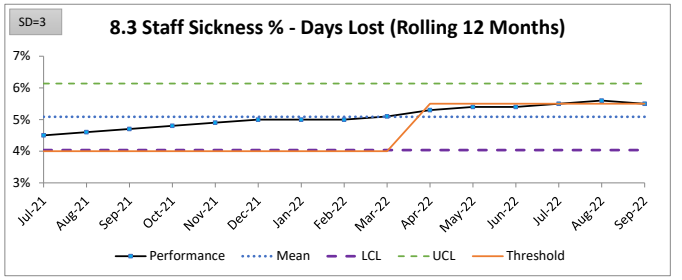


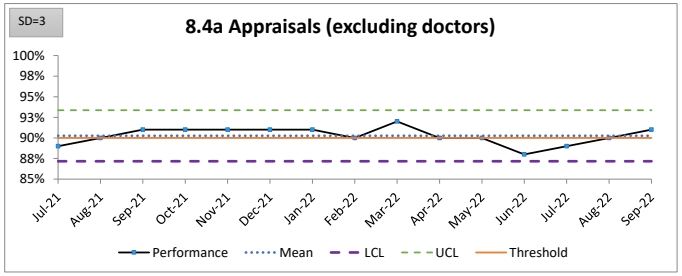


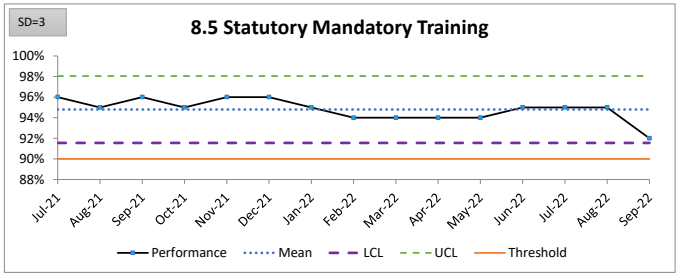
OBJECTIVE 8 - WORKFORCE PERFORMANCE

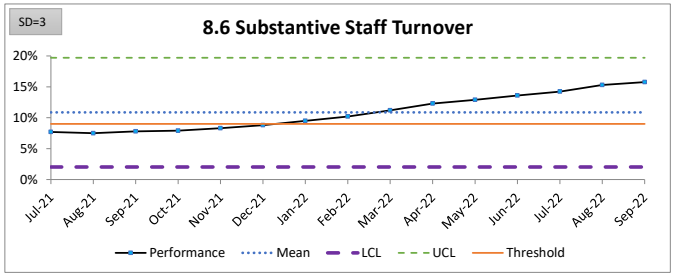












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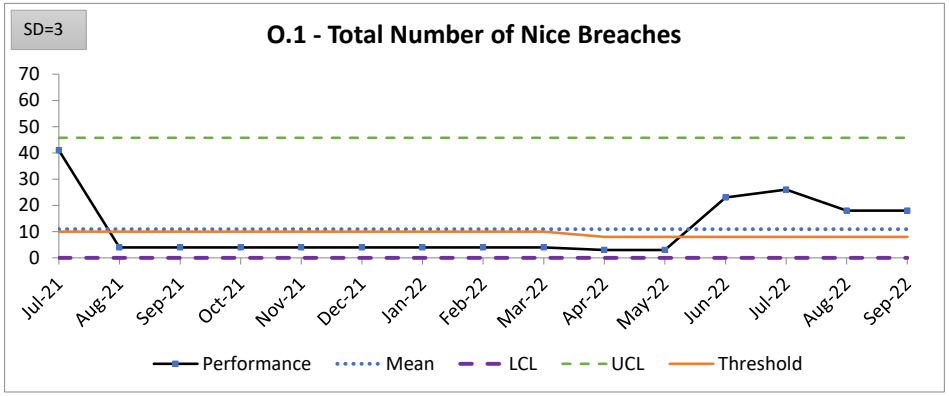

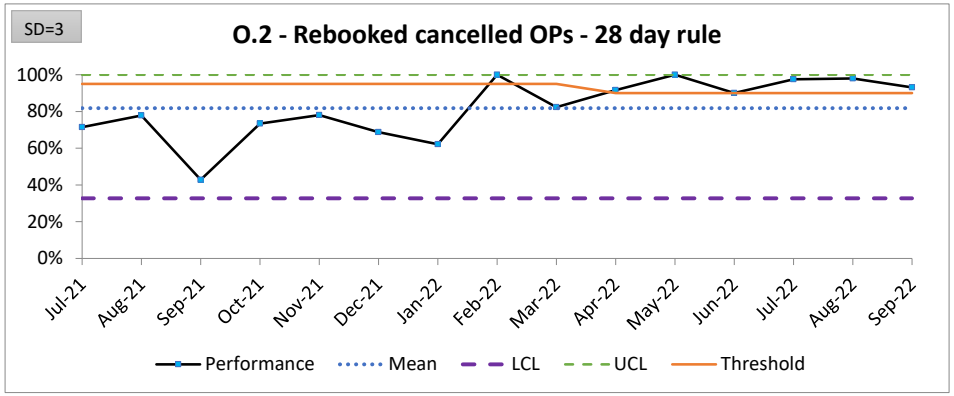

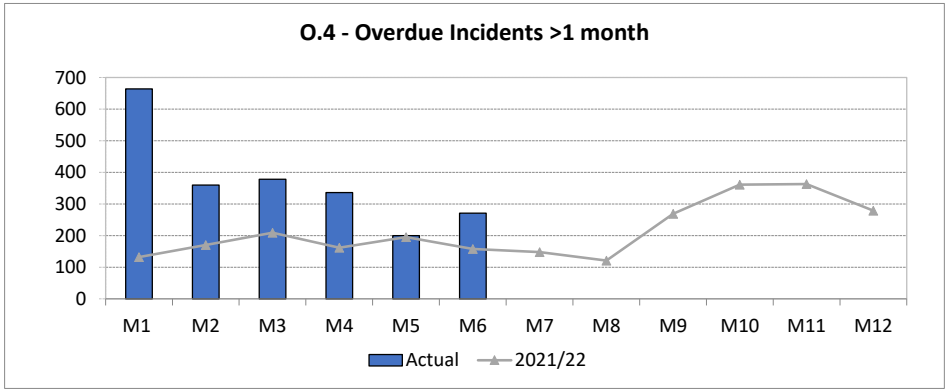

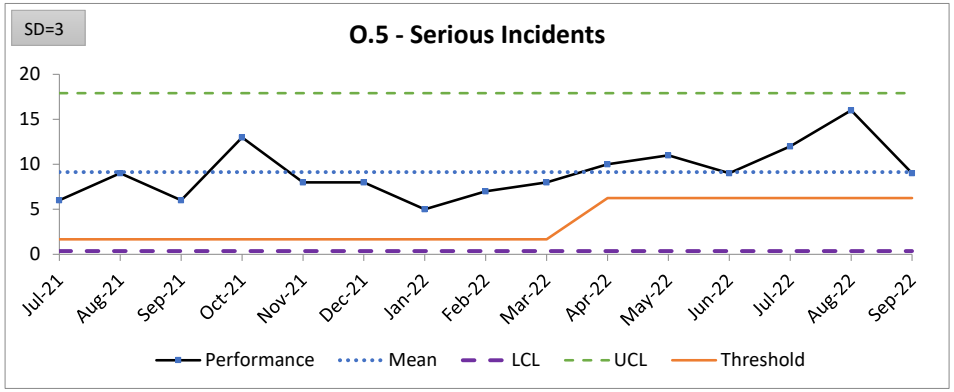

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Performance activity on a rolling 15 months/quarterly
Average on a rolling 15 months/quarterly
Lower Control Limit (LCL)
Upper Control Limit
Targets/Thresholds/NHSI Trajectories

Meeting title	**Trust Board**	**Date:** November 2022
Report title:	**Finance Paper Month 6 2022-23**	**Agenda item: 17**
Lead director **Report authors**	Terry Whittle Sue Fox Cheryl Williams	Director of Finance Deputy Head of Financial Management Financial Controller
FoI status:	Private document	

Report summary	An update on the financial position of the Trust at Month 6 (September 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 30th September 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 17-31

FINANCE REPORT FOR THE MONTH TO 30th SEPTEMBER 2022

FINANCE & INVESTMENT COMMITTEE

CONTENTS

EXECUTIVE SUMMARY

(1 & 2.) Revenue – Clinical revenue (ICB block contract and variable non-ICB income) is above plan. Income was received this month for the payment of the backdated wage award. Non-clinical revenue is slightly above plan due to income received for education and training.

(3. & 4.) Operating expenses – Pay costs are higher than plan due to the payment of the wage award (offset by income), increased costs for temporary staff and bank pay enhancements (for sickness and vacancies), and additional pay spend related to elective recovery. Non-pay is below. Inflationary pressures are lower than planned but remain volatile.

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

(8.) Elective Recovery Fund– ERF against the BLMK block has been recorded at planned levels to month 6 following informal guidance that this would not be subject to clawback by NHSE (April – Sept).

(9.) Covid expenditure – reduced costs mainly relating to lower backfill cover of staff shortages for Covid sickness absence.

(11.) Financial Efficiency– The Trust has achieved savings required up to month 6. The Trust has a shortfall in identified and approved schemes compared to the full year savings and is working to mitigate the gap (via additional savings/ERF/cost control).

(12.) Cash – Cash balance is £44.1m, equivalent to 49 days cash to cover operating expenses. Balances include £21m for capital schemes.

(13.) Capital – In line with plan and forecast to be within the CDEL allocation. In month there has been additional CDEL approved for NHP of £0.2m and Digital Diagnostics – Imaging of 0.07m. The trust has been advised it is unlikely there will be further CDEL for NHP. IFRS16 lease funding will be centrally held (by NHSE). The forecast has been reduced to take account of these items.

(14.) ICS Financial Position – BLMK ICS is broadly on plan up to M6.

Measures

Ref	All Figures in £'000	Month 6 YTD Plan	Month 6 YTD Actual	Month 6 YTD Var	Full Year Plan	Full Year Forecast	Full Year Var	RAG
1	Clinical Revenue	152,420	155,209	2,789	307,824	307,824	-	
2	Other Revenue	14,844	15,683	839	24,340	24,340	-	
3	Pay	(106,024)	(110,612)	(4,588)	(208,343)	(208,343)	-	
4	Non Pay	(50,187)	(49,890)	297	(98,408)	(98,408)	-	
5	Financing & Non-Ops	(10,031)	(9,763)	267	(20,804)	(20,804)	-	
6	Surplus/(Deficit)	1,022	626	(396)	4,609	4,609	-	
7	Control Total Surplus/(Deficit)	(3,740)	(4,099)	(359)	-	-	-	

Memos

8	ERF Delivery	3,691	3,691	-	7,381	7,381	-	
9	COVID expenditure	(4,100)	(2,745)	1,355	(5,776)	(5,776)	-	
10	High Cost Drugs	(10,573)	(10,523)	50	(21,197)	(21,197)	-	
11	Financial Efficiency	3,425	3,425	-	12,049	12,049	-	
12	Cash	47,129	44,074	(3,055)	29,943	29,943	-	
13	Capital Plan	(5,992)	(5,669)	323	(18,288)	(17,344)	944	
14	ICS Financial Position	(3,754)	(3,789)	(35)	-	-	-	

Key message

The Trust is reporting a £4m deficit (on a Control Total basis) for the period to September, £0.4m worse than plan. The impact of the wage award is partly offset by increased revenue. There is a rising pay cost burden due to bank enhancements and agency costs, both interventions are required to ensure staff availability to cover sickness and vacancies. Non-pay inflationary cost pressures were less than anticipated, however exposure to further inflationary price changes this year remains high. The Trust has achieved the required level of efficiency savings to date but has a recurrent savings gap (to plan) for the year, and the savings target increases in the second half of the year.

The cash position is robust, and creditors are paid promptly. The capital programme is on-track.

FINANCIAL PERFORMANCE- OVERVIEW MONTH 6

2. **Summary Month 6**

For the month of September 2022, financial performance (on a Control Total basis) is a £0.1m deficit, this is £0.1m worse than plan.

3. Clinical Income
Clinical income shows a favourable variance of £3.2m which is due to the additional income for the backdated wage award.

4. Other Income
Other income shows a favourable variance of £0.2m. Higher than planned income for education and training was received in month.

5. Pay
Pay spend is above plan with the payment of the wage award in September which was backdated to April. This is mostly offset by additional clinical income. The remainder of the in-month variance is due to increased temporary staffing costs. Further detail is included in Appendices 1 and 4.

6. Non-Pay
Non pay is above plan due to increased spend on drugs and clinical outsourcing. 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.

All Figures in £'000	Month 6			Month 6 YTD			Plan		
	Plan	Actual	Var	Plan	Actual	Var	Plan	Forecast	Var
Clinical Revenue	25,623	28,845	3,222	152,420	155,209	2,789	307,824	307,824	0
Other Revenue	1,591	1,817	227	9,804	10,673	869	19,169	19,169	0
Total Income	27,214	30,662	3,449	162,224	165,881	3,658	326,993	326,993	0
Pay	(17,348)	(20,747)	(3,399)	(106,024)	(110,612)	(4,588)	(208,343)	(208,343)	0
Non Pay	(8,130)	(8,354)	(224)	(50,187)	(49,890)	297	(98,408)	(98,408)	0
Total Operational Expenditure	(25,479)	(29,101)	(3,623)	(156,211)	(160,502)	(4,291)	(306,751)	(306,751)	0
EBITDA	1,735	1,561	(174)	6,013	5,379	(634)	20,242	20,242	0
Financing & Non-Op. Costs	(1,701)	(1,632)	70	(9,753)	(9,478)	274	(20,242)	(20,242)	0
Control Total Deficit (excl. top ups)	**34**	**(71)**	**(105)**	**(3,740)**	**(4,099)**	**(359)**	**0**	**0**	**0**
Control Total Deficit (incl. top ups)	**34**	**(71)**	**(105)**	**(1,740)**	**(4,099)**	**(359)**	**0**	**0**	**0**
Donated income	10	0	(10)	5,040	5,010	(30)	5,171	5,171	0
Depreciation	(48)	(48)	0	(277)	(285)	(8)	(563)	(563)	0
Impairments & Rounding	0	0	0	(1)	0	1	1	1	0
Reported deficit/surplus	**(4)**	**(119)**	**(115)**	**1,022**	**626**	**(396)**	**4,609**	**4,609**	**0**

Key message
For the month of September 2022, the position on a Control Total basis is a £0.1m deficit, which is slightly worse than plan. This is due to the payment of the wage award, which is mostly offset by clinical income, and an increase in spend on temporary staffing.

FINANCIAL PERFORMANCE - OVERVIEW YTD

8. **Summary Year to Date**

Cumulative financial performance (April-September) on a Control Total basis is a deficit of £4m. This is worse than plan by £0.3m. Overspends on pay costs offset by increased clinical income.

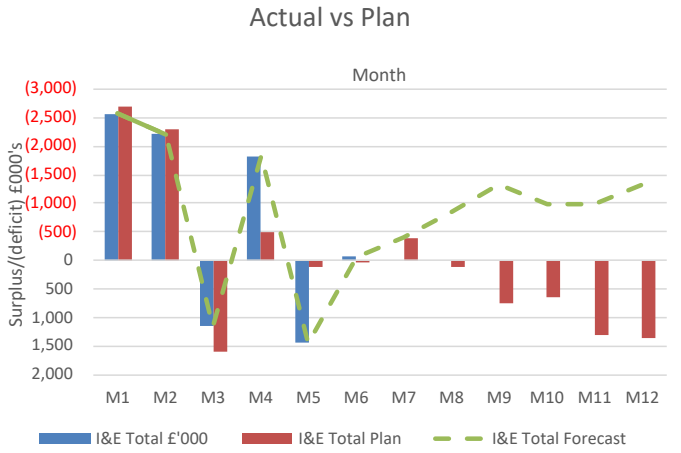
9. Clinical Income YTD
Clinical income shows a favourable variance of £2.8m which is due to overperformance on the remaining PbR contracts and revenue received for the wage award (pain in September). Further detail is included in Appendix 1.

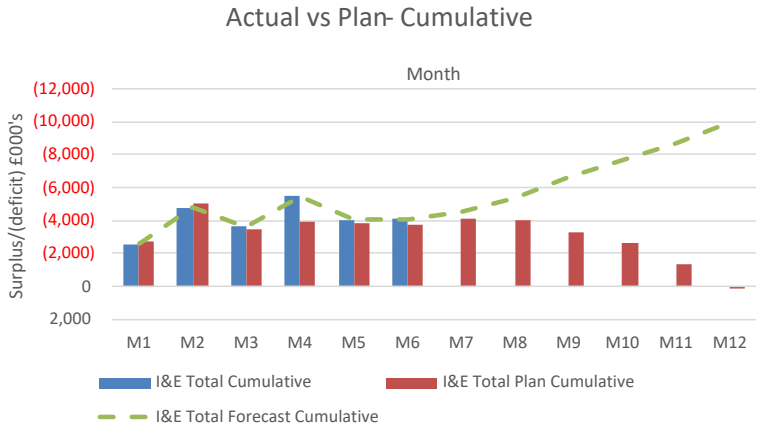
10. Other Income YTD
Other income shows a favourable variance of £0.8m. This is due to favourable variances against the R&D, education and training and covid testing income.

11. Pay YTD
Pay spend is above plan by £4.6m YTD due to the payment of the wage award. The impact of this is offset by increased clinical income. Spend on temporary staffing costs is also going up with to enhanced rates increasing uptake in clinical areas. Further detail is included in Appendices 1 & 4.

12. Non-Pay YTD
Non pay is below plan due to expenditure on clinical supplies and establishment expenses relating to inflationary reserves. 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.





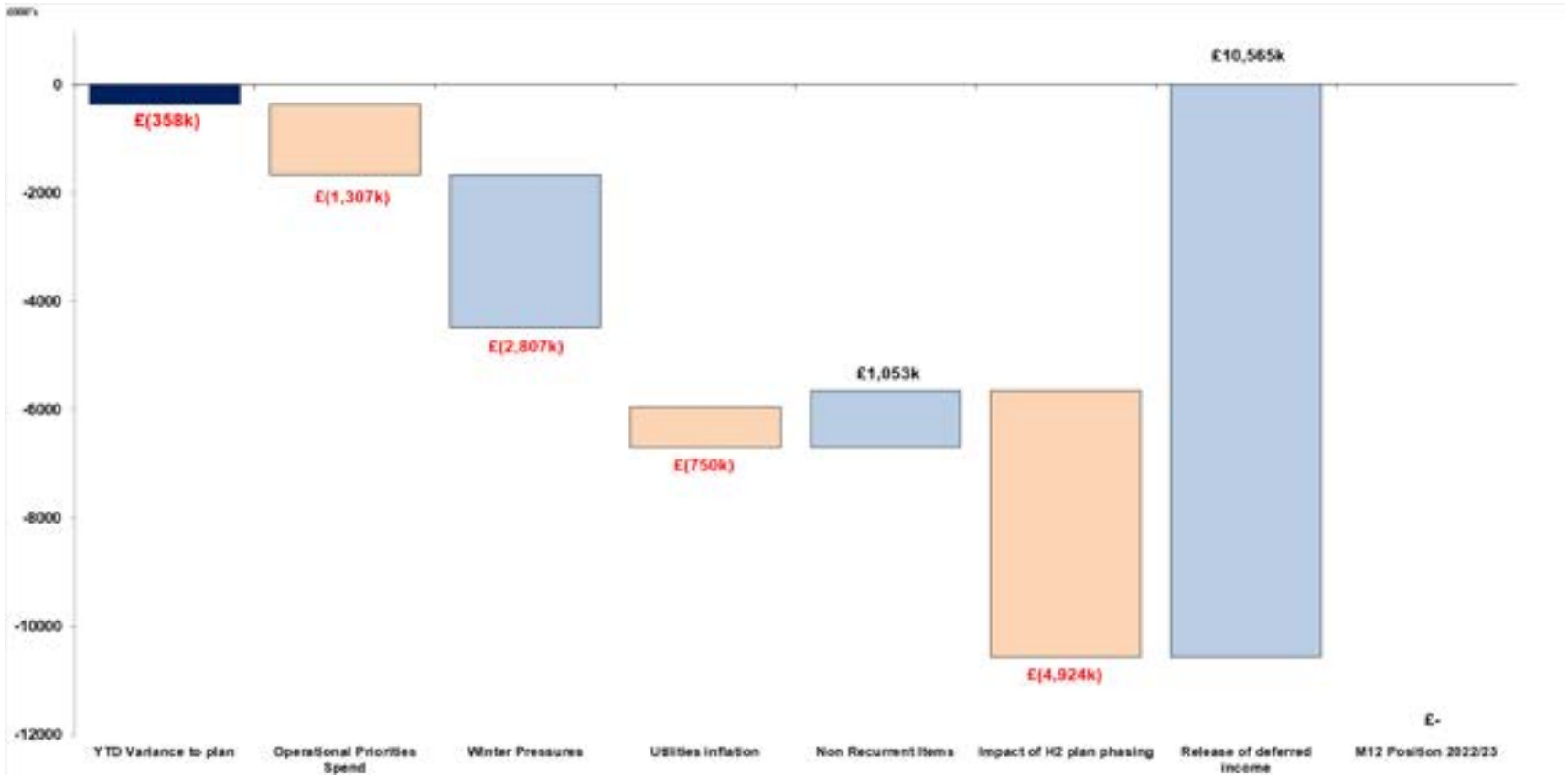
Key message
Up to September 2022, the position on a Control Total basis is a deficit of £4m. This is slightly worse than plan. Overspends on pay are offset by increased clinical income.

It should be noted that the plan in the second half of the year moves from a deficit to a breakeven position indicating an expected reduction in run-rate.

FINANCIAL PERFORMANCE – FORECAST OUTURN

14. Summary of key forecast assumptions

The Trust is currently forecasting delivery of the revised annual business plan – at breakeven performance. A forecast of current run-rate and expected future changes is shown below.



Key message
Due to the expected additional costs over the winter months and the impact of the savings programme in the second half of the financial year, there is an expectation that further release of non-recurrent deferred income (£10.5m) will be needed to achieve a breakeven position.

FINANCIAL PERFORMANCE - UNDERLYING RUN RATE

15. Adjusted expenditure run rate

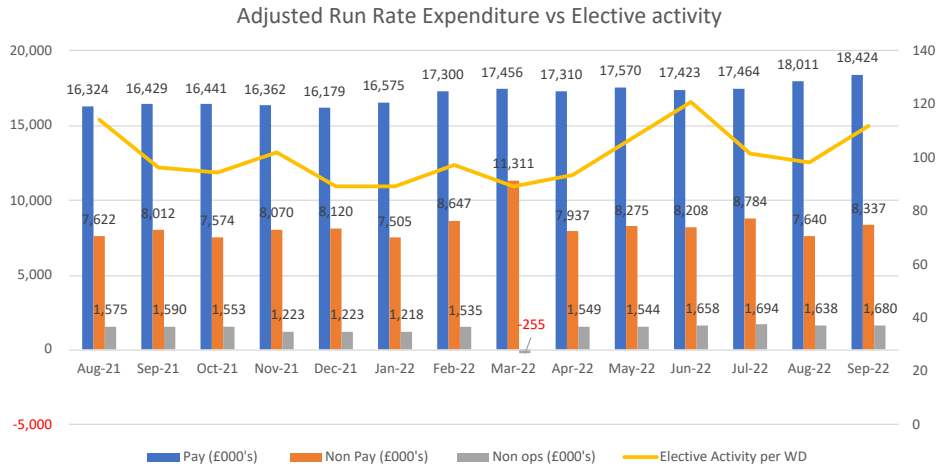
The graph shows adjusted run-rate expenditure (excl. direct COVID costs and material non recurrent expenditure) by category vs elective activity per day. This month the backdated wage award has also been excluded as a one-off cost.

Although spend on Covid related resource has reduced the monthly cost is £0.27m which relates mainly to pay cost for escalation and sickness backfill.

As the level of sickness across the Trust increases, the expected spend on temporary staffing costs is likely to increase to cover temporary gaps.

Temporary staffing costs are currently higher than expected due, in part, to the backfill of nurses recruited as part of the overseas campaign. Due to external delays with competency exams, agency staff are required to fill qualified nursing vacancies which would otherwise have been filled by the overseas nurses.

Note: Deferred income of £3.3m has been released to support the break-even plan, this is lower than the planned release of £4.6m to M6.



Key message

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

A detailed forecast is being undertaken to update the expected pay outturn (and key assumptions), impact of recurrent financial efficiencies and extent of the non-pay inflation cost pressure.

ACTIVITY PERFORMANCE & ERF

16. The Trust has recognised 100% of the expected ERF income available for the month on the basis that this will not be subject to clawback from NHS England. This is expected to continue in the second half of the financial year. 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.

17. Activity vs Plan (as per CIVICA)

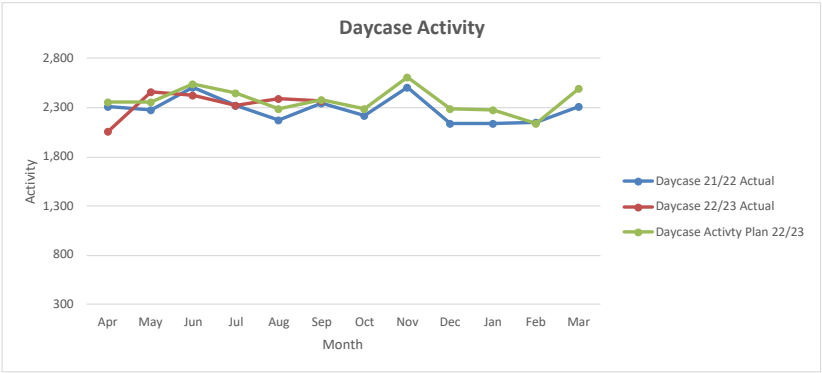
Day case activity-
Day cases have reduced since month 5 and are in line with the 22/23 plan and 21/22 actuals.

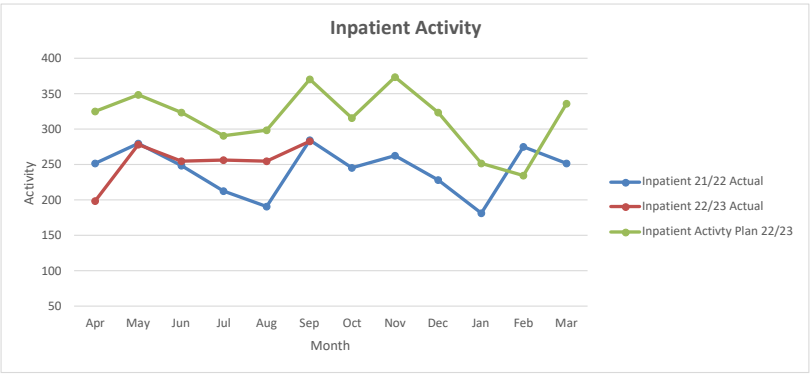
Elective Inpatient Activity-
Inpatient activity has increased since Month 5 and remain down against the 22/23 plan but in line with 21/22 actuals.

Outpatient Activity-
Outpatient activity has decreased since Month 5 and is up against the 21/22 actuals, however now below 22/23 plan.

Non-Elective Spells-
Non elective activity has increased since Month 5 and continues to be below the 22/23 plan and 21/22 actuals.

A&E activity-
A&E activity has increased since Month 5 and remains below 21/22 activity and 22/23 plan.





Key message
Inpatient elective activity increased slightly in September. ERF activity has been recorded at 100% to month 6 following guidance from NHS England that any underperformance will not be subject to clawback.

EFFICIENCY SAVINGS

18. The efficiency target is £3.4m to September 2022 and the schemes that have been signed off are delivering £1.8m. The remainder of the efficiency target is being achieved through managing the incremental cost of operational pressures bringing total efficiencies to £3.4m.

19. The Trust is increasing the focus on financial efficiency through the Better Value programme. The Trust has identified circa £7.2m (up to Month 6) from schemes against the total plan level of £12m.

Division	Target	Plan	% of target	FYE	Risk Adjusted Plan FYE	Recurrent	Non-recurrent	% of target	Risk Adjusted Plan FYE
	£000's	£000's		£000's	£000's	£000's	£000's	%	£000's
Medicine	3,399	2,520	74%	2,920	1,726	1,280	446	51%	1,961
Surgery	2,709	2,232	82%	2,197	1,276	573	703	47%	1,302
W&C	1,451	1,451	100%	1,451	1,428	403	1,048	98%	1,428
Core Clinical	2,716	2,309	85%	2,615	1,607	725	882	59%	1,696
Corporate	1,629	752	46%	784	1,161	507	656	71%	641
Central Ops	103	0	0%	0	0			0%	0
Latest position	**12,007**	**9,264**	**77%**	**9,966**	**7,200**	**3,488**	**3,735**	**60%**	**7,028**

20. It should be noted that the phasing of the required savings increases during the second half of the financial year. This is shown in the graph below:

Key message
YTD the Trust has delivered its £3.4m 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. The planned savings requirement increases significantly in the second half of the financial year.

CAPITAL- OVERVIEW YTD

21. The YTD spend on capital after accounting for donated assets and derecognised assets is £5.7m, which is broadly in line with Trust's revised capital plan (excluding national funding). There is £1.7m relating to derecognition of various assets following an internal review.

22. The Trust's ICS CDEL allocation is £15.9m and there is further approved national funding for NHP of £1.23m, increased by £0.17m in the month, Endoscopy £0.14m and £0.07m for Digital Diagnostic for Imaging. The Trust does not expect to receive any additional NHP funding in year. It has also been made aware that the funding of £0.3m for the impact of the new leases under IFRS16 will be held centrally and not allocated to individual systems. As a result, has revised its CDEL forecast to £17.34m MKUH are also not likely to be receive any addition funding from the BLMK IT Integrated Care Board (ICB) which wasn't within its capital plan.

23. 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	1.23	0.71
Endoscopy		0.14	0.14	
Dibital Diagnostic Funding - Imaging			0.07	
New Lease impact (IFRS16)		0.31		0.31
Sub Total CDEL	**15.90**	**2.38**	**1.44**	**1.02**
CDEL Allocation Approved	**17.34**			**1.02**
Total Planned CDEL	**18.28**			

Capital Item	**YTD Plan up to end of Sept £m**	**Actual up to end of Sept 22 £m**	**PO & Pre-commitments up to end of Sept 22**	**YTD Variance to YTD Plan £m**	**Status**
Pre-commitments					
CBIG	2.04	2.88	0.86	0.84	
Strategic	2.99	2.59	4.46	- 0.40	
Slippage from Pre-commitments					
Total Pre-commitments	**5.03**	**5.47**	**5.32**	**0.44**	
Scheme Allocations For 22/23 schemes					
CBIG including IT and Contingency	0.54	0.42	0.85	-0.12	
Strategic Radiotherapy	0.02	0.02	0.02	0.01	
Funded from Strategic Contingency					
Asbestos Removal for flat roofs	0.00	0.04	0.16	0.04	
Additional costs for Whitehouse	0.00	0.00	0.00	0.00	
EV Chargers	0.00	0.00	0.01	0.00	
Total Proposed Scheme Allocations	**0.56**	**0.48**	**1.03**	**- 0.08**	
Total Pre-commitments and Scheme Allocations (ICS CDEL Allocation)	**5.58**	**5.95**	**6.35**	**0.36**	
Nationally approved schemes					
NHP	0.43	0.31	0.86	- 0.12	
Endoscopy	0.00	0.00	0.00	0.00	
Dibital Diagnostic Funding - Imaging	0.00	0.00	0.00	0.00	
Total Nationally approved schemes	0.43	0.31	0.86	- 0.12	
CDEL Approved capital plan	**6.02**	**6.26**	**7.21**	**0.24**	
Donated Assets (excluded from CDEL)					
Maple Centre	0.00	0.00	5.00	0.00	
Pathlake	0.00	0.00	0.00	0.00	
Staff Rooms	0.03	0.00		-0.03	
Total Donated Assets	**0.03**	**0.00**	**5.00**	**-0.03**	
Net Adjustments		-0.60		-0.60	
Awaiting Approval					
New Leases Impact under IFRS 16 (applied but not confirmed)	0.01	0.00	0.00	-0.01	
NHP - external fees	0.00	0.00	0.00	0.00	
Total awaiting approval	**0.01**	**0.00**	**0.00**	**-0.01**	
Submitted CDEL capital plan	**6.00**	**5.66**	**12.21**	**-0.34**	

Key message
Capital expenditure is on plan up to September. The Trust is forecasting full year spend in-line with plan and will need to closely manage business-as-usual scheme costs and strategic capital expenditure on strategic schemes (Radiotherapy) to deliver the plan.

CAPITAL – FOT

24. The Trust is forecasting to spend its ICS allocation and nationally approved allocations in full and be within the revised £17.3m CDEL allocation which includes an additional £0.07m awarded in month relating to digital diagnostics for imaging and £0.17m for NHP.

25. Following the additional funding awarded for NHP in month, there still remains £0.7m in the Trusts submitted capital plan for NHP for external design fees. The Trust has been advised that it is unlikely to receive any additional funding for NHP, however it has not committed this funding and is not forecasting to spend this in 22/23. The national capital team have confirmed to the trust that they will hold the funding centrally for the impact of new leases under IFRS16 and no additional funding will be allocated to the Trust and the impact will not be part of the current ICS CDEL. These changes means that the trusts approved CDEL is currently expected to be £17.3m for 2022/23.

26. The CBIG scheme allocations for 22/23 were reviewed and signed off by the trust's internal approval processes during June. The business cases relating to these schemes are in the process of being worked up by the relevant scheme managers and to date 89% of the ICS CDEL allocation has approved Business Cases. The final schemes will be going through the internal approval process by the end of October.

27. The Strategic radiotherapy scheme includes a notional allocation of £4.5m for radiotherapy which has been approved in September at Trust Board and the cashflows for this are being worked through.

Key message
Capital is forecasting to be within the CDEL allocation of £17.3m which includes nationally funded schemes £1.4m for NHP £1.2m, Endoscopy £0.1m and digital diagnostics for imaging of £0.1m. The funding for the impact of new leases under IFRS16 is being centrally and will not be part of the ICS CDEL allocation.

Capital Item	22/23 Submitted Plan £m	22/23 Forecast £m	Variance To Plan £m	Status
Pre-commitments				
CBIG	2.24	2.24	0.00	
Strategic	5.73	5.24	-0.49	
Slippage from Pre-commitments		0.49	0.49	
Total Pre-commitments	**7.97**	**7.97**	**0.00**	
Scheme Allocations For 22/23 schemes				
CBIG including IT and Contingency	3.00	3.00	0.00	
Strategic Radiotherapy	4.50	4.50	0.00	
Funded from Strategic Contingency				
Asbestos Removal for flat roofs		0.16	0.16	
Additional costs for Whitehouse		0.04	0.04	
EV Chargers		0.05		
Total Proposed Scheme Allocations	**7.93**	**7.93**	**0.00**	
Total Pre-commitments and Scheme Allocations (ICS CDEL Allocation)	**15.90**	**15.90**	**0.00**	
Nationally approved schemes				
NHP	1.23	1.23	0.00	
Endoscopy	0.14	0.14	0.00	
Dibital Diagnostic Funding - Imaging		0.07	0.07	
Total Nationally approved schemes	1.37	1.44	0.07	
CDEL Approved capital plan	**17.26**	**17.34**	**0.08**	
Donated Assets (excluded from CDEL)				
Maple Centre	5.00	5.00	0.00	
Pathlake	0.14	-	-0.14	
Staff Rooms	0.03	0.03	0.00	
Total Donated Assets	**5.17**	**5.03**	**-0.14**	
Net Adjustments				
Awaiting Approval				
New Leases Impact under IFRS 16 (applied but not confirmed)	0.31	0.31	0.00	
NHP - external fees	0.71	-	-0.71	
Total awaiting approval	**1.02**	**0.31**	**-0.71**	
Submitted CDEL capital plan	**18.27**	**17.34**	**-0.93**	

CASH

28. Summary of Cash Flow

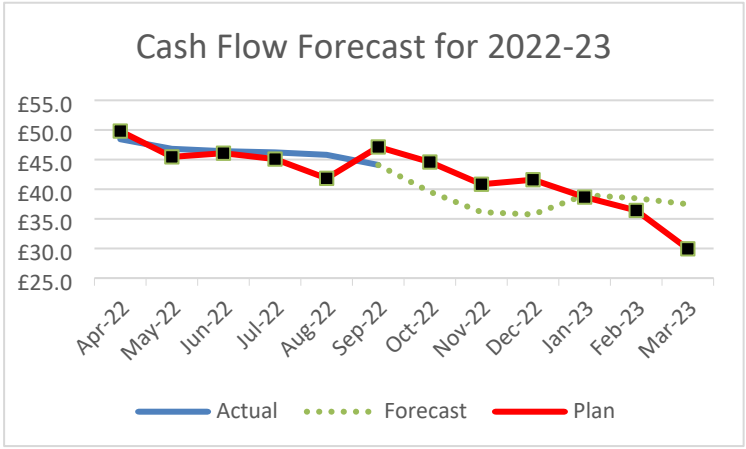
The cash balance at the end of September was £44.1m, this was £2.9m lower than the planned figure of £47m and a decrease on last month's figure of £45.8m. (see opposite).
See appendices 6-8 for the cashflow detail.

29. 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.

30. 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 M6 YTD Number	Actual M6 YTD £'000	Actual M5 YTD Number	Actual M5 YTD £'000
Non NHS				
Total bills paid in the year	35,035	94,486	29,696	82,608
Total bills paid within target	31,022	87,563	26,423	76,555
Percentage of bills paid within target	**88.5%**	**92.7%**	**89.0%**	**92.7%**
NHS				
Total bills paid in the year	929	3,844	791	3,251
Total bills paid within target	717	2,493	608	2,084
Percentage of bills paid within target	**77.2%**	**64.9%**	**76.9%**	**64.1%**
Total				
Total bills paid in the year	**35,964**	**98,330**	**30,487**	**85,859**
Total bills paid within target	**31,739**	**90,056**	**27,031**	**78,638**
Percentage of bills paid within target	**88.3%**	**91.6%**	**88.7%**	**91.6%**

Key message

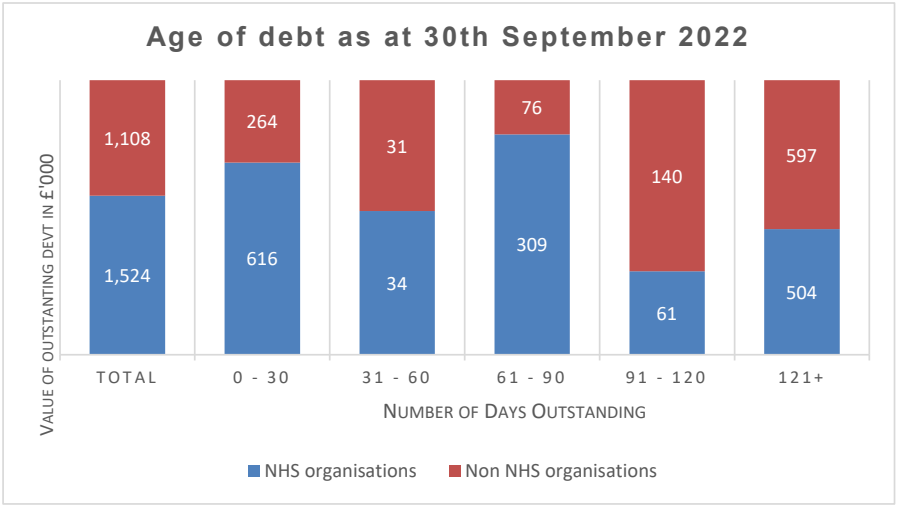
Cash is above plan by £4m, and the Trust has fallen below the 95% target for BPPC, mainly due to issues experience by SBS during their repatriation of AP services, and ongoing agency invoicing issues. Management is working to rectify payment performance to levels required.

BALANCE SHEET

31. 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 £12.5m; this is mainly driven by the inclusion of Right of Use assets related to the adoption of IFRS 16 1 April 2022 and capital purchases in year offset by in year depreciation.
- Current assets have decreased by £6.1m, this is mainly due to the decrease in cash £14m offset by an increase in receivables (£7.9m).
- Current liabilities have decreased by £6.2m, this is mainly due to the decrease in Trade Payables £4.5m and deferred income £2.5m offset by the inclusion of Right of Use assets related to the adoption of IFRS 16 1 April 2022 (£0.8m)
- 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.



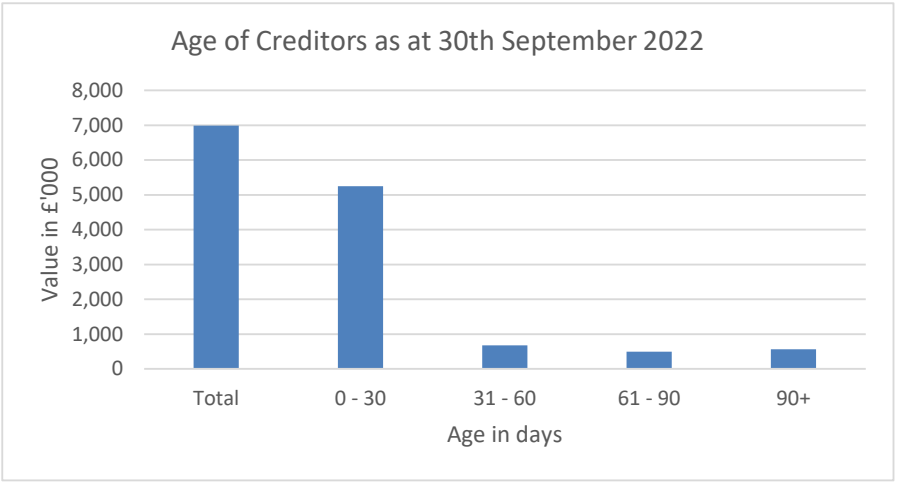
32. Aged debt

The debtors position as of 30th September is £2.6m, which is an increase of £0.1m from the August'22 position. Of this total £1.1m is over 121 days old, the detail is shown in Appendix 10.

The three largest NHS debtors are Bedford Hospitals NHS Foundation Trust £0.06m for salary recharges, NHS England £0.3m relating to midwifery and non-contract recharges and Oxford University Hospitals NHS FT £0.3m relating to salary and renal services recharges. The largest non-NHS debtors include £0.2m for overseas patients, £0.3m 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.

33. Creditors

The creditor's position is £7.0m, which is an increase of £1.3m from the August' 22 position. Of this £1.7m is over 30 days, with £1.2m 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

34. Utilisation of provisions

At the beginning of April, the Trust had £4.2m in provisions with £2.4m being current provisions, the largest of these being for legal cases £1.9m. During September the Trust has utilised a further £5k, YTD £34k. Details of the provisions are shown in the provisions table opposite.

35. Deferred Income

The Trust has reduced its deferred income YTD by £2.5m which is mainly due to released ICS/B and other NHS income partially offset by increased other NHS and non-NHS income. The total deferred income is £18.4m as detailed below.

Deferred Income	As at 1st April 2022	Additional in Year	Utilised in Year	As at 30th September 2022
		£000	£000	£000
NHS				
Cancer Alliance	(621.0)	(609.3)	226.3	(1,004.0)
ICB	(1,704.9)	(1,439.0)	3,410.9	267.0
Health Eduction England	(877.6)	(795.4)	651.8	(1,021.2)
ICS	(11,518.6)	(4.1)	734.5	(10,788.2)
Other NHS	(3,187.8)	(1,128.2)	1,701.8	(2,614.2)
Total NHS	(17,909.8)	(3,976.0)	6,725.3	(15,160.5)
Non NHS				
MK Council	(500.0)	(118.5)	0.0	(618.5)
R&D	(326.9)	(157.5)	117.1	(367.3)
Sensyne	(2,000.0)	0.0	0.0	(2,000.0)
Other Non NHS	(150.7)	(181.5)	79.6	(252.6)
Total Non NHS	(2,977.6)	(457.5)	196.7	(3,238.4)
Total Deferred Income	**(20,887.4)**	**(4,433.5)**	**6,922.0**	**(18,398.9)**

Provisions	As at 1st April 2022	Arising	Utilised in Year	As at 30th September 2022
Current	£000	£000	£000	£000
LTPS	(52.4)		5.2	(47.20)
Injury Benefit	(33.8)		24.0	(9.85)
Pension Compensation	(2.9)		1.5	(1.43)
Legal Claim Provision				
Legal- HR Pension	(40.0)		3.2	(36.8)
Legal - Other	(1,870.0)			(1,870.0)
Coroners costs	(126.3)			(126.3)
Other				
HMRC VAT - LIMS	(306.0)			(306.0)
Total Current Provisons	**(2,431.5)**	**-**	**33.9**	**(2,397.6)**
Non Current	£000	£000	£000	£000
Injury Benefit Provision	(834.6)			(834.6)
Pension Compensation	(15.8)			(15.8)
Pension Tax Provision	(330.5)			(330.5)
Modular Ward	(418.9)			(418.9)
WG Dilapidation	(132.3)			(132.3)
Off site storage Dilapidation costs 20-21	(43.0)			(43.0)
White house dilapidation costs 21-22	(36.0)			(36.0)
Total Non Current Provisons	**(1,811.0)**	**-**	**-**	**(1,811.0)**
Total Provisions	**(4,242.5)**	**-**	**33.9**	**(4,208.6)**

Key message

The Trust has £4.2m in provisions, of which £34k has been utilised YTD. In addition, there is deferred income of £18.4m. Management of the deferred income is being discussed with counterparties.

BAF

36. Financial risk register and the BAF
There are currently 11 risks on the Financial Risk Register which are reviewed monthly, there has been no new risks added in the month. There are three risks rated as a significant risk [16] which relate to current funding, transformation delivery and strategic capital. All the other risks have been reviewed and remain at the same level.

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

Key message
There have been no new risks added this month, of the current eleven finance risks there are three risks that are rated as a significant risk (BAF).

INTERGRATED CARE BOARD (ICB) KEY METRICS

The ICB I&E position can be summarised as follows:

Provider Maincodes			99PLANYTD	99ACTYTD		
Provider Summary Adjusted Financial Performance			1_1PLANYTD_2	1_1ACTYTD_2	1_1VARYTD_2	1_1%YTD_2
	Expected Sign		Net Expenditure Plan 30/09/2022 YTD £'000	Net Expenditure Actual 30/09/2022 YTD £'000	Net Expenditure Variance 30/09/2022 YTD £'000	Net Expenditure Variance 30/09/2022 YTD %
Provider 1 - Bedfordshire Hospitals NHS Foundation Trust	+/-	Rec	(13)	311	324	0.1%
Provider 2 - Milton Keynes University Hospital NHS Foundation Trust	+/-	Rec	(3,741)	(4,100)	(359)	(0.2%)
TOTAL Provider Surplus/(Deficit)	+		(3,754)	(3,789)	(35)	(0.9%)

The ICB plan is based on the 20th of June submitted plan and the allocation updates for month 6, including the b/fwd. CCG balance. The YTD position for the ICS is reflecting a £3.8m deficit which is £35k above plan. Within this position the ICB is breakeven, BHT are £324k better than plan and MKFT £359k worse than plan. The forecast for the system remains as breakeven.

RECOMMENDATIONS TO BOARD

38. Finance & Investment Committee is asked to note the financial position of the Trust as of 30th September and the proposed actions and risks therein.

APPENDICIES

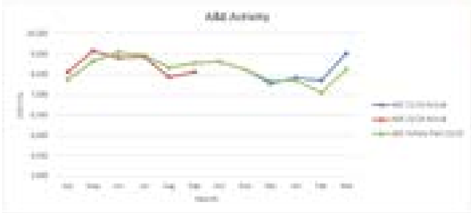
Appendix 1

Statement of Comprehensive Income
For the period ending 30th September 2022

Clinical Activity Summary
For the period ending 30th September 2022

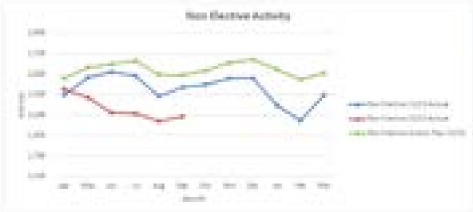
Appendix 3

Clinical Activity Run Rates
For the period ending 30th September 2022



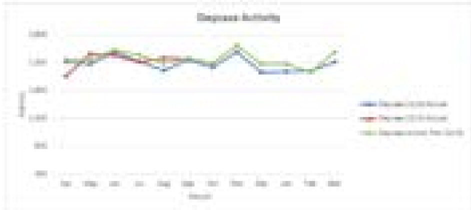
In Month Plan	In Month Actual	Variance	YTD Plan	YTD Actual	YTD Variance	Prior Year In Month	PY vs month Diff	% Diff	PY YTD	Diff	% Diff
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

A&E activity has increased since Month 5, and remains below 21/22 activity and 22/23 plan.



In Month Plan	In Month Actual	Variance	YTD Plan	YTD Actual	YTD Variance	Prior Year In Month	PY vs month Diff	% Diff	PY YTD	Diff	% Diff
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

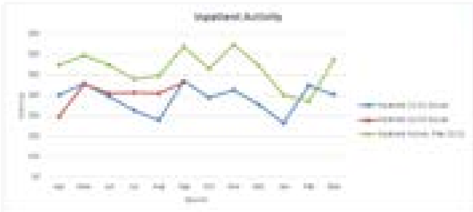
Non elective activity has increased since Month 5, and continues to be below the 22/23 plan and 21/22 actuals.



In Month Plan	In Month Actual	Variance	YTD Plan	YTD Actual	YTD Variance	Prior Year In Month	PY vs month Diff	% Diff	PY YTD	Diff	% Diff
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

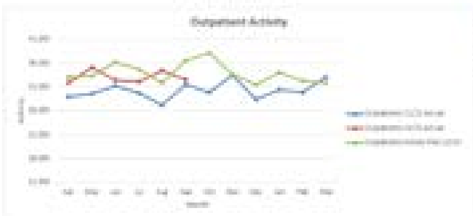
Daycases have marginally decreased since Month 5 and are now inline with the 22/23 plan and 21/22 actuals.

*Included Chemotherapy Delivery Day Case



In Month Plan	In Month Actual	Variance	YTD Plan	YTD Actual	YTD Variance	Prior Year In Month	PY vs month Diff	% Diff	PY YTD	Diff	% Diff
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Inpatient activity has increased since Month 5 and remain down against the 22/23 plan but inline with 21/22 actuals.



In Month Plan	In Month Actual	Variance	YTD Plan	YTD Actual	YTD Variance	Prior Year In Month	PY vs month Diff	% Diff	PY YTD	Diff	% Diff
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

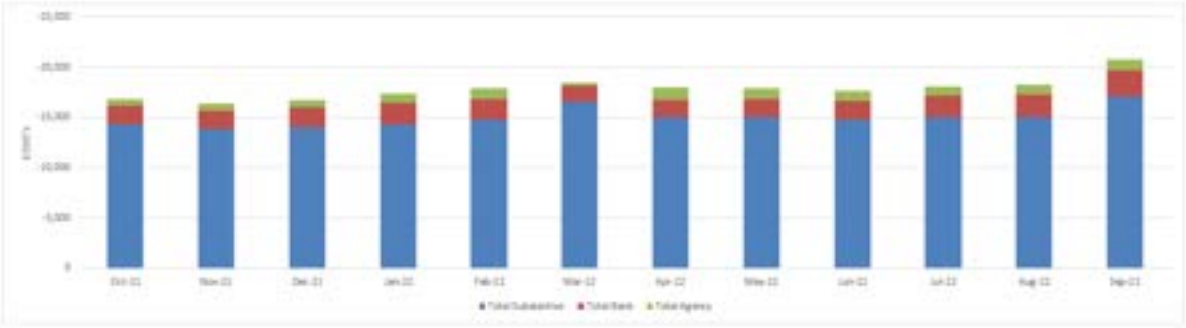
Outpatient activity has decreased since Month 5 and is up against the 21/22 actuals, however now below 22/23 plan.

Appendix 4

Pay Expenditure
For the period ending 30th September 2022

Year to date pay expenditure is £110.6, this is adverse to plan by £4.5m. The in-month variance is driven by the payment of the wage award and associated backpay. There were also additional bank and agency staff costs due to enhanced rates.

TRUST		Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Month Budget	Month Actual	Variance	YTD Budget	YTD Actual	YTD Variance	Month Change	Month Actual	Month Change	Trend WTE
														£'000	£'000	£'000	£'000	£'000	£'000	£'000	WTE	WTE	
Substantive	Med Staff	-4,527	-4,509	-4,675	-4,639	-4,810	-1,897	-5,048	-4,891	-4,749	-4,935	-5,072	-5,372	(4,942)	(5,372)	(430)	(29,820)	(30,067)	(246)	(300)	510	0	
	Nurses and Midwives	-3,811	-3,707	-3,714	-3,761	-3,796	-2,418	-3,841	-3,934	-3,801	-3,883	-3,745	-4,264	(4,328)	(4,264)	64	(26,254)	(23,468)	2,787	(519)	889	12	
	Sci Tech & Ther	-1,964	-1,936	-1,896	-1,993	-1,965	-1,484	-1,930	-1,976	-1,949	-1,921	-1,918	-2,186	(2,198)	(2,186)	12	(13,087)	(11,880)	1,207	(269)	516	5	
	Healthcare assistants, etc	-1,414	-1,389	-1,362	-1,430	-1,518	-1,135	-1,557	-1,640	-1,619	-1,664	-1,656	-2,106	(1,502)	(2,106)	(604)	(9,110)	(10,243)	(1,133)	(450)	665	4	
	Admin & Clerical	-2,300	-2,059	-2,167	-2,274	-2,184	-1,654	-2,403	-2,367	-2,405	-2,386	-2,395	-2,895	(2,692)	(2,895)	(203)	(16,259)	(14,851)	1,408	(500)	754	8	
	Other	-276	-217	-231	-240	-237	-7,920	-262	-245	-255	-260	-270	-289	(259)	(289)	(30)	(1,567)	(1,578)	(11)	(19)	15	1	
Total Substantive		**-14,292**	**-13,837**	**-14,045**	**-14,337**	**-14,710**	**-16,508**	**-15,040**	**-15,053**	**-14,779**	**-15,049**	**-15,057**	**-17,112**	**(15,923)**	**(17,112)**	**(1,191)**	**(96,097)**	**(92,087)**	**4,011**	**(2,056)**	**3,348**	**29**	
Bank	Med Staff (Locums)	-289	-222	-335	-295	-366	278	-316	-345	-374	-379	-418	-470	(272)	(470)	(198)	(1,556)	(2,302)	(745)	(52)	21	2	
	Nurses and Midwives	-691	-662	-704	-801	-747	-733	-577	-625	-653	-741	-697	-848	(313)	(848)	(535)	(2,636)	(4,139)	(1,503)	(152)	149	6	
	Sci Tech & Ther	-114	-106	-112	-166	-148	-269	-113	-165	-162	-158	-238	-253	(42)	(253)	(211)	(254)	(1,089)	(835)	(16)	43	1	
	Healthcare assistants, etc	-572	-579	-583	-611	-583	-630	-506	-501	-493	-620	-629	-792	(363)	(792)	(430)	(2,175)	(3,538)	(1,363)	(166)	190	(3)	
	Admin & Clerical	-210	-240	-254	-259	-255	-297	-166	-168	-184	-212	-206	-234	(23)	(234)	(212)	(137)	(1,170)	(1,033)	(28)	54	(4)	
Total Bank		**-1,876**	**-1,808**	**-1,988**	**-2,152**	**-2,100**	**-1,651**	**-1,677**	**-1,803**	**-1,865**	**-2,109**	**-2,185**	**-2,598**	**(1,013)**	**(2,598)**	**(1,585)**	**(6,759)**	**(12,238)**	**(5,479)**	**(413)**	**457**	**2**	
Agency	Med Staff	-170	-169	-169	-266	-202	383	-193	-270	-292	-247	-359	-365	(82)	(365)	(283)	(512)	(1,728)	(1,216)	(6)	18	(1)	
	Nurses and Midwives	-284	-372	-434	-463	-601	-401	-812	-517	-367	-418	-436	-463	(173)	(463)	(289)	(1,617)	(3,013)	(1,396)	(27)	69	(1)	
	Sci Tech & Ther	-66	-68	-46	-52	-73	-81	-66	-128	-55	-94	-93	-89	(108)	(89)	18	(680)	(566)	114	4	11	0	
	Healthcare assistants, etc	-26	-19	-4	-31	-41	-31	-81	-31	-57	-69	-69	-71	(16)	(71)	(54)	(98)	(376)	(278)	(2)	20	(2)	
	Admin & Clerical	-44	-15	-6	-29	-75	-42	-45	-48	-77	-65	7	8	0	8	8	(52)	(220)	(169)	2	1	(1)	
	Other	-39	-58	-60	-50	-75	-78	-56	-72	-82	-55	-61	-57	(35)	(57)	(22)	(209)	(383)	(175)	4	7	(1)	
Total Agency		**-630**	**-700**	**-719**	**-892**	**-1,067**	**-249**	**-1,253**	**-1,065**	**-969**	**-948**	**-1,012**	**-1,036**	**(414)**	**(1,036)**	**(622)**	**(3,168)**	**(6,287)**	**(3,120)**	**(24)**	**126**	**(5)**	
Total		**-16,798**	**-16,345**	**-16,752**	**-17,361**	**-17,877**	**-18,409**	**-17,970**	**-17,922**	**-17,613**	**-18,106**	**-18,254**	**-20,747**	**(17,348)**	**(20,747)**	**(3,399)**	**(106,024)**	**(110,612)**	**(4,588)**	**(2,493)**	**3,930**	**26**	



Appendix 5

Non-Pay Expenditure
For the period ending 30th September 2022

Year to date non-pay expenditure is £59.6m, this is better than plan. Non pay is broadly on plan for the month with a slight increase in high-cost drugs and outsourcing spend.

Trust		Oct-21 £'000	Nov-21 £'000	Dec-21 £'000	Jan-22 £'000	Feb-22 £'000	Mar-22 £'000	Apr-22 £'000	May-22 £'000	Jun-22 £'000	Jul-22 £'000	Aug-22 £'000	Sep-22 £'000	Month Budget £'000	Month Actual £'000	Month Variance £'000	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Month Change £'000	Trend
Non Pay	Drug expense (excl. HCD)	(496)	(320)	(445)	(496)	(344)	(303)	(530)	(430)	(82)	(541)	(417)	(456)	(390)	(456)	(65)	(2,434)	(2,944)	(511)	(39)	
	High Cost Drugs	(1,757)	(1,913)	(1,786)	(1,802)	(1,580)	(1,995)	(1,655)	(1,919)	(1,919)	(1,722)	(1,926)	(1,870)	(1,746)	(1,870)	(124)	(10,573)	(10,523)	49	56	
	Clinical supplies and services	(1,571)	(1,544)	(1,654)	(1,697)	(2,109)	(759)	(1,755)	(1,835)	(1,253)	(2,084)	(1,814)	(1,796)	(1,787)	(1,796)	0	(11,147)	(10,537)	610	17	
	General supplies and services	(397)	(414)	(428)	(455)	(520)	(705)	(419)	(356)	(420)	(461)	(403)	(369)	(378)	(369)	9	(2,296)	(2,428)	(131)	34	
	Establishment Expenses	(1,060)	(1,122)	(1,205)	(1,191)	(1,197)	(4,917)	(1,218)	(1,112)	(1,118)	(1,817)	(499)	(1,073)	(1,133)	(1,073)	60	(7,342)	(6,856)	505	(574)	
	Premises and fixed plant	(1,306)	(1,480)	(1,465)	(1,583)	(1,550)	(6,432)	(1,728)	(1,523)	(1,724)	(1,478)	(1,193)	(1,505)	(1,504)	(1,505)	(1)	(9,221)	(9,058)	162	(312)	
	Outsource to Commercial sector	(541)	(599)	(436)	(105)	(684)	(1,306)	(642)	(702)	(702)	(674)	(739)	(819)	(673)	(819)	(146)	(4,023)	(4,370)	(348)	(81)	
	Education and Training Expenses	(77)	(136)	(98)	(96)	594	(208)	(146)	(159)	(165)	(52)	(271)	(69)	(133)	(69)	65	(871)	(862)	9	203	
	Consultancy expenses	0	(2)	1	(1)	9	(2)	(4)	(4)	(0)	(85)	19	(1)	(1)	(1)	0	(8)	(75)	(67)	(20)	
	Miscellaneous Operating Expenses	(371)	(292)	(708)	(175)	(415)	(822)	(443)	(279)	(320)	(396)	(421)	(396)	(374)	(396)	(22)	(2,275)	(2,256)	17	24	
	Non Pay Savings Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total Non Pay		(7,576)	(7,822)	(8,222)	(7,599)	(7,595)	(17,446)	(8,542)	(8,318)	(7,704)	(9,309)	(7,663)	(8,354)	(8,130)	(8,354)	(224)	(50,187)	(49,890)	297	(691)	
Non-operating costs	Depreciation and Amortisation	(1,131)	(779)	(779)	(779)	(779)	(246)	(1,126)	(1,126)	(1,154)	(1,255)	(1,206)	(1,275)	(1,268)	(1,275)	(7)	(7,146)	(7,142)	4	(69)	
	Impairment - owned and donated	0	0	0	0	(520)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Profit/Loss on Asset Disposal	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Interest Payable	(0)	(22)	(22)	(22)	(22)	(22)	(30)	(21)	(44)	(32)	(31)	(21)	(28)	(21)	7	(169)	(178)	(9)	10	
	Restructuring Cost															0			0	0	
	PDC Dividend Payable	(422)	(422)	(422)	(422)	(422)	552	(428)	(428)	(502)	(455)	(455)	(455)	(455)	(455)	(0)	(2,716)	(2,716)	(0)	(0)	
	Unwinding of discounts	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total Non Operating costs		(1,553)	(1,223)	(1,223)	(1,218)	(1,535)	306	(1,584)	(1,544)	(1,658)	(1,694)	(1,638)	(1,680)	(1,748)	(1,680)	70	(10,031)	(9,763)	267	(41)	
TOTAL NON-PAY & NON OPERATING COSTS		(9,129)	(9,045)	(9,445)	(8,817)	(9,130)	(17,140)	(10,090)	(9,862)	(9,362)	(11,003)	(9,301)	(10,034)	(9,880)	(10,034)	(154)	(60,217)	(59,653)	564	(733)	

Statement of Cash Flow
As of 30th September 2022

	Audited Mth12 2021-22 £000	Mth 6 £000	Mth 5 £000	In Month Movement £000
Cash flows from operating activities				
Operating (deficit) from continuing operations	2,699	3,247	2,961	286
Operating (deficit)	**2,699**	**3,247**	**2,961**	**286**
Non-cash income and expense:				
Depreciation and amortisation	11,278	7,142	5,867	1,275
Impairments	715	0	0	0
(Gain)/Loss on disposal	(48)	0	0	0
(Increase)/Decrease in Trade and Other Receivables	9,003	(7,880)	(7,539)	(341)
(Increase)/Decrease in Inventories	(375)	(17)	(16)	(1)
Increase/(Decrease) in Trade and Other Payables	14,788	(4,828)	(5,837)	1,009
Increase/(Decrease) in Other Liabilities	5,945	(2,488)	(1,310)	(1,178)
Increase/(Decrease) in Provisions	(338)	(33)	(28)	(5)
NHS Charitable Funds	(561)	0	0	0
Other movements in operating cash flows	(1)	(2)	(3)	1
NET CASH GENERATED FROM OPERATIONS	**43,105**	**(4,859)**	**(5,905)**	**1,046**
Cash flows from investing activities				
Interest received	36	272	203	69
Purchase of intangible assets	(4,160)	163	(1,176)	1,339
Purchase of Property, Plant and Equipment, Intangibles	(37,974)	(7,311)	(5,161)	(2,150)
Net cash generated (used in) investing activities	**(44,598)**	**(6,876)**	**(6,134)**	**(742)**
Cash flows from financing activities				
Public dividend capital received	15,273	200	200	0
Capital element of finance lease rental payments	(201)	(143)	(165)	22
Interest element of finance lease	(267)	(178)	(157)	(21)
PDC Dividend paid	(4,663)	(2,045)	0	(2,045)
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**	**(2,166)**	**(122)**	**(2,044)**
Increase/(decrease) in cash and cash equivalents	**9,210**	**(13,901)**	**(12,161)**	(1,740)
Opening Cash and Cash equivalents	**48,765**	**57,975**	**57,975**	
Closing Cash and Cash equivalents	**57,975**	**44,074**	**45,814**	**(1,740)**

Appendix 7

Cash Flow Forecast Table for 12 months to September 2023

Month	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Total	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
BANK balance b/f	**45,820**	**44,074**	**39,573**	**36,137**	**35,736**	**39,020**	**38,473**		**37,470**	**37,901**	**38,548**	**39,130**	**39,299**	**39,150**
Activity SLA's, inc Over performance	26,501	24,416	24,800	25,426	24,909	25,393	25,109	301,278	22,938	22,938	22,938	22,938	22,938	22,938
Other patient related income	1,005	1,204	1,118	1,118	1,118	1,118	1,064	8,843	-	-	-	-	-	-
Non activity SLAs	136	68	110	110	110	110	110	1,026	-	136	110	110	110	110
Other non patient related income	1,497	3,761	629	679	834	679	3,313	24,470	2,572	2,572	2,572	2,572	2,572	2,572
Grant for capital assets	0	0	430	0	0	0	0	430	0	0	0	0	0	0
Donations for Capital Assets	-	46	10	10	5,085	10	10	5,171	-	-	-	-	-	-
PDC Funded Capital Approved (NHP)	-	-	300	100	100	100	1,137	1,937	-	-	-	-	-	-
Interest receivable	0	75	0	0	0	0	0	202	-	-	-	-	-	0
TOTAL RECEIPTS	**29,139**	**29,570**	**27,398**	**27,444**	**32,157**	**27,411**	**30,743**	**343,356**	**25,510**	**25,646**	**25,620**	**25,620**	**25,620**	**25,620**
Pay (Substantive + Bank)	(18,965)	(17,963)	(17,446)	(17,446)	(17,446)	(17,561)	(17,803)	209,557	(15,677)	(15,677)	(15,677)	(15,677)	(15,677)	(15,677)
Direct debits & standing orders	(545)	(316)	(516)	(380)	(380)	(240)	(519)	5,585	(380)	(380)	(380)	(380)	(380)	(380)
NHS creditors	(2,087)	(2,594)	(2,391)	(2,391)	(2,391)	(2,391)	(2,391)	27,988	(2,301)	(2,301)	(2,301)	(2,301)	(2,301)	(2,301)
Non NHS creditors	(6,538)	(7,388)	(5,408)	(5,616)	(5,616)	(5,186)	(5,166)	82,650	(6,519)	(6,519)	(6,519)	(6,519)	(6,519)	(6,519)
Capital BAU	(468)	(1,667)	(1,972)	(1,911)	(2,939)	(2,479)	(1,344)	16,351	(201)	(121)	(161)	(573)	(891)	(547)
Donated/Government Granted assets	-	(2,171)	(3,000)	-	-	-	-	5,171	-	-	-	-	-	-
Capital Other	(238)	(1,571)	-	-	-	-	-	9,192	-	-	-	-	-	-
PDC Funded Capital Approved (NHP)	-	(400)	(100)	(100)	(100)	(100)	(1,137)	1,937	-	-	-	-	-	-
PDC	(2,045)	-	-	-	-	-	(3,386)	5,431	-	-	-	-	-	(2,500)
TOTAL PAYMENTS	**(30,886)**	**(34,070)**	**(30,834)**	**(27,845)**	**(28,873)**	**(27,958)**	**(31,746)**	**(363,861)**	**(25,079)**	**(24,998)**	**(25,038)**	**(25,450)**	**(25,769)**	**(27,924)**
NET PAYMENTS / RECEIPTS	**(1,746)**	**(4,501)**	**(3,436)**	**(401)**	**3,284**	**(547)**	**(1,003)**	**(20,505)**	**431**	**648**	**581**	**169**	**(149)**	**(2,304)**
Bank balance b/f								57,975						
Bank balance c/f	**44,074**	**39,573**	**36,137**	**35,736**	**39,020**	**38,473**	**37,470**	**37,470**	**37,901**	**38,548**	**39,130**	**39,299**	**39,150**	**36,846**

Appendix 8

13-week Cash Flow Forecast up to the 23rd December 2022

c	1	2	3	4	5	6	7	8	9	10	11	12
Week ending: (Friday)	07-Oct-22 £'000 Forecast	14-Oct-22 £'000 Forecast	21-Oct-22 £'000 Forecast	28-Oct-22 £'000 Forecast	04-Nov-22 £'000 Forecast	11-Nov-22 £'000 Forecast	18-Nov-22 £'000 Forecast	25-Nov-22 £'000 Forecast	02-Dec-22 £'000 Forecast	09-Dec-22 £'000 Forecast	16-Dec-22 £'000 Forecast	23-Dec-22 £'000 Forecast
Bank balance b/f	**44,074**	**40,327**	**63,410**	**46,182**	**38,158**	**35,659**	**33,649**	**53,741**	**46,185**	**35,359**	**33,572**	**54,863**
Activity SLA's, inc Over performance & C	-	24,998	(582)	-	-	-	24,800	-	-	-	25,426	-
Other non patient related income	484	588	65	130	2,493	39	430	130	30	139	380	30
Other Income RBS	5	5	-	10	-	4	10	10	10	4	10	10
Other Income Citi	310	203	15	100	-	-	-	100	-	100	-	-
Cash Sheet Income	3	9	-	-	-	15	-	-	-	15	-	-
Credit Card Income	111	47	-	20	-	20	20	20	20	20	20	20
TOTAL RECEIPTS	**571**	**25,732**	**644**	**130**	**2,493**	**579**	**25,690**	**1,098**	**30**	**239**	**26,076**	**998**
Payroll costs	(431)	(438)	(10,226)	(6,869)	-	(461)	(461)	(7,587)	(8,938)	(461)	(461)	(7,587)
Direct debits & standing orders	(123)	(161)	(27)	(2)	(218)	(129)	(28)	(4)	(219)	(4)	(152)	(4)
NHS creditors	(414)	(492)	(1,688)	-	(699)	-	(1,692)	-	(699)	-	(1,692)	-
Non NHS creditors	(2,226)	(1,522)	(2,544)	(1,096)	-	(1,808)	(2,227)	(872)	(500)	(1,308)	(1,227)	(1,624)
Capital Clinical Urgent and Essential Mair	(35)	-	(954)	(187)	(491)	(91)	(1,191)	(191)	(500)	(153)	(1,253)	(253)
Capital Donation Funded	(1,089)	(15)	(483)	-	(3,584)	-	-	-	-	-	-	-
Capital External Loan Funded	-	-	-	-	-	-	-	-	-	-	-	-
Capital Other	-	(22)	(1,549)	-	-	-	-	-	-	-	-	-
PDC	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL PAYMENTS	**(4,319)**	**(2,650)**	**(17,872)**	**(8,154)**	**(4,992)**	**(2,589)**	**(5,598)**	**(8,654)**	**(10,856)**	**(2,026)**	**(4,785)**	**(9,468)**
NET PAYMENTS / RECEIPTS	**(3,747)**	**23,082**	**(17,228)**	**(8,024)**	**(2,499)**	**(2,010)**	**20,092**	**(7,556)**	**(10,826)**	**(1,786)**	**21,291**	**(8,470)**
Bank balance c/f	**40,327**	**63,410**	**46,182**	**38,158**	**35,659**	**33,649**	**53,741**	**46,185**	**35,359**	**33,572**	**54,863**	**46,393**

Appendix 9

Statement of Financial Position as of 30th September 2022

	Audited Mar-22	Sep-22 YTD Actual	YTD Mvmt	% Variance
Assets Non-Current				
Tangible Assets	189.6	191.1	1.5	0.8%
Intangible Assets	22.3	20.5	(1.8)	(8.3%)
ROU Assets	0.0	12.8	12.8	100.0%
Other Assets	1.0	1.0	0.0	1.3%
Total Non Current Assets	**212.9**	**225.4**	**12.5**	**5.7%**
Assets Current				
Inventory	4.1	4.1	0.0	0.0%
NHS Receivables	3.5	5.8	2.3	54.8%
Other Receivables	7.2	12.8	5.6	86.2%
Cash	58.0	44.0	(14.0)	(30.4%)
Total Current Assets	**72.8**	**66.7**	**(6.1)**	**(10.0%)**
Liabilities Current				
Interest -bearing borrowings	(0.2)	(1.0)	(0.8)	51.2%
Deferred Income	(19.4)	(16.9)	2.5	(12.7%)
Provisions	(2.4)	(2.4)	0.0	0.0%
Trade & other Creditors (incl NHS)	(60.4)	(55.9)	4.5	(8.7%)
Total Current Liabilities	**(82.4)**	**(76.2)**	**6.2**	**(8.2%)**
Net current assets	**(9.6)**	**(9.5)**	**0.1**	**(0.7%)**
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**	**195.5**	**(5.8)**	**(3.0%)**
Taxpayers Equity				
Public Dividend Capital (PDC)	275.1	275.3	0.2	0.1%
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)	(130.1)	0.7	(0.5%)
Total Taxpayers Equity	**194.6**	**195.5**	**(5.1)**	**(2.7%)**

Debtor Analysis as of 30th September 2022

Top ten debtors £'000	Total	0 - 30	31 - 60	61 - 90	91 - 120	121+
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	635	212	0	257	0	166
NHS ENGLAND	280	56	28	30	30	136
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	256	256	2	14	-28	12
BEDFORD BOROUGH COUNCIL	128	-14	0	0	8	134
OXFORD HEALTH NHS FOUNDATION TRUST	103	9	0	0	0	94
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FT	102	6	0	0	56	40
UNIVERSITY OF BUCKINGHAM	85	1	0	0	0	84
NORTH NORTHAMPTONSHIRE COUNCIL	83	0	0	0	83	0
MEDICAL PROPERTY MANAGEMENT LTD	76	11	14	0	0	51
NHS BEDFORDSHIRE, LUTON AND MILTON KEYNES ICB	48	48	0	0	0	0
OTHER	836	295	21	84	52	384
Total	**2,632**	**880**	**65**	**385**	**201**	**1,101**

Debtors by category £'000	Total	0 - 30	31 - 60	61 - 90	91 - 120	121+
NHS CLINICAL COM GROUPS	48	48	0	0	0	0
NHS COM BOARD COM SUPPORT UNIT	279	56	28	29	30	136
NHS ENGLISH TRUSTS	317	264	4	9	-25	65
NHS FOUNDATION TRUSTS	883	251	2	271	56	303
NHS OTHER DH ORGANISATIONS	-3	-3	0	0	0	0
NON NHS COMPANY	380	97	20	50	95	118
NON NHS DH PUB CORP TRADE FNDS	6	0	0	0	0	6
NON NHS HEALTH BODIES	104	70	0	0	20	14
NON NHS INDIVIDUAL	126	1	7	18	0	100
NON NHS INSURANCE COMPANIES	66	40	2	6	3	15
NON NHS LOCAL AUTHORITIES	6	0	0	0	0	6
NON NHS OVERSEAS VISITORS	168	52	2	2	13	99
NON NHS PRIVATE PATIENT	3	1	0	0	0	2
NON NHS PUBLIC BODIES	244	2	0	0	8	234
NON NHS SOLICITORS	0	0	0	0	0	0
NON NHS WELSH SCOTS+NI BODIES	2	1	0	0	1	0
STAFF	3	0	0	0	0	3
Total	**2,632**	**880**	**65**	**385**	**201**	**1,101**

Debtors by type £'000	Total	0 - 30	31 - 60	61 - 90	91 - 120	121+
NHS organisations	1,524	616	34	309	61	504
Non NHS organisations	1,108	264	31	76	140	597
Total	**2,632**	**880**	**65**	**385**	**201**	**1,101**

Debtors' comments

The debtor's position as of 30th September'22 stands at £2.6m, which is an increase of £0.1m from the August'22 position.

- Bedfordshire Hospitals NHS Foundation Trust has 14 pending invoices relating to salary recharges. Debt tallying £212k is under 30 days of ageing. All debt is being actively chased for Oct'22 payment.
- NHS England has 19 overdue invoices relating to salary, training, and Diabetic Retinopathy recharges. All debt is being actively chased for Oct'22 payment with debt totalling £56k being under 30 days of ageing.
- Oxford University Hospitals NHS FT has 18 pending invoices including Renal recharges (£107k). All debt is being actively chased for Oct'22 payment with debt totalling £256k being under 30 days of ageing. Receipts of £250k have been recorded in Oct'22 to date.
- Bedfordshire Borough Council has 21 overdue invoices all relating to Sexual Health cross recharges which are currently under dispute and monitored by the Divisional Business partner. Receipts of £50k have been recorded in Oct'22 to date.
- Oxford Health NHS Foundation Trust has 6 pending invoices mainly relating to rates recharges of which are under review and actively being chased for Oct'22 payment.
- University Hospitals Southampton NHS FT has 8 overdue invoices relating to salary recharges. All debt is being actively chased for Oct'22 payment
- University of Buckingham has 3 overdue invoices including 20/21 Q4 salary recharges which is currently under review by the Deputy director of Finance and the Finance Business Partner. All debt is being actively chased for Oct'22 settlement.
- North Northamptonshire County Council has 8 pending invoices. All debt relating to Sexual Health recharges which have been created to replace recharge invoices which were created to Northamptonshire County Council in error. All debt is being actively chased for Oct'22 payment.
- Medical Property Management Ltd has just 8 pending invoices mainly relating to utilities recharges All debt is being actively chased for Oct'22 settlement.
- NHS Bedfordshire, Luton and Milton Keynes ICB 4 overdue invoices relating to salary recharges. All debt of £48k is under 30 days of ageing and being actively chased for Oct'22 payment.
- A schedule of large invoices over £5k and over 60 days old is shown in **Appendix 11**

Appendix 11

Debtor Invoices >60 days old and >£5,000 in value as of 30th September 2022

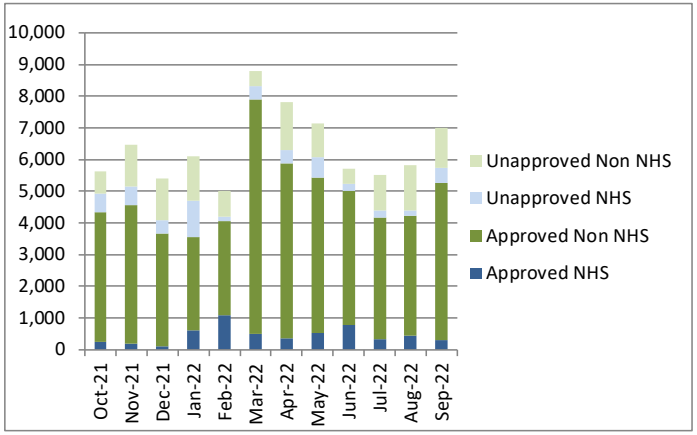
	Debtor	Total Amt over 60 days+	No. of Invoices	Date of Invoices	Total Amt over 90 days+	Status
1	BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	£423K	11	Apr'22 - Jun'22	£166K	BLMK recharges for cancer services, HSDU and Endoscopy services. Debt totalling £257k is under 30 days of ageing and all invoices being actively chased for Oct'22 settlement.
2	NHS ENGLAND	£193K	3	Jan'22 - Jul'22	£165K	Maternity Services Recharges. All invoices being actively chased for Oct'22 payment.
3	BEDFORD BOROUGH COUNCIL	£119K	10	Sept'18 - Jun'22	£111K	Sexual Health recharge currently under query and being actively reviewed by Senior Business Partner - Medicine.
4	OXFORD HEALTH NHS FT	£93K	4	Apr'19 - Nov'21	£93K	Non Domestic rates recharges. Invoice being actively chased for Oct'22 payment.
5	NORTH NORTHAMPTONSHIRE COUNCIL	£83K	8	May'22	£83K	Sexual Health recharge currently under query and being actively reviewed by Senior Business Partner - Medicine.
6	UNIVERSITY OF BUCKINGHAM	£80K	1	Nov'20	£80K	Medical placement recharges currently under query re pending £20K CMR and under review with the Deputy Director of Finance.
7	UNIVERSITY HOSPITAL SOUTHAMPTON NHS FT	£78K	3	Dec'21 - May'22	£78K	Salary recharges. Invoice being actively chased for Oct'22 payment.
8	MEDICAL PROPERTY MANAGEMENT LTD	£51K	4	Jan'22 - May'21	£51K	Utilities recharges. Invoice being actively chased for Oct'22 payment.
9	PP OVERSEAS PATIENT (COVERING 5 INVOICES)	£48K	5	Dec'18 - May'22	£25K	Invoice currently under dispute with Patients. All details have been logged with the Home Office/UK Borders.
10	CMR SURGICAL LTD	£48K	1	Jun'22		Research Fellow Funding - Actively being chased for Oct'22 payment.
11	ROYAL FREE LONDON NHS FOUNDATION TRUST	£37K	1	Mar'22	£37K	Salary Recharge. Actively being chased for Oct'22 payment.
12	SALARY OVERPAYMENTS (COVERING 3 INVOICES)	£28K	3	Oct'17 - Jun'22	£15K	Invoices under review/investigation with pending proposed legal action and actively chased.
13	OXFORD UNIVERSITY	£28K	1	Jan'22	£28K	Salary Recharge. Actively being chased for Oct'22 payment.
14	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	£23K	3	Mar'22 - Jun'22	£9K	Pathology & Cystic Fibrosis drug recharges - currently under review and actively chased for Oct'22 payment.
15	ADMK LTD	£20K	1	May'22	£20K	Utilities recharges. Invoice being actively chased for Oct'22 payment.
16	NORTHAMPTONSHIRE COUNTY COUNCIL	£8K	1	Jan'18	£8K	Sexual Health recharge currently under query and being actively reviewed by Senior Business Partner - Medicine.
17	CENTRAL BEDFORDSHIRE COUNCIL	£8K	1	Jul'17	£8K	Sexual Health recharge currently under query and being actively reviewed by Senior Business Partner - Medicine.
18	CAMBRIDGE UNIVERSITY HOSPITALS NHS FT	£7K	1	Jun'22		Salary Recharge. Actively being chased for Oct'22 payment.
19	THE CO-OPERATIVE FUNERALCARE	£6K	1	Apr'22	£6K	Mortuary recharges. Actively being chased for Oct'22 payment.
20	WEST NORTHAMPTONSHIRE COUNCIL	£5K	1	Feb'22	£5K	Pathology Recharge. Actively being chased for Oct'22 payment.
		£1.4M	**64**		**£988K**	
	Invoices cleared from Aug'22					
1	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	£6K	1	Mar'22	£6K	Paid in full Sept'22
2	NHS PROPERTY SERVICES LTD	£8K	1	Apr'22	£8K	Paid in full Sept'22
	Total	**£14K**	**2**		**£14K**	
	All other debt over 60 days less than £5K	**£463K**	**368**		**£394K**	**All debt actively reviewed and chased.**

Creditors Analysis
as of 30th September 2022

Approved (£'000)	Total	0 - 30	31 - 60	61 - 90	90+
NHS Organisations	305	309	18	0	(22)
Non NHS Orgs	4,968	3,758	446	332	432
Total	**5,273**	**4,067**	**464**	**332**	**410**

Unapproved (£'000)	Total	0 - 30	31 - 60	61 - 90	90+
NHS Organisations	450	311	2	103	34
Non NHS Orgs	1,265	867	212	61	125
Total	**1,715**	**1,178**	**214**	**164**	**159**

Total Creditors (£'000)	Total	0 - 30	31 - 60	61 - 90	90+
Total	**6,988**	**5,245**	**678**	**496**	**569**



Approved NHS (£'000)	Total	0 - 30	31 - 60	61 - 90	90+
ST HELENS & KNOWSLEY HOSPITALS NHS TRUST	101	101	0	0	0
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	49	49	0	0	0
NHS BLOOD & TRANSPLANT	26	26	0	0	0
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	23	0	15	0	8
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	19	72	0	0	(53)
OXFORD HEALTH NHS FOUNDATION TRUST	16	16	0	0	0
SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST	15	15	0	0	0
FRIMLEY PARK HOSPITAL NHS FOUNDATION TRUST	14	14	0	0	0
NHS TRUST DEVELOPMENT AUTHORITY	12	0	0	0	12
NORTHAM PTON GENERAL HOSPITAL NHS TRUST	9	0	0	0	9
Others	21	16	3	0	2
Total	**305**	**309**	**18**	**0**	**(22)**

Approved Non NHS (£'000)	Total	0 - 30	31 - 60	61 - 90	90+
GALLIFORD TRY HPS LTD	1,089	1,089	0	0	0
DRAEGER MEDICAL UK LTD	571	379	186	4	2
BYTES SOFTWARE SERVICES LTD	357	270	0	87	0
WORKMAN LLP	353	0	0	181	172
SUPPLY CHAIN COORDINATION LIMITED	249	235	0	0	14
MEDICA REPORTING LTD	234	81	83	70	0
MEDICAL PROPERTY MANAGEMENT LTD	202	202	0	0	0
PORTAKABIN LTD	110	73	0	37	0
MEDSTROM LTD	100	87	3	0	10
GE MEDICAL SYSTEMS LTD	96	97	0	0	(1)
Others	1,607	1,245	174	(47)	235
Total	**4,968**	**3,758**	**446**	**332**	**432**

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

Appendix 13

Finance Risk Register
For the period ending 30th September 2022

Reference	Created on	Description	Impact of risk	Risk response	Scope	Last review	Next review	Status	Original score	Current score	Target score	Controls implemented	Risk appetite	Risk response	Change from previous Mth
RSK-134	04-Nov-2021	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability THEN there may be an increase in operational expenditure in order to manage COVID-19	LEADING TO potential for material increase in efficiency requirement from NHS funding regime to support DHSC budget affordability.	Treat	Organisation	10-Oct-22	11-Nov-22	Planned	20	16	8	Budgets have been reset for 22/23 based on current financial regime; financial controls and oversight have been reintroduced to manage financial performance, Cost efficiency programme has been reset to target focus on areas of greatest opportunity to delivery. The trust will work with BLMK system partners during the year to review overall BLMK performance	High	Tolerate	No change
RSK-202	23-Nov-2021	IF Transformation delivery is not adequately resourced and prioritised and/or schemes are unrealistic and not well planned THEN There is a risk that the Trust is unable to achieve the required efficiency improvements through the transformation programme leading to an overspend against plan	LEADING TO the Trust potentially not delivering its financial targets leading to potential cash shortfall and non-delivery of its key targets	Treat	Organisation	10-Oct-22	11-Nov-22	Planned	20	16	9	Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partners, Cross-cutting transformation schemes are being worked up, Savings plan for 22/23 financial year not yet fully identified.	Medium	Tolerate	No change
RSK-305	06-Dec-2021	If there is insufficient 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	Treat	Organisation	10-Oct-22	11-Nov-22	Planned	16	16	9	Trust is discussing this with the regional Capital Team	High	Treat	No change
RSK-203	23-Nov-2021	IF the are negative impacts on the supply chain 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	LEADING TO some unavailability of clinical products, delays to deliveries and services may be disrupted or reduce resulting in impact on patient care	Tolerate	Organisation	10-Oct-22	11-Nov-22	Planned	16	15	6	Clinical Procurement nurse has registered to join the NHSI/E Supply Resilience Forum in August 2022.Trust's top suppliers have been reviewed and issues with supply under constant review(23-Nov-2021),Procurement business partners use the NHS Spend Comparison Site and local knowledge supported by the clinical procurement nurse to source alternative products(23-Nov-2021)	Medium	Tolerate	No change

Finance Risk Register
For the period ending 30th September 2022

Reference	Created on	Description	Impact of risk	Risk response	Scope	Last review	Next review	Status	Original score	Current score	Target score	Controls implemented	Risk appetite	Risk response	Change from previous Mth
RSK-355	21 June 2022	IF Sensyme Health's financial and management ownership changes Then there is a risk that Sensyne Health ceases to be a going concern	LEADING TO financial loss and reputational damage	Tolerate	Organisation	10-Oct-22	11-Nov-22	Planned	16	12	12	The Trust is collaborating with other NHS shareholders (with the support of expert advisors/Sensyne Health Board observer) to leverage influence with Sensyne Health and protect NHS shareholder interests. The Trust is taking legal advise on the implications	Low	Treat	No change
RSK-364	15 July 2022	IF SBS are not able to respond to supplier queries and finance queries in a timely manner THEN there is a risk that there will be a delay in paying suppliers	LEADING to suppliers putting the Trust on stop and not delivering key supplies	Treat	Organisation	10-Oct-22	11-Nov-22	Planned	16	12	6	The Trust is meeting on a monthly basis with senior SBS client relationship team to discuss the issues and get a plan from SBS of how the situation can improve, In addition extra temporary resources are being employed to support the finance and procurement team to deal with the additional supplier queries. The Finance team are reviewing any suppliers who are providing stop notifications and arranging urgent payment if required	Low	Treat	No change
RSK-206	23-Nov-2021	IF the Trust is unable to recruit staff of the appropriate skills and experience; there continues to be unplanned escalation facilities; There are higher than expected levels of enhanced observation nursing; and there is poor planning for peak periods / inadequate rostering for annual/other leave. THEN the Trust may be unable to keep to affordable levels of agency and locum staffing	LEADING TO Adverse financial effect of using more expensive agency staff and potential quality impact of using temporary staff	Tolerate	Organisation	10-Oct-22	11-Nov-22	Planned	16	9	9	Weekly vacancy control panel review agency requests(23-Nov-2021),Control of staffing costs identified as a key transformation work stream(23-Nov-2021),Capacity planning(23-Nov-2021),Robust rostering and leave planning(23-Nov-2021),Escalation policy in place to sign-off breach of agency rates(23-Nov-2021),Fort-nightly executive led agency reduction group meeting with aim of delivering reduction in both quantity and cost of agency used(23-Nov-2021),Agency cap breaches are reported to Divisions and the FIC(23-Nov-2021),Divisional understanding of how to reduce spend on temporary staffing to be developed(23-Nov-2021)	Medium	Tolerate	No change
RSK-204	23-Nov-2021	IF data sent to external agencies (such as NHS Digital, Advise Inc and tenders) from the Procurement ordering system contain patient details THEN there is a risk that a data breach may occur with reference to GDPR and Data Protection Act as the procurement department deals with large volumes of data.	LEADING TO a data breach and potential significant fine	Tolerate	Organisation	10-Oct-22	11-Nov-22	Planned	16	6	6	All staff attend an annual mandatory training course on Information Governance(23-Nov-2021),Staff are encouraged to use catalogues which reduces the requirements for free text(23-Nov-2021),Data sent out to external agencies is checked for any patient details before submitting(23-Nov-2021)	Medium	Tolerate	No change

Finance Risk Register
For the period ending 30th September 2022

Reference	Created on	Description	Impact of risk	Risk response	Scope	Last review	Next review	Status	Original score	Current score	Target score	Controls implemented	Risk appetite	Risk response	Change from previous Mth
RSK-205	23-Nov-2021	IF there is Incorrect processing through human error or system errors on the Procurement systems THEN there is risk that there may be issues with data quality within the procurement systems	LEADING TO Incorrect ordering resulting in a lack of stock and impacting on patient safety	Tolerate	Organisation	10-Oct-22	11-Nov-22	Planned	12	6	6	Monthly reviews on data quality and corrections(23-Nov-2021),Mechanisms are in place to learn and change processes(23-Nov-2021),Data validation activities occur on monthly basis(23-Nov-2021),A desire to put qualifying suppliers in catalogue(23-Nov-2021)	Medium	Tolerate	No change
RSK-207	23-Nov-2021	IF there is major IT failure internally or from external providers THEN there is a risk that key Finance and Procurement systems are unavailable	LEADING TO 1. No Purchase to pay functions available ie no electronic requisitions, ordering, receipting or payment of invoices creating delays for delivery of goods. 2. No electronic tenders being issued. 3. No electronic raising of orders or receipting of income	Tolerate	Organisation	10-Oct-22	11-Nov-22	Planned	12	6	6	If its an external issue, SBS the service provider of the purchase to pay and order and invoicing has a business continuity plan in place(23-Nov-2021),If its an internal issue. The Trust has arrangements with the CCG who also use SBS to use their SBS platform(23-Nov-2021)	Medium	Tolerate	No change
RSK-209	23-Nov-2021	IF staff members falsely represent themselves, abuse their position, or fail to disclosure information for personal gain THEN the Trust/Service Users/Stakeholders may be defrauded	LEADING TO financial loss and reputational damage	Tolerate	Organisation	10-Oct-22	11-Nov-22	Planned	12	6	6	Anti-Fraud and Anti-Bribery Policy(23-Nov-2021),Standards of Business Conduct Policy including Q&A section(23-Nov-2021),Standing Orders(23-Nov-2021),Local Counter Fraud Specialist in place and delivery of an annual plan(23-Nov-2021),Proactive reviews also undertaken by Internal Audit(23-Nov-2021),Register of Gifts and Hospitality(23-Nov-2021),Register of Declarations(23-Nov-2021)	Medium	Tolerate	No change

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

Meeting Title	**Board Report**	**Date: November 2022**
Report Title	**Workforce Report – Month 6**	**Agenda Item Number: 18**
Lead Director	Danielle Petch, Director of Workforce	
Report Author	Louise Clayton, Deputy Director of Workforce	

Introduction	Standing Agenda Item		
Key Messages to Note	This report provides a summary of workforce Key Performance Indicators for the previous 12 months up to 30 September 2022 (Month 6) and relevant Workforce and Organisational Development updates to Trust Board.		
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Review** [ ]

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	Employ the best people to care for you

Report History	
Next Steps	JCNC & TEC
Appendices/Attachments	See Appendix 1: Bank and Agency Fill Rate

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators as at 30 September 2022 (Month 6), covering the preceding 13 months.

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

Indicator	Measure	Target	09/2021	10/2021	11/2021	12/2021	01/2022	02/2022	03/2022	04/2022	05/2022	06/2022	07/2022	08/2022	09/2022
Staff in post (as at report date)	Actual WTE		3328.6	3342.5	3347.7	3349.0	3390.5	3410.0	3414.4	3418.4	3418.8	3417.5	3445.6	3437.0	**3458.0**
	Headcount		3807	3823	3827	3830	3878	3904	3900	3902	3904	3901	3930	3917	**3946**
Establishment *(as per ESR)*	WTE		3724.7	3730.4	3725.7	3718.1	3722.9	3727.6	3716.9	3723.9	3839.8	3842.5	3840.8	3837.0	3881.4
	%, Vacancy Rate - Trust Total	**10.0%**	10.6%	10.4%	10.1%	9.9%	8.9%	8.5%	8.1%	8.2%	11.0%	11.1%	10.3%	10.4%	10.9%
	%, Vacancy Rate - Add Prof Scientific and Technical									23.0%	33.9%	33.2%	35.2%	32.4%	31.3%
	%, Vacancy Rate - Additional Clinical Services *(Includes **HCAs**)*									12.6%	2.9%	4.0%	4.3%	3.3%	10.1%
	%, Vacancy Rate - Administrative and Clerical									4.6%	8.8%	8.6%	8.5%	8.4%	8.1%
	%, Vacancy Rate - Allied Health Professionals									11.0%	18.7%	19.5%	20.2%	18.8%	18.9%
	%, Vacancy Rate - Estates and Ancillary									16.9%	13.9%	14.4%	14.3%	12.9%	11.5%
	%, Vacancy Rate - Healthcare Scientists									2.6%	3.5%	0.6%	0.8%	0.0%	0.0%
	%, Vacancy Rate - Medical and Dental									3.3%	4.9%	3.3%	0.0%	2.8%	0.0%
	%, Vacancy Rate - Nursing and Midwifery Registered									6.2%	15.3%	16.0%	15.5%	15.3%	15.3%
Staff Costs (12 months) *(as per finance data)*	%, Temp Staff Cost (%, £)		11.9%	12.1%	12.3%	12.5%	12.7%	12.9%	13.1%	13.4%	13.7%	14.0%	14.3%	14.5%	**14.8%**
	%, Temp Staff Usage (%, WTE)		12.6%	12.7%	12.8%	12.9%	13.0%	13.1%	13.2%	13.5%	13.7%	13.8%	14.0%	14.1%	**14.2%**
Absence (12 months)	%, 12 month Absence Rate	5.5%	4.8%	5.0%	5.0%	5.0%	5.0%	5.1%	5.3%	5.4%	5.4%	5.5%	5.6%	**5.5%**	*5.4%*
	- %, 12 month Absence Rate - Long Term		*2.8%*	*2.9%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*2.9%*	***2.9%***	*2.8%*
	- %, 12 month Absence Rate - Short Term		*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.1%*	*2.3%*	*2.4%*	*2.4%*	*2.5%*	*2.7%*	***2.6%***	*2.6%*
	%,In month Absence Rate - Total	4.0%	5.4%	6.1%	5.5%	6.0%	6.3%	5.4%	5.6%	5.0%	4.3%	4.4%	5.6%	**4.1%**	*4.2%*
	- %, In month Absence Rate - Long Term	*2.0%*	*3.0%*	*3.5%*	*3.3%*	*3.3%*	*3.0%*	*2.8%*	*2.5%*	*2.3%*	*2.6%*	*2.6%*	*2.6%*	***2.5%***	*2.3%*
	- %, In month Absence Rate - Short Term	*2.0%*	*2.4%*	*2.5%*	*2.3%*	*2.7%*	*3.3%*	*2.6%*	*3.1%*	*2.7%*	*1.7%*	*1.8%*	*3.0%*	***1.6%***	*1.9%*
	- %, In month Absence Rate - COVID-19 Sickness Absence		0.6%	0.6%	0.6%	1.2%	2.3%	1.6%	2.2%	1.5%	0.5%	0.7%	1.7%	**0.6%**	*0.4%*
Starters, Leavers and T/O rate (12 months)	WTE, Starters		333.0	349.4	347.1	362.3	390.3	376.5	382.0	409.1	427.3	433.9	447.8	492.1	**505.8**
	Headcount, Starters		376	393	395	411	441	428	431	459	481	490	507	550	**570**
	WTE, Leavers		227.7	232.0	241.5	254.8	277.9	296.9	329.4	364.6	380.6	400.1	417.1	449.4	**469.0**
	Headcount, Leavers		271	276	289	304	332	357	395	435	456	480	500	542	**562**
	%, Leaver Turnover Rate	9%	7.8%	7.9%	8.3%	8.8%	9.5%	10.2%	11.2%	12.3%	12.9%	13.6%	14.2%	15.3%	**15.8%**
	%, Stability Index		86.2%	85.6%	85.2%	85.9%	85.5%	85.3%	84.8%	83.7%	82.9%	82.7%	82.8%	82.5%	**82.6%**
Statutory/Mandatory Training	%, Compliance	90%	96%	95%	96%	96%	95%	94%	94%	94%	94%	95%	95%	95%	**92%**
Appraisals	%, Compliance	90%	91%	91%	91%	91%	91%	90%	92%	90%	90%	88%	89%	90%	**91%**
Time to Hire (days)	General Recruitment	35	59	53	56	52	72	65	72	58	52	65	59	64	**56**
	Medical Recruitment (excl Deanery)	35	53	81	65	43	52	49	68	47	79	63	89	72	**73**
Employee relations	Number of open disciplinary cases		7	9	10	9	10	7	9	4	4	9	13	14	**15**

2.1. The table in appendix 1 shows the bank and agency **fill rate**. Fill rate for night duty is still higher than for days across both nursing and HCSW.

2.2. The Trust's **vacancy rate** is 10.9%. The Trust's staff in post figure has increased from the previous month, and there are an additional 139 staff in post compared to the same period in the previous year.

2.3. **Staff absence** has started to return to within tolerance with 4.2% absence for the month with a smaller proportion of this due to Covid (0.4%). It is anticipated that this figure will increase in M7 as school-aged children return to education settings. Sickness absence figures are in line with other NHS employers in the ICS.

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 significant change in a 3 month period, currently at 82.6%. **Staff turnover** has increased to 15.8% which is in line with other NHS employers in the ICS. Several social media campaigns and events have occurred in M6 with the MK Job Show is being held in Central MK being the busiest the Trust has experienced. MKUH had a prime presentation slot across both days and worked closely with the advertising campaign company to launch the new artwork and campaign. M7 will see further activity in the campaign with a radio, bus, and shopping centre creative campaign across several counties.

2.5. **Time to hire** continues to fluctuate (down to 56 days in month) 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. There are just under 400 candidates in the recruitment pipeline, which is a mix of internal and external candidates. The focus has been to bring candidates into the Trust as quickly as possible and in M8 the team will focus on clearing the back-end of the system to allow for better reporting and to reduce old notifications to appointing managers.

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 92% and **appraisals** compliance at 91%. Divisions are addressing any underperformance against these KPIs locally and are asked to create recovery plans against target. **Women's and Children's Division** remains below tolerance.

2.8. There are 144 nursing vacancies across the Trust. There are 79 applicants in pre-employment stages. Out of the 111 international nurses, 61 have passed their OSCE, of which 48 have received their NMC Registration and 13 are awaiting their PIN. The last cohort of tranche 1 are due to arrive late November/December, however the delays in their Visas with the Home Office are impacting their arrival date.

2.9. The Trust's Finance and Investment Committee received a business case for a second tranche of international nurses, an additional 100 and this was approved. The programme will continue until a further 100 nurses are recruited. The project team will remain in post to facilitate this. The Trust has bid for additional regional monies to support this initiative and is presently awaiting the outcome.

2.10. There are 140 HCSW vacancies (B2 and B3) across the Trust. This figure does not include the Nurse Associates, 8 of which are due to qualify in October. There are 56 applicants in pre-employment, which will offset the vacancy rate once they start in post. There has been a significant increase in these vacancies in month due to an exercise undertaken in Finance to convert bank/agency wte into substantive HCSW positions. The Recruitment Team are working closely with the Divisions to arrange recruitment events to fill these posts as soon as possible.

3. Continuous Improvement, Transformation and Innovation

3.1. HR Services are implementing the **Work Any Hours campaign** where flexible shift times are available through the bank 'Flexi-Pool' and ward areas are allocated on arrival at the shift. This is being launched in M7 to attract nurses and HCSWs who may be able to do ad-hoc shifts with self-selected start and finish times, to support wards where there are shortages. In M8 we will be launching the campaign to create a substantive flexi-pool for each Division and will be working closely with nursing to manage this new approach to recruiting.

4. Culture and Staff Engagement

4.1. The 2022 **Protect and Reflect Event** launched on 3rd October and has run pop-up clinics at Oak House and Witan Gate House for COVID and Flu vaccinations alongside the regular offering in the Academic Centre. Staff can book to have one or both of their vaccines and received a blue light card voucher if they complete their staff survey. This year the staff survey also went to bank workers, as an online survey only, in addition to substantive staff.

4.2. The recently published **FTSU e-Learning** for managers has been rolled out across the Trust and is being well received.

4.3. The Trust is publishing its **Annual Equality, Diversity, and Inclusion Report** in M7 and the team will be communicating MKUH's results and creating infographics for staff to help communicate the data. The full report was reviewed by the Workforce Committee and an overview presentation will be brought to the Trust Board at the next available opportunity.

5. Current Affairs & Hot Topics

5.1. **Goodie bags** with treats and snacks in were delivered to the wards and departments by the HR Teams to say thank you to everyone for their hard work and commitment over the summer and in advance of the winter. These were generally well received.

5.2. The Education Team are moving forward with phase 2 of the **MK Way Leadership Programme.** This will see the programme become more modular with set itineraries by staff group, along with a “pick and mix” style menu for staff to book onto training specific to their individual development needs. The Education Team will be working with professional leads to offer a range of sessions and skills training to newly appointed managers using this programme.

6. Recommendations

Members are asked to note the report.

Appendix 1

	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	**71%**	**91%**	**97%**	**103%**
A & E	86%	78%	99%	72%
AMU	63%	116%	106%	111%
DOCC	81%	22%	99%	-
MAU 2	75%	109%	103%	102%
NNU	69%	86%	88%	93%
Phoenix Unit	65%	110%	85%	98%
Ward 10	0%	7%	0%	0%
Ward 15	80%	97%	103%	118%
Ward 16	63%	93%	70%	130%
Ward 17	68%	96%	100%	113%
Ward 18	86%	94%	143%	109%
Ward 19	90%	89%	137%	111%
Ward 20	85%	89%	120%	107%
Ward 21	67%	122%	99%	114%
Ward 22	66%	89%	106%	92%
Ward 23	73%	96%	108%	137%
Ward 24	79%	99%	102%	109%
Ward 3	67%	89%	99%	99%
Ward 5	65%	56%	93%	97%
Ward 7	68%	96%	104%	113%
Ward 8	75%	95%	109%	99%
Ward 9	69%	80%	80%	78%
Ward 25	72%	119%	116%	110%
Ward 4	48%	43%	81%	97%

Appendix 2


Our City, Our Hospital, Our People.


Milton Keynes University Hospital NHS
Our City, Our Hospital, Our

Freedom to Speak Up Guardian 6 Month Report 2022

Executive Summary

This half year report to the Trust Board on Freedom to Speak Up (FTSU) in the Trust is for the period January 2022 to July 2022. The Freedom to Speak Up Guardian (FTSUG) is a role that has been in place across NHS Acute Trusts since 2016. Philip Ball is Lead Guardian and Lead Nurse Palliative and End of Life Care.

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

In the period under consideration, 10 concerns have been raised.

- Four were reported as having some element of bullying and harassment involved – mainly through incivility when dealing with other departments, or a line manager.
- One reported as detriment – where speaking up had been met with some degree of resistance to change.
- Two were about patient safety – mainly about the pressures on teams and groups of staff where low numbers and low morale were having an impact.
- Three were about worker safety – about numbers of staff, being asked to do tasks that were not within capability.
- At the time of writing, most cases were dealt with through intervention with line managers or workforce department assistance. Some witnesses took their own action, and others decided that no further action was required.
- No ongoing investigations have been required, though there are potential investigations at the time of writing.
- All current Guardians have acted to support witnesses.

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

The current Guardians are Angela Legate, Lizzie Taylor, Karen Phillips, Hafsa Omar and Philip Ball. The Guardians are supported by seven Champions who act a first points of contact and signposts to Guardians where required. The Champions and Guardians have met where possible during 2021-22 to keep in touch with developments.

Protected time for Guardians was an issue that has been addressed through the Protected Working Time policy.

This is a half year report. This report has not been presented to any committees or groups in the Trust prior to Board presentation.

Audit of FTSU service in 2022

FTSU at the Trust was audited at the end of 2021 and in early 2022 the report identified the following findings and actions detailed.

External reporting of FTSU concerns – the audit identified a discrepancy in the numbers of cases reported in one quarter to the National Guardian Office (NGO). The Lead Guardian looked back over the figures and could see that there had been human error. At the end of each NGO year – the financial year, there is an

opportunity to check and revise figures submitted, and this was done. In future, at least two Guardians will check and agree the numbers to be submitted each quarter.

The Trust Board received an annual report from the FTSU Guardian. Recent NGO and NHSE guidance is that a report should be put before Board twice yearly. This has been rectified and has resulted in this half year report.

NHSE FTSU review tool – The last Board review using the FTSU self-assessment tool was 2019. The Lead Guardian was unaware of any monitoring of completion of actions taking place, the review having been undertaken by a previous Lead Guardian. The Director of Workforce and Director of Nursing – Professional Development are undertaking the 2022 review on behalf of the Board and expect to be able to provide feedback to the Board and the Lead FTSU Guardian shortly.

Speaking up policy –

This was due for review in September 2022, and a draft has been prepared based on the latest agreed NHSE and NGO Speaking Up policy content. The Lead Guardian created the first draft based on the imaginative template, the HR team have moved the content to the Trust template, and it is being forwarded for consultation at the time of writing.

Access to Guardians and Champions –

The audit highlighted a requirement for additional ways to contact the Guardians, and to publicise who they are. At the time of writing a proposal regarding the purchase of a Speaking Up app has been forwarded to the Executive Team. The app has been developed by a Guardian and has reporting and data collection functions included.

Receiving concerns –

The audit found concerns were responded to within two days of receipt. The FTSU email inbox is monitored by the Guardians and usually there is a response within two days. Where a Guardian feels they do not have capacity to pick a case up, they will alert other Guardians to make sure of a response.

Investigating, responding to and Learning from Concerns –

The audit showed a sample of concerns were resolved at the stage of reporting to Guardians. Since then, further cases have on occasion required forwarding on for investigation by an appropriate person. Due to maintaining confidentiality the outcome of investigations is not easy to give feedback on.

Activities Underway and Plans for Q3 & Q4, 2022/23 -

- The Lead Guardian worked 7.5 hours per week in the role from April 2022 and raised this to 15 hours per week from October.
- The approach to FTSU was re-launched during 2022 aiming for more activity in October 2022, as it is the 'Speak Up' month – a speaking up pledge competition is in place in October 2022.
- FTSU featured heavily at this year's Event in the Tent and the Trust managed to secure the National Freedom to Speak Up Guardian as a speaker. This session was well received by staff and the National Guardian gave positive feedback about the FTSU activities taking place across the Trust
- The FTSU national e-Learning was launched by the national team, and this has been adopted by MKUH. All three courses; employee, manager, and Board member, have been mandated based on job role and uptake has been good since launch. As these courses have been mandated, they will be included in employee, Divisional and Trust training compliance percentages going forward
- The addition of questions on the leaver's questionnaire about awareness of the FTSU Guardians and whether they had used the service – HR have been working on an improved leavers exit interview process.
- To participate in the development of the role of the Freedom to Speak Up Guardian and continue to be active in the East of England regional group, through the quarterly meetings and WhatsApp.
- To attend the virtual NGO Annual Conference due on 29th March 2022 – this was attended – included an interesting session with Sir Robert Francis.
- Evaluation of the effectiveness of the Freedom to Speak Up Guardian role in the Trust through use of feedback to the Guardian about how well use of the service has worked. Feedback received where given has been positive.
- Become regular contributors to team, departmental and divisional meetings; engage with networks such as the Ability and BAME that are developing at MKUH – an ongoing process.
- Implement the web-based form that can be accessed by MKUH staff to report concerns – this can be via the QR code.
- Use the postcards developed about the FTSU service that are given to all new starters as well as current staff, with a version available in the Trust Intranet – these are regularly distributed at Induction, and in meetings attended by Guardians.

Recommendation

The Trust Board is asked to note the contents of this 6-month report by the Freedom to Speak Up Guardian.

Philip Ball FSTU Guardian, 13th October 2022


Hello, we are the Freedom to Speak Up Team, which is made up of Guardians and Champions.
You can contact us by phone on 07779 986 470.
Leave a message and we will respond as soon as possible if we cannot answer immediately.
We are usually available to meet five days a week during usual working hours, at a prearranged time and place.
A team member will help you as soon as they are able to. The FTSU team is here to help keep those in our care safe, whether that means patients, colleagues or ourselves.
We are also available on email:
freedomtospeakup@mkuh.nhs.uk
You can find out more on the intranet.

Meeting Title	**Trust Board**	**Date: 26th October 2022**
Report Title	**Significant Risk Register Report**	**Agenda Item Number: 20**
Lead Director	*Kate Jarman, Director of Corporate Affairs*	
Report Author	*Paul Ewers, Risk Manager*	

Introduction	*The report includes all significant risks across all Risk Registers (where the Current Risk Rating is graded as 15 or above), as of 26th October 2022.*		
Key Messages to Note	*Points to note in the report for the members of the Board/Committee/Group/Forum to focus on (please delete)*		
Recommendation *(Tick the relevant box(es))*	**For Information** √	**For Approval** ☐	**For Review** ☐

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	*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*

Report History	*The Risk Report is an ongoing agenda item*
Next Steps	*Public Board*
Appendices/Attachments	*Significant Risk Register*

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

	September	October	Indicator
Total Significant Risks	41	45	

Risks Overdue Review

Total Risks Overdue Review	7 risks	17%	3 risks	7%	
Musculoskeletal	2		0		
Estates	1		1		
Head & Neck	0		1		
Imaging	0		1		
Musculoskeletal	2		0		
IT	2		0		
Therapies	1		0		
Pharmacy	1		0		

Completeness/Accuracy of Risk Review

Risks being treated with no outstanding mitigations recorded on Radar	7	17%	7	16%	
Therapies	3		1		
Estates	0		1		
Acute Medicine	1		0		
Internal Medicine	1		0		
Anaesthetics & Theatres	1		0		
Finance	1		0		
IT	0		2		
Child's Health	0		1		
Haematology & Oncology	0		1		
Diagnostic & Screening	0		1		

Risks being tolerated with no implemented mitigations	0	0%	0	0%	

Risks being tolerated where Current Score is above Target Score	3	7%	3	7%	
Emergency Department	1		1		
Finance	2		2		

New Significant Risks

There were 4 new significant risks added to Radar since the last report:

RSK-381 - IF the obsolete Nitrous Oxide Manifold was to fail. THEN the Trust will be unable to source replacements and it may not be repairable. **Current Risk Score = 20**

RSK-382 – IF the MRI Emergency exit is too small for evacuation of patients on beds and trolleys. THEN there would be a delay in evacuating patients on beds and trolleys. **Current Risk Score = 15**

RSK-001 – 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. **Current Risk Score = 16**

RSK-388 – IF the MRI Emergency exit is too small for evacuation of patients on beds and trolleys. THEN there would be a delay in evacuating patients on beds and trolleys. **Current Risk Score = 15**

3. UPDATES

The Risk Manager continues to review CSU/Divisional risk meeting papers, attending ad hoc CSU/Divisional meetings, and meeting with Risk Owners and Department Managers. They also provide support with the monitoring, review, and management of their risks, and to help develop oversight of risk across the Trust. The Trust Secretary and the Risk Manager have developed a risk communications framework to significantly enhance risk awareness among the Trust staff.

4. NEXT STEPS

Steps are being taken to improve how risk is reported throughout the organisation, and to the Board. Other steps are being taken by the Risk Manager to develop an ongoing Risk Management training programme for staff. This will include looking at what information staff need to know at their induction, through to how regularly staff need to update and refresh their Risk Management knowledge and skills.

5. RECOMMENDATION

The Committee is asked to review and discuss this paper.

6. APPENDICES

Appendix 1 - Significant Risk Register

Reference	Created on	Owner	Description	Impact of risk	Scope	Region	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-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	11-Oct-2022	16-Nov-2022	Planned	25	25	2	Purchase new scopes (27-Jul-2022),Review the feasibility of using disposable scopes	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 grade To review for disposable scopes
RSK-019	22-Sep-2021	Sushant Tiwari	IF there is an increased number of incidents of violence and aggression in Emergency Department THEN there will be an impact on patient safety, staff mental and physical health	LEADING TO an increased risk of physical or verbal damage to staff or other patients, risk of delay in care whilst incidents resolved; potential for litigation or claims dependent on harm; Increased staff sickness rate, poor retention and recruitment of staff; negative impact on Trust reputation; poor patient experience	Region	Emergency Department	18-Oct-2022	23-Nov-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 by Risk Owner - Risk remains.
RSK-035	28-Sep-2021	Helen Chadwick	IF there is a high turnover of staff due to: work pressure, not having the opportunity to work at the top of their licence, lack of capacity for development, lack of capacity for supervision / support. Also difficulty in recruiting. Loss of staff to primary care which offers more attractive working hours. THEN there will be insufficient staff in pharmacy to meet demands of the organisation and ensure patient safety in the use of medicines.	LEADING TO: 1. increased length of stay due to TTO delay 2. increase in prescribing errors not corrected 3. increase in dispensing errors 4. increase in missed doses 5. failure to meet legal requirements for safe and secure use of medicines 6. harm to the patients 7. adverse impact on mental health of Pharmacy staff All resulting in adverse patient outcomes. Lack of financial control on medicines expenditure Breach of CQC regulations	Organisation		29-Sep-2022	31-Dec-2022	Planned	20	20	6	Actively recruiting staff (30-Sep-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 increased risk of infection due to overcrowding of facilities, and there will be a lack of capacity for appropriate management of CT and MRI within KPI and DM01 timescales	LEADING TO financial targets being missed, negative impact on reputation due to long waiting times Reputation, and financial due to increased infection rates, and staff leaving due to poor working conditions.	Region	Diagnostic & Screening	11-May-2022	20-Jun-2023	Planned	20	20	16	Business Case to be developed for Radiographers,Review of Radiologists - demand and capacity,New CT Machine to be implemented,Recruitment of staff	Extended working hours and days(04-Nov-2021),Some scans sent off site to manage demand(04-Nov-2021),Reduced appointment times to optimise service(04-Nov-2021)	Medium	Treat	Risk reviewed by Triumvirate. Risk linked to RSK-112. Risks merged. Additional controls added.
RSK-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 manage. Staff morale will reduce as they will not be providing the appropriate level of assessment and treatment to their patients. Length of stay may increase as patients will not be seen in line with care plans due to prioritising discharges. High volume of patients not being seen daily, only new assessments, discharges and acute chests being reviewed.	Organisation		11-Oct-2022	24-Nov-2022	Planned	16	20	6	Closure or Reduction in Escalation Beds (18-Oct-2022)	Therapy staff attend board rounds and work with the MDT to determine priority patients. The skills mix and workforce is reviewed twice weekly between Occupational Therapy and Physiotherapy to determine cover for the base wards. To work closely with community services to raise awareness and to increase discharge opportunities i.e. in reaching Therapies working with Long stay Tuesday initiative Therapies supporting new discharge pathway/process in the Trust Over recruitment of PT and OT band 5's Locum cover for vacant posts. Daily attendance at 10.30 system wide discharge call. Inpatient Therapy Service participation in MADE events. Review of staffing model across inpatient medical and frailty wards.(12-Nov-2021)	Low	Treat	Risk reviewed at Therapies CIG - No change to risk
RSK-159	12-Nov-2021	Adam Baddeley	If patients referred to the Occupational Therapy and Physiotherapy inpatient services covering medical wards are not being seen in timely manner, then there will be a delay in these patients being assessed, treated and discharged.	Leading to deconditioning of vulnerable/complex patients requiring a short period of therapy; increased length of stay; potential readmission, increased demand for packages of care requiring double handed provision.	Organisation		11-Oct-2022	24-Nov-2022	Planned	20	20	6	Review of Governance Structure (18-Oct-2022),Review Model of Care (13-Sep-2022),Review Equity Tool - Safe Staffing (13-Sep-2022),Review Workforce Model and Structure (13-Sep-2022),Recruitment and Retention of staff (18-Oct-2022)	Daily prioritisation of patients cross covering and review of skill mix locum cover x1 OT and x1 PT in place Ward book for escalation wards setup and band 7 reviews the caseload on the ward daily Monday- Friday and requests the most urgent are reviewed. Recruitment process ongoing but vacancies have reduced slightly. Over recruitment of band 5 OT and PT roles. Non-recurrent funding application for increase in therapy assistants over winter months.(12-Nov-2021),Education and Training of staff(19-Apr-2022)	Low	Treat	Risk reviewed at Therapies CIG - No change to risk
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		06-Sep-2022	31-Jan-2023	Planned	20	20	5	Replacement procured, implementation planned (16-Feb-2022)		Low	Treat	Risk likelihood increased due to recent WiFi issues believed to be linked to lack of CORE replacement.
RSK-341	17-May-2022	Paula Robinson	IF there is a delay with imaging reporting for CT and MRI for patients on cancer pathways THEN there could be a delay with diagnosis and the commencement of treatment	LEADING TO potential increase in the required treatment, potential poorer prognosis for patient, poor patient experience, increase in complaints and litigation cases.	Organisation		05-Sep-2022	21-Feb-2023	Planned	20	20	8	2x Specialist Doctors appointed on a fixed-term basis to uplift internal reporting capacity (14-Jun-2022),Specialist Radiology to be recruited to uplift reporting capacity,Explore alternative outsourcing for some specialist areas (e.g. lung),Imaging Business Case for substantive Radiologists and Radiographers	PTL tracking to escalate to imaging leads(18-May-2022),Agency Locum Consultant appointed 2 days a week to uplift internal reporting capacity(14-Jun-2022),Temporary reduction in double reporting for Quality Assurance to increase real-time scan reporting(14-Jun-2022),Current Radiologists doing 30% over standard reporting levels(14-Jun-2022)	Low	Treat	Risk reviewed by Claire McGillycuddy. No change to risk - review again February 2023

Reference	Created on	Owner	Description	Impact of risk	Scope	Region	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-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	11-Oct-2022	16-Nov-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
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 guidelines, procedures and patient information documents - the lead colposcopist may not be supported in the acquisition and validation of data to support the production of quarterly and annual performance information, including the mandatory KC65 return support, and represent the views of, colposcopy nurses within the department - There may not be support from a lead nurse for staff within the colposcopy department and safe staffing levels and co-ordinate the training of nursing and administration staff within colposcopy, ensuring competence within their respective roles - Safe standards may not be maintained within the clinical environment, supporting the failsafe processes ensure the provision of an appropriate clinical environment for the day to day delivery of colposcopy that meets standards - Assurance of nursing and administration staff within the colposcopy service meet mandatory training requirements may not be met	Leading to; Not meeting the NHS Cervical screening: programme and colposcopy management	Region	Women's Health	11-Oct-2022	16-Nov-2022	Planned	20	20	1	Recruit lead nurse	Create business case for lead nurse(10-Aug-2022)	Low	Treat	No change
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 wait pathway, which will increase the non-urgent referral wait list, including an increase in referrals. AND The service may not meet the Cervical screening: programme and colposcopy management of clinic staffing and facilities (1 level one registered nurse trained in colposcopy and A second support nurse trained in colposcopy).	Leading to; The service not meeting the Cervical screening: programme and colposcopy management practices	Region	Women's Health	11-Oct-2022	16-Nov-2022	Planned	15	20	3	Recruit lead nurse for colposcopy	Use of Locum and bank medical and nursing staff(10-Aug-2022),Advert and employ additional nursing staff(10-Aug-2022),Consultants using SPA time to support clinic session(10-Aug-2022),Business case for additional staffing(10-Aug-2022),Additional clinics on evenings and weekends(10-Aug-2022)	Low	Treat	No change
RSK-382	15-Sep-2022	Michael Stark	IF the obsolete Nitrous Oxide Manifold was to fail THEN the Trust will be unable to source replacements and it may not be repairable.	LEADING TO failure to supply theatres with Nitrous Oxide, resulting in potential loss of service, reduced patient safety, substandard care and loss of reputation.	Organisation		10-Oct-2022	20-Oct-2022	Overdue	20	20	1			Low	Treat	A recent business case to replace the existing plant was not approved.
RSK-001	06-Sep-2021	Tina Worth	IF all known incidents, accidents and near misses are not reported on the Trust's incident reporting system (Radar); THEN the Trust will be unable to robustly investigate all incidents and near-misses within the required timescales;	LEADING TO an inability to learn from incidents, accidents and near-misses, an inability to stop potentially preventable incidents occurring, potential failure to comply with Duty of Candour legislation requiring the Trust to report all known incidents where the severity was moderate or higher, potential under reporting to the Learning from Patient Safety Events (LfPSE) system, and potential failure to meet Trust Key Performance	Organisation		23-Oct-2022	31-Dec-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 (24-Oct-2022)	Incident Reporting Policy(06-Sep-2021),Incident Reporting Mandatory/Induction Training(06-Sep-2021),Incident Reporting Training Guide and adhoc training as required. Radar to provide on site & bespoke training IT drop in hub to be set up 2 days a week for staff drop ins(06-Sep-2021),Datix Incident Investigation Training sessions(06-Sep-2021),Daily review of incidents by Risk Management Team to identify potential Serious Incidents and appropriate escalation(06-Sep-2021),Serious Incident Review Group (SIRG) ensure quality of Serious Incident Investigations(06-Sep-2021),SIRG ensure appropriate reporting of Serious Incidents to Commissioners(06-Sep-2021),Standard Operating Procedure re Risk & Governance Team supporting the closure of incident investigations during unprecedented demand on service(06-Sep-2021),Implementation of new Risk Management Software to make incidents easier to report and improve engagement with staff(06-Sep-2021)	Low	Treat	Risk unchanged.

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RSK-036	28-Sep-2021	Helen Chadwick	If there is no capacity in the Pharmacy Team THEN there is a risk that Pharmacy and Medicines Policies and Procedures may not be reviewed and updated in a timely manner, nor new policies developed	Leading to: Potential for Policies & Procedures to be out of date Potential for staff to follow out of date Policies & Procedures Failure to meet CQC requirements Lack of guidance for staff Potential harm to patients	Organisation		08-Sep-2022	16-Dec-2022	Planned	16	16	6	Recruitment of staff (28-Sep-2022)	Use of remote bank staff to update policies(28-Sep-2021),Business Case for additional Pharmacy staff(19-Apr-2022)	Low	Treat	Risk reviewed by Jill McDonald: The control of the pharmacy related risk remains dependent on staff recruitment. We are out to advert across all grades of pharmacist at present with some success however a number of posts will need readvertised. I do not expect the current recruitment to have a major impact for at least 3 months. Claire McGillycuddy requested review date is in 4 months
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 from past injections).	LEADING TO a delay to sight saving treatment – time critical treatment.	Region	Head & Neck	23-Aug-2022	02-Oct-2022	Overdue	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 measure,Training up of Optometrists to do injections,Recruitment to SAS and fellowship roles,Team to consider an increase in nursing staff to run eye injection clinics (24-Aug-2022),Nurse in training due to start in September & 2 nurses on ophthalmology course	Introduction of further Injection Clinics all day Friday (staff permitting)(21-Apr-2022),One stop clinics were introduced - increase 2 sessions to 4 - consultant led(21-Apr-2022)	Low	Treat	controls updated
RSK-079	14-Oct-2021	Celia Hyem-Smith	IF there are increased referral rates, a lack of space to deliver treatment, an inability to deliver timely treatment (rehab/maternity), and a lack of administrative resources THEN the Physiotherapy waiting lists may reach unacceptable levels	LEADING TO patient's not receiving timely treatment/intervention, patient's becoming unconditioned, continual pressure to provide appointments, a reduced patient outcomes and unnecessary waiting time for appointments. Increased staff stress and sickness, staff being unable to treat as many patients as pre Covid-19, staff having to use clinical time for admin duties	Region	Therapies	11-Oct-2022	27-Nov-2022	Planned	20	16	12	Approval given for locum support until the end of November 2021 (12-Sep-2022),All referrals triaged on receipt and rated as urgent, routine and non-urgent. Maintain contact with long waiters to determine if they still need our service. Packs and leaflets sent out, as appropriate (03-May-2022),Set slots kept for very urgent cases but does not meet needs. (08-Aug-2022),12-month fixed term contract approved for 1.00 WTE, Band 6 member of staff (29-Jun-2022),Request made to use the therapy treatment room on ward 14 for outpatient services. This area could remove 4 staff from the existing space and free up three clinic rooms and the need to access the gym (12-Sep-2022),Plans to re-instate small group sessions allowing approx. 40 patients to be seen per week (08-Aug-2022)	Virtual clinic appointments have been introduced as part of the treatment pathway(14-Oct-2021),Additional areas suitable for telephone and video clinics have been identified and additional resources supplied(14-Oct-2021),Reconfiguration of department to support virtual working, enable social distancing and allowing appropriate staff to work from home(14-Oct-2021),An additional room has been refurbished for MSK. Refurbishment of two orthotics rooms has provided workspace for the WMH team.(14-Oct-2021),Separate risk assessment completed relating to under resourcing within the admin team(14-Oct-2021)	Medium	Treat	Risk reviewed at Therapies CIG - 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 may frequently fall under the remit of the T&O Team or be nursed on a surgical ward when they should be under a neurological team.	LEADING TO Potential reduction in patient safety - T&O surgeons and nursing teams may be unaware of how to care for patients with moderate to severe head injuries especially patient who are anticoagulated. Clinicians may have to wait for an opinion from the Tertiary Centre staff training, competency and experience Serious incidents Reduced patient experience	Region	Musculoskeletal	23-Oct-2022	28-Nov-2022	Planned	12	16	8	Implementation of Pathway Unit	- On going discussions with Senior Medical Team - CSU Lead to escalate via trauma network - Alert process is in place for escalation within T&O & externally. - Resources available at tertiary site for advice/support(15-Oct-2021),1, 2 c& 3. mitigating controls - Policy for management of head injuries has been developed - Awaiting appointment of head injury liaison Nurse - Long term plan for observation block to be built.(15-Oct-2021),GAPS: - Trust is not in line with other trauma units - Regional trauma centre advises head injury should not be managed by trauma and orthopaedics and after 24 hours the patient should be referred to neurosurgery. - Potential delay in opinion from Tertiary Centre(15-Oct-2021)	Low	Treat	24.10.2022 EB - Risk Reviewed - to remain at current rating and level. Review again when maple unit opens
RSK-088	15-Oct-2021	Zuzanna Gawlowski	IF there is overcrowding and insufficient space in the Neonatal Unit. THEN we will be unable to meet patient needs or network requirements (without the increase in cot numbers and corresponding cot spacing).	LEADING TO potential removal of Level 2 status if we continue to have insufficient space to adequately fulfil our Network responsibilities and deliver care in line with national requirements.	Region	Paediatric Services	16-Oct-2022	09-Jan-2023	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 asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID(15-Oct-2021),3. Added to capital plan(15-Oct-2021)	Low	Treat	risk reviewed remains the same

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RSK-093	22-Oct-2021	Elizabeth Pryke	IF there is insufficient staffing within the dietetics department in paediatrics THEN they will be unable to assess and advise new patients and review existing patients in a timely manner.	LEADING TO an impact on patients nutritional status and longer term dietary management on what is a very vulnerable group of patients. The majority of our caseload is infants or tube fed infants and children where there nutrition and growth is a priority	Organisation		11-Oct-2022	24-Nov-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 the expectation that senior dietetic staff can cover the complex paediatric cases.(22-Oct-2021),2 new starters to join the team in the next few weeks will start to increase paediatric dietetic provision - to review waiting list once new starters in post(19-Apr-2022),Paediatric Dietetic Assistant Practitioner appointed - to start on 9.5.22, after induction will help to reduce risk(29-Apr-2022)	Low	Treat	Risk reviewed at Therapies CIG - 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 THEN the Trust will be unable to prove control, monitoring and validation of the sterilisation process as a control measure. Both units are reviewed only 1 day per month - a bulk of this time is spent checking records and the other aspects of the role do not get the sufficient time required to review and follow up.	LEADING TO possible loss of ISO 13485 accreditation due to non-compliance to national standards. Inconsistent checks or lack of scheduled tests for the steam plant also increase the risk.	Organisation		20-Sep-2022	30-Dec-2022	Planned	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 is now aware that the site will not have any day to day operational AP(D) cover. (10-Jun-2022)	Estates management informed and plans in place to receive reports on time and to standard. Independent monitoring system in place monitoring machine performance. Weekly PPM carried out on machinery. An action plan has been created by estates, to include training the specialist estates officer so he can gain the recognised qualification he needs to carry out the role of the Authorised person for decontamination(AP(D)) and for additional training of the estates competent persons(CP(D) who test the decontamination equipment.(29-Oct-2021)	Low	Treat	Reviewed by Mark Brown, no change to current risk rating
RSK-126	04-Nov-2021	Zuzanna Gawlowski	IF cot spacing in the Neonatal Unit does not comply with BAPM guidance or the latest PHE guidance for COVID-19 (the Unit is seeking to increase both total cot spacing and cot numbers by 4 HDU/ITU cots in line with Network 5 year projections of acuity and demand, and spacing in line with National Recommendations) THEN there will be overcrowding and insufficient space in the Neonatal Unit, exacerbated by need for social distancing due to COVID-19. The milk kitchen was condemned due to this	LEADING TO an inability to meet patient needs or network requirements. We will now also be unable to meet PHE recommendations for social distancing This may result in a removal of Level 2 status if we continue to have insufficient space to adequately fulfil our Network responsibilities and deliver care in line with national requirements. This may also impact on our ability to protect babies and their families during COVID	Organisation		16-Oct-2022	09-Jan-2023	Planned	25	16	9	Business Case for Refurnishing Milk Kitchen and Sluice	Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards(04-Nov-2021),Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID(04-Nov-2021),Added to capital plan(04-Nov-2021),Feasibility study completed(04-Nov-2021)	Low	Treat	Risk reviewed no changes currently score remains the same
RSK-134	04-Nov-2021	Karan Hotchkin	If the future NHS funding regime is not sufficient to cover the costs of the Trust THEN the Trust will be unable to meet its financial performance obligations or achieve financial sustainability and there may be an increase in operational expenditure in order to manage COVID-19	LEADING TO increase in efficiency requirement from NHS funding regime to support DHSC budget affordability.	Organisation		09-Oct-2022	11-Nov-2022	Planned	20	16	8	The current funding has now been clarified .The trust will work with BLMK system partners during the year to review overall BLMK performance	Cost and volume contracts replaced with block contracts (set nationally) for clinical income(04-Nov-2021),Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until end of March 2022)(04-Nov-2021),Budgets to be reset for FY22 based on financial regime; financial controls and oversight to be reintroduced to manage financial performance(04-Nov-2021),Cost efficiency programme to be reset to target focus on areas of greatest opportunity to deliver(04-Nov-2021)	High	Treat	Risk transferred from Datix
RSK-135	04-Nov-2021	Jessica Dixon	IF the Pathology LIMS system is no longer sufficient for the needs of the department, due to being outdated with a limited time remaining on its contract THEN the system is at risk of failure, virus infiltration and being unsupported by the supplier	LEADING TO the Pathology service being halted and contingency plans would have to be implemented. Sensitive information could lost or security of the information could be breached.	Region	Diagnostic & Screening	11-Oct-2022	11-Dec-2022	Planned	16	16	4	Low Level Design to be completed (11-Oct-2022)	Systems manager regularly liaises with Clinysis to rectify IT failures(04-Nov-2021),Meetings with S4 to establish joint procurement take place periodically(04-Nov-2021),Project Manager role identified to lead project for MKUH(04-Nov-2021),High Level Design Completed(01-Dec-2021)	Low	Treat	Project Board have announced that there is a further 2 month delay to the LIMS go live date - this will push the go live date back until Oct 2023. MKUH IT have been made aware and have agreed that no further slippage can be accepted after Oct. Delay mostly due to Micro delays, as Clinysis project lead has changed several times and due to the complexity of the LLD. Options of actions going forward have been proposed by the S4 project managers to be agreed at the next S4 board meeting end of Oct. To review in 2 months at next POT.
RSK-202	23-Nov-2021	Karan Hotchkin	IF Transformation delivery is not adequately resourced and prioritised and/or schemes are unrealistic and not well planned THEN There is a risk that the Trust is unable to achieve the required efficiency improvements through the transformation programme leading to an overspend against plan	LEADING TO the Trust potentially not delivering its financial targets leading to TO potential cash shortfall and non-delivery of its key targets	Organisation		09-Oct-2022	11-Nov-2022	Planned	20	16	9		Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partners(23-Nov-2021),Cross-cutting transformation schemes are being worked up(23-Nov-2021),Savings plan for 21/22 financial year not yet fully identified(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix
RSK-258	29-Nov-2021	Anthony Marsh	IF the Switchboard resources cannot manage the service activity THEN this may result in poor performance	LEADING TO failure To meet KPI's and Emergency Response Units will put Patients, Staff and Visitors at risk and Communication with Users will give poor perception of the We Care action initiative	Organisation		20-Sep-2022	30-Dec-2022	Planned	20	16	4		Re-profiled staff rotas(29-Nov-2021),Bank staff employed where possible(29-Nov-2021),IT Department implemented IVR to assist in reducing the volume of calls through the switchboard(29-Nov-2021),Contingency trained staff available to assist(29-Nov-2021),Two additional workstations/consoles created in Estates Information office and Security office to allow for remote working(29-Nov-2021),Review of staff rota profile(04-Mar-2022)	Low	Treat	No changes to current risk rating

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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		09-Oct-2022	11-Nov-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-337	28-Apr-2022	Sarah Knight	IF the Children's Physiotherapy Department at MKUH has a waiting time for routine MSK and Core appointments of approximately 9 months. THEN the Trust is not meeting the target 18 week waiting time from receipt of referral, for routine musculoskeletal (MSK) appointments	LEADING TO a delay in the Physiotherapist's initial assessment, a delay in treatment, and an impact on patient safety and experience	Region	Therapies	11-Oct-2022	30-Nov-2022	Planned	12	16	12	Recruitment of vacant posts (05-Oct-2022),Complete demand and capacity work to better forecast what staffing is needed to cover this service (05-Oct-2022),Send receipt of referral letters, asking parents/guardians to contact the department if they notice any significant deterioration in their child's ability or function (11-Oct-2022),Produce patient leaflets to send to patients upon referral, to provide information and advice on various conditions. Where suitable, these can also recommend basic exercises for patients to manage or improve their condition (11-Oct-2022)	All referrals are triaged and coded on receipt by a Band 7 Physiotherapist(28-Apr-2022),Referrals with insufficient information to enable triage are sent back to the referrer with a request for more information(28-Apr-2022),The department runs three 'sprint clinics' a month, where only new patients are seen, to reduce the delay in initial assessment(28-Apr-2022),The department runs two gait clinics a month. Gait problems tend to require short episodes of treatment, and therefore this facilitates the quick discharge of patients, reducing the waiting list(28-Apr-2022)	Medium	Treat	Risk reviewed at Therapies CIG - Current risk should be 16, not 12. Risk updated
RSK-015	21-Sep-2021	Mariama Bah	IF there are ligature point areas in Ward 1 in various areas of the department THEN patients may use ligature points to self-harm	LEADING TO physical injury/cuts/overdose/ill health/death to patients, and psychological impact, stress, anxiety, breakdown to staff/visitors; Absence from work; Reduced staffing through absence; Ongoing mental health impact	Organisation		15-Oct-2022	31-Dec-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-2022),Safer bed spaces in Bay 1 and bay 3. Hospicom brackets removed in siderooms(25-May-2022),Senior nurses on the ward made aware of safe bed spaces. If bed space not available and patient high risk will work to move other patients to make space or request one to one.(25-May-2022),Dissemination of Ligature risk policy and the appropriate pathway to the unit, via staff communications , "Message of the week" and word of mouth.(25-May-2022),Staff made aware to remove unnecessary ligature risks if clinically not required. Eg. Suction/oxygen/equipment/call bell.(25-May-2022),Tuff cut scissors in resus trolley(25-May-2022),Request for one to one enhanced observation nurses based on Mental Health Risk Assessment. Ranging from Health Care Assistant, Registered Mental Health Nurse or security. If not available manage in numbers as best as possible, however is a risk to patient and also the ward.(25-May-2022),Patient own drug (POD) cupboards by bedside and all drugs are locked away(25-May-2022),Equipment such as	Low	Treat	No changes
RSK-025	22-Sep-2021	Elizabeth Winter	IF there are vacancies of Band 5 and senior nursing skill mix 247 THEN wards could be experiencing some issues with nurse staffing levels and skill mix	LEADING TO a potential impact on patient Safety, staff wellbeing, the number of complaints received and incidents e.g. pressure ulcers reported. There is a significant cost risk incurred in relation to using agency staff, leading to increased pressure on Trust finances. Incidents may not be properly identified and raised.	Region	Internal Medicine	12-Oct-2022	24-Nov-2022	Planned	15	15	4		On-going recruitment drive(11-Oct-2021)	Low	Treat	Risk Reviewed at Internal Medicine CIG - No Change
RSK-055	01-Oct-2021	Robyn Norris	IF Theatres are unable to cover the demand for theatre staff in both elective and emergency/trauma theatre sessions, and are not able to manage staffing shortages across the theatre department THEN the team will be unable to meet the changes and developments in the service. Examples of the increased staffing demand below: Robotic lists x 5 days a week, COVID-19 secure pathway, increased elective activity & trauma activity & staffing the theatre procedure room.	LEADING TO less support for junior staff currently in post. The lack of experienced staff may also create issues around staff skill mix. Patient operations may be cancelled due to a lack of staff. This creates increased stress level with the clinical teams.	Region	Anaesthetics & Theatres	25-Sep-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. Even with the additional support from bank and agency staff we still struggle to provide staff for all sessions, this has recently led to cancelling lists. These risks are exacerbated when staff are off sick or absent for training / annual leave.(01-Oct-2021),GAPS: There are significant gaps in the theatre rota - 19 WTE posts are required to meet latest review of theatre staffing requirements.(01-Oct-2021),Recruited to 8x WTE(27-Apr-2022),Recruited 5x International Nurses(27-Apr-2022),Approval of Business Case for 10x additional members of staff(27-Apr-2022),10x additional members of staff to be recruited(27-Apr-2022),Recruitment programme is underway(13-Jun-2022)	Medium	Treat	Risk reviewed at Anaesthetics & Theatres CIG - risk remains

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RSK-082	15-Oct-2021	Emma Budd	IF the trauma activity beyond existing capacity (5 cases per day on trauma list) continues to increase alongside the implemented green pathway for orthopaedic elective care patients THEN the Trauma and Orthopaedic department has lost capacity to escalate on to elective lists for trauma patients. As such with just one trauma list per day, there may be insufficient capacity to meet trauma needs.	LEADING TO insufficient trauma capacity, the department may not be able to operate on all trauma patients within the required timelines leading to poor outcomes. The Trust may be required to close to trauma or cancel all elective lists for the day in theatres 11 and theatres 12 in order to facilitate trauma patients who are not covid swabbed, isolated for 72 hours or given social distancing advice. This will lead to longer elective wait times and possible 52 week breaches. Alternatively, the Trust may be required to close to trauma due to insufficient capacity.	Region	Musculoskeletal	23-Oct-2022	28-Nov-2022	Planned	12	15	6	10x additional members of staff to be recruited	Divisional Director for Operations to work with T&O and Theatre teams to implement all day weekend emergency theatre lists.(15-Oct-2021),Utilisation of theatre pm 1 for procedures that do not include metal work twice a week if staffing is available.(15-Oct-2021),Cancellation of elective activity if required.(15-Oct-2021),There are occasional surges in trauma cases especially at the weekend which impacts on trauma/ elective lists on Mondays.(15-Oct-2021),Approval of Business Case for 10x additional members of staff(27-Apr-2022)	Low	Treat	24.10.2022 Risk Reviewed - rating to remain at same level- ongoing
RSK-101	25-Oct-2021	Melissa Davis	IF the maternity service at MKUK do not have their own dedicated set of theatres. THEN maternity are left vulnerable to not having a guaranteed emergency theatre available 24hrs a day.	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	31-Aug-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	Elective Caesarean work is completed the Theatre 1 during a booked morning session, Theatre 3 is set for obstetric emergencies.(01-Sep-2022)	Low	Treat	Risk description updated following clarification requested by the board.
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	11-Oct-2022	16-Nov-2022	Planned	16	15	6	Implement Ockenden 2 (Recalculated headroom/gap),Review establishment birth rate+ report (07-Sep-2022)	There are significant efforts to recruit new midwives.(26-Oct-2021),The early recognition by GOLD and the Chief Executive to advertise for new midwives following the Ockenden report.(26-Oct-2021),Also working with NMC to achieve PIN numbers early for newly qualified staff.(26-Oct-2021),Enhanced bank rates.(26-Oct-2021),Rolling job advert for band 5/6 clinical midwives(27-Apr-2022)	Low	Treat	No change
RSK-142	04-Nov-2021	Elizabeth Pryke	IF there is insufficient capacity and ongoing unsustainable demand for dietetic input for Paediatric patients (both inpatient and outpatient) . IF Home Enterally Fed Paediatrics patients continue to be seen our outpatient structure which is not adequate to meet their demands and needs (rather than the community contract). This means that these high risk groups of Children and Young People are not accessing the necessary specialist nutritional support at the appropriate time in their development THEN staff may be unable to cover a service that has not been serviced correctly, and the paediatric team cannot provide a full dietetic service to children and young people in the Milton Keynes area	LEADING TO patient care and patient safety may be at risk, vulnerable children may become nutritionally compromised, the service may be unable to assess and advise new patients and review existing patients in a timely manner, and there may be an impact on patients nutritional status and longer term dietary management on what is a very vulnerable group of patients. The majority of our caseload is infants or tube fed infants and children where there nutrition and growth is a priority.	Organisation		11-Oct-2022	24-Nov-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 CIG - No change to risk
RSK-170	12-Nov-2021	Imran Sheikh	IF the Autoclave machines are not replaced THEN there is a risk that the Pathology department will be unable to sterilise bio-hazardous laboratory waste prior to discarding. Accumulation of waste potentially infective, bad odour, and consuming much needed space. External contractors can remove category 1 and 2 waste only, category 3 waste cannot be removed from the site without being processed through the autoclave.	LEADING TO Health & safety risk to the laboratory staff; Failure to meet COSHH regulations in relation to waste management and autoclave of all HG3 known and suspected biological agents/clinical materials waste; potential disruption to the service; potential to affect Trust's reputation; accumulation of waste products; limiting user of autoclave to preserve lifespan	Region	Diagnostic & Screening	11-Oct-2022	31-Oct-2022	Pending	12	15	5	Business Case Development for replacement/repair of autoclaves (12-Sep-2022),Ensure robust Autoclave contingency plan to deploy contractors to collect and manage hazardous waste is tried and tested,Review and update SOP/safe systems of work relating to handling and management of HG3 waste,Change Control to establish robust segregation of waste until autoclaves are replaced – as agreed with HSE as part of the enforcement letter. Procedure update to be included as part of change control.	PPE; Gloves, safety goggles, ear defenders and Lab coat worn at all times, with good hand hygiene practice. Heavy duty gloves, full face visor and apron must be worn when unloading.(12-Nov-2021),Health & Safety training and competency procedures for all staff working with HG3 waste and the autoclaves.(12-Nov-2021),The autoclave maintenance is performed once per week to regularly check working order and functionality.(12-Nov-2021),Autoclave thermometric tests and calibrations to ensure correct processing of load. Checking printout of every run to ensure process passed. Only authorised staff to work on autoclaves.(12-Sep-2022),2nd autoclave being used to supply spares – these will run out(12-Sep-2022),Report deficiencies to Estates. Report incidents onto RADAR and escalate to senior management team(12-Sep-2022),Waste is being segregated in to two waste streams to ensure only HG3 waste is autoclaved to reduce over use of the autoclaves – All routine microbiology waste is being sent for incineration, whereas all waste produced from the CL3 room that is potentially HG3 waste is being disposed of in autoclave bags, inside autoclave metal tins and being	Low	Treat	Reviewed at POT Oct. IS not in attendance however update around autoclaves, quotes and specifications did not match therefore further investigation required by estates. IS leading on pushing this forwards.
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 products may be disrupted	LEADING TO some unavailabilty of clinical products, delays to deliveries and services may be disrupted or reduce resulting in impact on patient care	Organisation		09-Oct-2022	02-Jan-2023	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 procurement nurse to source alternative products(23-Nov-2021),Clinical Procurement nurse to join the NHSI/E Supply Resilience Forum(15-Aug-2022)	Medium	Tolerate	Still ongoing risk

Reference	Created on	Owner	Description	Impact of risk	Scope	Region	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment
RSK-250	26-Nov-2021	Craig York	IF staff across MKUH continue to use eCARE in the same way, that the volumes of requests made to the IT Department remain at their current rate, and the volume of change and project work continues at the current volume THEN the IT Department will become less responsive and a range of functions within eCARE will continue to be left without action	LEADING TO increased clinical risk, increased risk to performance of eCARE, potential disruption to staff, and delays in the deliver or projects and realising their benefits	Organisation		06-Sep-2022	31-Jan-2023	Planned	15	15	3	Prioritisation of workload is in place to cover the most impacting of issues or projects, however this only reduces the potential impact slightly		Low	Treat	Volume of work is increasing month on month without additional staff to support.
RSK-271	30-Nov-2021	Ayca Ahmed	IF there is insufficient space within the Medical Equipment Library (MEL) THEN MEL staff will be unable to carry out the required cleaning process to comply with the appropriate guidelines set by CQC and MHRA	LEADING TO Lack of cleaning and processing space due to the growth of the MEL over the years means not keeping unprocessed and processed equipment separately, not complying with CQC Regulation 15: Premises and equipment and MHRA Documentation: Managing Medical Devices January 2021	Region	Estates	19-Oct-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-2021),Issue has been raised at Space Committee (June 2021)(30-Nov-2021),2019-2020 Additional office has been provided, outside of the main department for the Service Manager and the Equipment training Auditor. This has created some additional space for the Library(30-Nov-2021),2019-2020 Additional storage provided outside of main department in the location of a storage facility within a staircase approved and provided for a number of services under an approved Business Case on the Capital Programme(30-Nov-2021)	Medium	Treat	Reviewed by Medical Devices Manager, no change to risk rating.
RSK-310	22-Dec-2021	Melissa Davis	IF all maternity related incidents are not reported on the Trust incident reporting system THEN maternity's ability to demonstrate effective governance processes and procedures, both within internal trust mechanisms and to the external stakeholders will be negatively affected	LEADING TO a potential reduction in the ability to learn from incidents and improve patient care/safety, an increase in incidents occurring, and complaints and claims being received	Region	Women's Health	11-Oct-2022	16-Nov-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
RSK-324	09-Feb-2022	Helder Prata	IF there are significant nursing vacancies within the Paediatric Unit, including Maternity Leave and Long-Term Sickness - we are currently 38% of permanent staff roles unfilled- this is being partially mitigated with use of regular Agency and Bank staff THEN there will not be sufficient/safe numbers of nursing staff to cover shifts.	LEADING TO an increased risk for children's safety due to the absence of permanent skilled staff; an increased use of agency; an increasing number of shifts that do not comply with national recommended safe staffing levels	Region	Paediatric Services	16-Oct-2022	09-Jan-2023	Planned	15	15	9	We are using regular Paediatric Agency and Bank staff to fill gaps wherever possible, we are planning a minimum of 50% of permanent staff on each shift. We are constantly advertising and interviewing for replacement staff- we are steadily recruiting. We are effectively managing Long term sickness in accordance with Trust guidance and with the input of HR,Establishment Review to be completed		Low	Treat	Reviewed by triumvirate 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 won't be contacted in a timely manner.	Leading to increased waiting lists and poor patient outcomes. Lack of capacity to book appointments leaving diary slots unfilled; patients not achieving expected outcomes especially if treatment is not provided within post surgical timescales; negative impact and possible litigation against the Trust	Region	Therapies	11-Oct-2022	24-Nov-2022	Planned	15	15	9	Approval for two bank staff until 1.7.22 (08-Aug-2022)		Medium	Treat	Risk reviewed at Therapies CIG - No change to risk
RSK-343	23-May-2022	Elizabeth Pryke	If there is insufficient dietetic staff in post THEN the service may be unable to meet referrals demand	Leading to patients not receiving dietetic input as needed, which could result in: - Insufficient dietetic education for adults with complex nutritional issues, including adults with diabetes, gastrointestinal disease, those either malnourished or at risk of malnutrition needing nutritional support etc. - Reduction in patient experience and poorer outcomes - MDT will not work effectively as insufficient dietetic input, increasing workload of other members of MDT - Patients with long term conditions such as Diabetes, CHD etc will not have the support to develop the skills for independence and self-management to achieve good health outcomes	Region	Therapies	02-Oct-2022	31-Oct-2022	Pending	15	15	9		Triaging patient referrals based on clinical need Daily team huddle to try and manage this and ensure communication is good across the team Advised ward staff so they can start first line nutritional support(23-May-2022),Setting up weekend telephone clinic(23-May-2022),Patients triaged as more urgent will be seen - reduced service communicated to senior nurses, consultants etc(14-Jun-2022),Patients triaged as more urgent will be seen - reduced service communicated to senior nurses, consultants etc(14-Jun-2022),Locum started to provide x 2 clinics / week(29-Jun-2022)	Low	Treat	1 x locum in place to help with telephone OP clinics, staff members working additional bank hours. Recruited to 2 posts - start dates for later in October / November.
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	21-Oct-2022	31-Dec-2022	Planned	12	15	9	weekly restore and recovery clinical meetings and weekly operational meetings		Medium	Treat	
RSK-381	08-Sep-2022	Thozama Cele	MRI Emergency exit too small for evacuation of patients on beds/trolleys.	standard beds and trolleys are not able to fit through the emergency exit. A folding trolley is available to use to fit through but this is not what it was designed for. In addition restricts bed patients to a maximum of one at any given time which could delays for other patients who may need an urgent MRI.	Region	Diagnostic & Screening	13-Sep-2022	09-Oct-2022	Overdue	5	15	5			Low	Treat	
RSK-388	17-Oct-2022	Jane Grant	IF Audiology Services do not get a second testing room equipped for the testing of younger and complex children THEN there will be a delay in offering appointments to these children	LEADING TO delayed diagnosis, delayed treatment, delayed management and diagnostic breaches.	Region	Head & Neck	16-Oct-2022	21-Nov-2022	Planned	15	15	4	Contact Estates and external company to explore options for conversion of workshop on Level 4 to testing facility	Current room being used to full capacity.(17-Oct-2022)	Low	Treat	Risk approved at Audiology Clinical Governance Meeting

Meeting Title	Trust Board Meeting in Public	**Date: 03/11/22**
Report Title	Audit Committee Summary Report for the meeting held on 18 July 2022	**Agenda Item Number:** 21
Chair	Gary Marven, Non-Executive Director	
Report Author	Julia Price, Senior Corporate Governance Officer	

Key Messages to Note

1. Matters approved by the Committee

- The internal audit contract award to RSM UK on a 3+1 year extension term following a competitive process with two organisations bidding.
- The internal audit work plan for 2022/23 and the Internal Audit Charter.
- Write-offs of £57k.
- The Data Security and Protection Toolkit Report 2021/2022.

2. Summary of matters considered at the meeting

The Auditor Representation Letter
The External Audit Contract award to Grant Thornton, endorsed by the Council of Governors on a 3+1 year extension term.
The Counter Fraud Annual Report for 2021/22 and Work Plan for 2022/23.
The Counter Fraud E-Rostering Review and Procurement and Contract Management Review reports
The Financial Controller's Report.
The Health and Safety Report and the focus on reducing violence and aggression.

3. Highlights of Board Assurance Framework (BAF) Review

The Committee noted the continuing work to update the BAF ensuring it remained fit for purpose with new risks being considered and others downgraded to be managed at an operational level.

4. Risks/concerns (Current or Emerging) identified

None.

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	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

Meeting Title	Trust Board	**Date:** 03 November 2022
Report Title	Summary Report for Finance and Investment Committee held on 06 September 2022	**Agenda Item Number:** 21
Chair	Heidi Travis, Non-Executive Director	
Report Author	Julia Price, Senior Corporate Governance Officer	

Key Messages to Note

1. Matters recommended for Trust Board approval

The Radiotherapy Business Case

2. Items identified for escalation to the Board

Performance and ERF funding in contrast to other areas within the East of England

3. Summary of matters considered at the meeting

- The Trust's operational and financial performance for July 2022
- An update on capital programme expenditure for 2022/23
- A report on the financial sustainability audit which was a condition of additional funding from NHSE to support cost pressures in 2022/23
- Progress on the transition to a different payroll provider, East Lancashire Financial Services, due to take effect on 01 January 2023
- Progress with the application for Future Focused Finance Accreditation due for submission at the end of September 2022

4. Highlights of Board Assurance Framework Review

The Board Assurance Framework was reviewed. There were no highlights to report.

5. Risks/concerns (Current or Emerging) identified

There were no risks or concerns identified.

Strategic Objectives Links	7 Spending money well on the care you receive 9 Expanding and improving your environment 10 Innovating and investing in the future of your hospital

Meeting Title	Trust Board Meeting In Public	**Date:** 03 November 2022
Report Title	Summary Report of the Charitable Funds Committee held on 15 September 2022	**Agenda Item Number:** 21
Chair	Haider Husain, Non-Executive Director	
Report Author	Julia Price, Senior Corporate Governance Officer	

Key Messages to Note

1. Matters approved by the Committee

The following business cases were approved:

- Staff Hub garden and ramp, requested by Sarah Crane, Chaplain, and funded by the NHS Charities Together Stage 1 wave three grant
- Cancer Centre MDT room, funded by the High Sherriff Golf Day
- Cancer Centre end of life courtyard, funded by a grant from the Childwick Trust
- Arts for Health MK, renewal of costs for another year for the maintenance and management of artwork and gardens

2. Items identified for escalation to Trust Board

3. Summary of matters considered at the meeting

The Charitable Funds Finance, Activities and Project Report
The Meaningful Activities Facilitator Report
Arts for Health MK and the shift in focus from hospital wall art to include creative courtyards in support of health and wellbeing

4. Highlights of Board Assurance Framework Review

The BAF was not reviewed at the meeting. There are no risks for which the Charitable Funds Committee is the lead committee.

5. Risks/concerns (Current or Emerging) identified

None

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	2. Improving your experience of care

Meeting Title	Trust Board Meeting in Public	**Date:** 03 November 2022
Report Title	Trust Executive Committee	**Agenda Item Number:** 21
Chair	Joe Harrison, Chief Executive Officer	
Report Author	Julia Price, Senior Corporate Governance Officer	

Key Messages to Note

1. Matters approved by the Committee/

The Trust's Travel Strategy

Funding for:
The Same Day Emergency Care workforce in the Maple Centre
11 CTG machines
Consultant office in cellular pathology
Emergency lighting
Ward and public bathroom replacements
Additional capital for the PCI service
Sterile storage facilities
EV chargers

The following policies/guidelines:
Sickness Absence and Attendance Policy and Procedure
Delivering Single Sex Accommodation Policy
Night Mode Standard Operating Procedure
Wound Care Guideline and Formulary
Maternity and Neonatal Safety Champions Roles

2. Summary of matters considered at the meeting

- Changes to the way serious incidents were to be investigated following the launch of the new national Patient Safety Incident Response Framework
- The update on health and safety matters including the new Violence Prevention Strategy developed by the Violence and Unacceptable Behaviour Steering Group
- The Trust's operational performance in July 2022, affected by staffing issues across the Milton Keynes system, and the impact 65 open escalation beds had had on elective activity
- Progress with the building of the Maple Centre due to be handed over to the Trust at the end of the month
- Financial and workforce performances in July 2022
- Divisional risk management and the significant risk register
- The quality improvement strategy and progress with that agenda

3. Highlights of Board Assurance Framework Review

The BAF was due a review at Trust Board Seminar in October

4. Risks/concerns (Current or Emerging) identified

None

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	*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. Employing the best people to care for you* *9. Expanding and improving your environment* *10. Innovating and investing in the future of your hospital*

AUDIT COMMITTEE
TERMS OF REFERENCE

1. Constitution

1.1 The Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the Audit Committee (known as 'the Committee'). The Committee is a non-executive chaired committee and as such has no delegated authority other than that specified in the Terms of Reference;

1.2 The Committee has been established by the Trust Board to:

- Ensure the effectiveness of the organisation's governance, risk management and internal control systems
- Ensure the integrity of the Trust's financial statements, the Trust's Annual Report and in particular the Annual Governance Statement
- Monitor the work of internal and external audit and ensure that any actions arising from their work are completed satisfactorily.

2. Delegated Authority

The Committee has the following delegated authority:

2.1.1. The authority to require any officer to attend and provide information and/or explanation as required by the Committee;

2.1.2. The authority to take decisions on matters relevant to the Committee;

2.2 The Committee does not have the authority to commit resources. The Chair may recommend to the Board that resources be allocated to enable assurance in relation to particular risks or issues.

3. Accountability

3.1 The Committee is accountable to the Trust Board. Any changes to the Terms of Reference must be approved by the Trust Board, and notified to the Council of Governors;

3.2 The Chair of the Committee is accountable to the Board and to the Council of Governors.

4. Reporting Lines

4.1 Following each meeting, the Chair of the Committee will provide a written report to the next available meeting of the Trust Board meeting in public, drawing the Board's attention to any issues requiring disclosure or Board approval;

4.2 The Chair of the Committee will, based on the Trust Secretariat's schedule, provide written reports back to the Council of Governors ~~through a regular written report~~;

4.3 The Committee will receive regular reports from the Chairs of other assurance Committees and formal reports from Executive ~~d~~Directors to cover the breadth of its delegated responsibilities.

4.4 The Committee will report to the Board at least annually on its work in support of the annual governance statement, specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness and embeddedness of risk management in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a Trust
- The robustness of the processes behind the quality accounts

4.5 The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

5. Purpose

5.1 The Audit Committee will provide assurance to the Board on:

- the effectiveness of the organisation's governance, risk management and internal control systems
- the integrity of the Trust's financial statements, the Trust's Annual Report and in particular the Annual Governance Statement
- the work of internal and external audit and any actions arising from their work

5.2 The Audit Committee will have oversight of the internal and external audit functions and make recommendations to the Board and to the Appointments~~Nominations~~ Committee of the Council of Governors on the reappointment of the external auditors.

5.3 The Audit Committee will review the findings of other assurance functions such as external regulators and scrutiny bodies and other committees of the Board.

6. Duties of the Audit Committee

To promote the Trust's mission, values, strategy and strategic objectives.

6.1 Integrated Governance, Risk Management and Internal Control

6.1.1 The Audit Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that support the achievement of the organisation's objectives.

6.1.2. In particular, the Committee will review the adequacy of:

- the Board Assurance Framework;
- the Annual Governance Statement, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to discussion by the Board where possible;

- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the disclosure statements in the above;
- the policies for ensuring compliance with NHS Improvement and other regulatory, legal and code of conduct requirements;
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority;
- the Trust's insurance arrangements.

6.1.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these. It will also seek reports and assurances from officers as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key Committees so that it understands processes and linkages. However, these other Committees must not usurp the Audit Committee's role.

6.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management, which meets the requirements of the Public Sector Internal Audit Standard 2017 and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal
- reviewing and approving the Internal Audit programme and operational plan, ensuring that this is consistent with the audit needs of the organisation
- reviewing the major findings of internal audit work, management's response, and ensuring co-ordination between the Internal and External Auditors to optimise audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- reviewing the responses by management to the internal audit recommendations
- annually reviewing the effectiveness of internal audit

6.3. External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This will be achieved by:

- considering the appointment and performance of the External Auditor
- discussing and agreeing with the External Auditor, before the audit commences, on the nature and scope of the audit as set out in the annual plan.

- discussing with the External Auditors their local evaluation of audit risks and assessment of the Trust and the impact on the audit fee
- reviewing all External Audit reports, including discussion of the annual audit letter and any work carried outside the annual audit plan, together with the appropriateness of management responses
- Ensure that there is in place a clear policy for the engagement of external auditors to supply non audit services.

6.4 Whistleblowing

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical and safety matters and ensure that any such concerns are investigated proportionately and independently. In this regard, the Committee will receive a quarterly update from the Trust's Freedom to Speak Up Guardians.

6.5 Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications on the governance of the organisation.

These will include, but will not be limited to, any reviews by NHS Improvement-, Department of Health, Arms' Length Bodies or others (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

In addition, the Committee will receive the minutes and review the work of other committees within the organisation, whose work could be of assistance to the Committee in gaining assurance around risk management and internal control across the organisation.

The Committee will annually review its own effectiveness and report the results of that review in an annual report to the Trust Board~~The committee will periodically review its own effectiveness and report the results of that review to the Board~~.

6.6 Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud Authority standards and shall review the outcomes of the work in these areas.

7. Membership

7.1 The Membership of the Audit Committee shall be as follows:

- A Non-Executive Director who is not the Chairman or Chair of another Board Committee will be appointed by the Chair of the Trust Board to Chair the Audit Committee.
- Two other Non-Executive Directors, neither of whom should be the Chair of the Finance and Investment Committee, or the Chair of the Trust Board.

7.2 Other Non-Executive Directors of the Trust, but not including the Board Chair, may substitute for members of the Audit Committee in their absence, in order to achieve a quorum.

7.3 The meeting is deemed quorate when at least two members are present. The attendance of other Non-Executive Directors of the Trust who are substituting for members, will count towards achieving a quorum.

7.4 At least one member of the Audit Committee must have recent and relevant financial experience. Other members of the Committee must receive suitable training and induction on taking on their role.

8. Attendance

8.1 The following posts shall be invited to attend routinely meetings of the Audit Committee in full or in part, but shall neither be a member nor have voting rights:

- The Director of Finance
- Medical Director (or their representative)
- Deputy Chief Executive
- Deputy of Director of Finance
- Financial Controller
- Director of Corporate Affairs
- The Internal Auditor
- The External Auditor
- A Counter Fraud Specialist
- The Trust Secretary

8.2 The Chair of the Trust Board and Chief Executive should be invited to attend to discuss with the Committee the process for assurance that supports the Annual Governance Statement.

8.3 The Committee may ask any other officials of the organisation to attend to assist it with its discussions on any particular matter.

8.4 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

9. Responsibilities of Members, Contributors and Attendees

9.1 Members of the Committee must attend at least 75% of meetings, having read all papers beforehand (Attendees (or their substitutes as agreed with the Chair in advance of the meeting) should attend all meetings);

9.2 Officers presenting reports for consideration by the Committee should submit such papers to the Trust Secretary by the published deadline (at least 7 days before the meeting). Papers received after this deadline will normally be carried over to the following meeting except by prior approval from the Chair;

9.3 Members and Attendees must bring to the attention of the Committee any relevant matters that ought to be considered by the Committee within the scope of these Terms of Reference that have not been able to be formalised on the agenda under Matters Arising or Any Other Business. All efforts should be made to notify the Trust Secretary of such matters in advance of the meeting;

9.4 Members and Attendees must send apologies to the Trust Board Secretary and also seek the approval of the Chair to send a deputy if unable to attend in person at least 3 days before the meeting;

9.5 Members and Attendees must maintain confidentiality in relation to matters discussed by the Committee;

9.6 Members and Attendees must declare any conflicts of interest or potential conflicts of interest at the start of each meeting in accordance with Milton Keynes University NHS Foundation Trust policy (even if such a declaration has previously been made);

10 Information Requirements

10.1 For each meeting the Audit and Risk Assurance Committee will be provided (ahead of the meeting) with:

• a report summarising any significant changes to the organisation's strategic risks and a copy of the strategic/corporate Risk Register;

• a progress report from the Head of Internal Audit summarising: work performed (and a comparison with work planned);

• key issues emerging from the work of internal audit;

• management response to audit recommendations;

• any changes to the agreed internal audit plan; and

• any resourcing issues affecting the delivery of the objectives of internal audit;

• a progress report (written/verbal) from the External Audit representative summarising work done and emerging findings (this may include, where relevant to the organisation, aspects of the wider work carried out by the National Audit Office, for example, Value for Money reports and good practice findings);

• management assurance reports; and

• reports on the management of major incidents, "near misses" and lessons learned.

10.2 As appropriate the Committee will also be provided with:

• proposals for the terms of reference of internal audit / the internal audit charter;

• the internal audit strategy;

• the Head of Internal Audit's Annual Opinion and Report;

• quality assurance reports on the internal audit function;

• the draft accounts of the organisation;

• the draft Governance Statement;

- a report on any changes to accounting policies;
- external Audit's management letter;
- a report on any proposals to tender for audit functions;
- a report on the Trust's approach to cyber-security, including updates on how cyber threats have been dealt with
- a report on co-operation between internal and external audit; and
- the organisation's Risk Management Strategy.

11 Frequency

11.1 The Committee will meet at least five times a year in March, May, June, July, September and December. The May meeting shall specifically focus on reviewing the Trust's Annual Report and Accounts and will be timed to fit in with the statutory timetable set down by Monitor. The Chair of the Audit Committee may convene additional meetings, as necessary.

11.2 The Board or the Accounting Officer may ask the Committee to convene further meetings to consider particular issues on which the Committee's advice is required.

12 Management

The Committee shall request and review reports and seek positive assurances from directors and managers on the arrangements for governance, risk management and internal control

The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit) as relevant to the arrangements.

13 Financial Reporting

The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The Audit Committee shall review the Annual Report and Financial Statements, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- changes in, and compliance with, accounting policies and practices
- unadjusted mis-statements in the financial statements
- decisions on the interpretation of policy
- significant judgements in preparation of the financial statements
- significant adjustments resulting from internal and external audits.
- Letters of representation
- Explanations for significant variances.

The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

14 Committee Administration

14.1 The Trust Secretary shall provide secretarial support to the Committee;
14.2 Papers should be distributed to Committee members no less than five clear days before the meeting;

15. Review

Terms of Reference will normally be reviewed annually, with recommendations for changes submitted to the Trust Board for approval.

Version Control

Version	Date	Author	Comments	Status
0.1	December 2008	James Bufford	Approved for Board by Audit Committee December 2008	Draft
1.0	January 2009	James Bufford	Approved by Board	Approved
1.1	Dec 09	Maria Wogan	Reviewed by Audit Committee – proposed amendments to the Board March 2010	For approval
1.2	March 10	Maria Wogan	Annual Review by the Board	Approved
2.0	Sept 2011	Geoff Stokes	Annual review by the Board	Approved
2.1	Jan 2012	Geoff Stokes	Add clinician to attendees list	
2.2	June 2012	Michelle Evans-Riches	Change to membership as Clinician cannot be a member	Approved
3.0	March 2013	Michelle Evans-Riches	Review by Audit Committee and Trust Board	Approved
4.0	Sep 2013	Michelle Evans-Riches	Annual Review	Approved
5.0	Sep 2014	Michelle Evans-Riches	Annual Review	Approved
6.0	Nov 2017	Adewale Kadiri	Annual Review	Approved
7.0	Oct 2018	Adewale Kadiri	Annual Review	Approved
8.0	Nov 2020	Julia Price	Annual Review by the Board	Approved
9.0	November 2021	Kwame Mensa-Bonsu	Annual Review by the Trust Board	Approved
10.0	November 2022	Kwame Mensa-Bonsu	Annua Review by the Trust Board	

Milton Keynes University Hospital NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE TERMS OF REFERENCE

1. Constitution

1.1 The Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the Charitable Funds Committee (known as 'the Committee'). The Committee is a non-executive chaired committee and as such has no delegated authority other than that specified.

1.2 The Committee is established under Standing Order 5 of Annex 7 of the Trust's Constitution.

2. Delegated Authority

2.1 The Committee has the following delegated authority:

2.1.1 The authority to require any officer to attend a meeting and provide information and/ or explanation as required by the Committee

2.1.2 The authority to take decisions on matters relevant to the Committee

2.1.3 The authority to establish sub-committees and the terms of reference of those sub-committees

2.2 The Committee has the authority to commit charitable fund resources. The Committee supports the fundraising activities of the Hospital Charity on behalf of the NHS Trust. The Hospital Charity is a charitable trust and the corporate trustee is the NHS Foundation Trust. All Board members act as trustees of the Charity.

3. Accountability

- The Charitable Funds Committee is a committee of the Trust Board. A minute of each meeting will be taken and approved by the subsequent meeting.

- Following each meeting, the Chair of the Committee will provide a written report to the next available meeting of the Trust Board meeting in public, drawing the Board's attention to any issues requiring disclosure or Board approval.

- The Chair of the Committee shall provide written reports to the Audit Committee, highlighting matters which provided information and assurance around risk management and internal control systems across the organisation.

- The Chair of the Committee will, based on the Trust Secretariat's schedule, provide written reports to the Council of Governors

- The Committee will annually review its own effectiveness and report the results of that review in an annual report to the Trust Board. ~~The Committee will also make an annual report to the Board.~~

4. Duties of the Charitable Funds Committee

The Charitable Funds Committee is charged by the Board to:

i) support, guide and encourage the fundraising activities of the Trust;
ii) monitor charitable and fundraising income;
iii) oversee the administration, investment and financial systems relating to all charitable funds held by the hospital charity;
iv) develop policies for fundraising and for the use of funds;
v) ensure compliance with all relevant Charity Commission regulations, and other relevant items of guidance and best practice;
vi) review the work of other committees within the organisation, whose work can provide relevant assurance to the Charitable Funds Committee's own scope of work;
vii) consider any funding request above the Directorate Fund level, or outside the scope of these funds, which is made to the Charitable Funds Committee. These must have been through the relevant standard Trust approvals processes for either Capital or Revenue (See Appendix One).
viii) consider and approve any urgent requests in advance of any formal meeting, on an exceptional basis through the approval of the named executive director and the committee chair.
ix) oversee and advise on the running of major fundraising campaigns.

5. Membership, Attendance and Quorum

5.1 Membership

The Membership of the Charitable Funds Committee shall be as follows:

- A Non-Executive Director will be appointed by the Chair of the Board of Directors to Chair the Charitable Funds Committee.
- One Non-Executive Director who may be an associate Non-Executive Director
- Director of Corporate Affairs.
- A named Governor from the Council of Governors.

The Chief Executive and the Chair of the Trust Board of Directors will be ex-officio members of the Committee, but their attendance will not count towards quorum.

Other Non-Executive Directors of the Trust, including associate Non-Executive Directors may substitute for members of the Charitable Funds Committee in their absence. Such directors will count towards the achievement of a quorum.

An external individual may be appointed as a member of the Committee with the consent of the Board.

The Secretary of the Committee will be the Trust Secretary.

The meeting is deemed **quorate** when at least one Non-Executive Director, one Executive Director or their nominated representative and one other member is present. ~~Deputies cannot be considered as contributing to the quorum.~~

6. Attendance

6.1 The following posts shall be invited to routinely attend meetings of the Charitable Funds Committee in full or in part but shall neither be a member nor have voting rights.

- Head of Charity
- Named representatives (2) from the Finance Directorate
- Trust Secretary
- Invited representatives from the clinical directorates

7. Responsibilities of Members and Attendees

7.1 Members or attendees of the Committee have a responsibility to:

7.1.1 Attend at least 75% of meetings
7.1.2 Identify agenda items for consideration by the Chair at least 14 days before the meeting
7.1.3 Submit papers, as required, by the published deadline (7 days before the meeting) on the approved template
7.1.4 If unable to attend, send apologies to the Trust Secretary and where appropriate seek the approval of the Chair to send a deputy
7.1.5 Maintain confidentiality, when confidential matters are discussed within the Committee.
7.1.6 Declare any conflicts of interest or potential conflicts of interest at the start of each meeting in accordance with Milton Keynes University Hospital NHS Foundation Trust policy, even if such a declaration has already been made.

8. Meetings and Conduct of Business

8.1 Frequency

The Committee will meet four times a year on a quarterly basis and at least 14 days prior to the Trust Board to allow a committee report to be submitted.

8.2 Calling Meetings

Meetings of the Charitable Funds Committee are subject to the same procedures as specified in Standing Order 3 of Annex 8 of the Constitution for the Board of

Directors. A meeting may be called by the Secretary of the Committee or the Chair of the Committee or the other Non-Executive Director Member of the Committee.

8.3 Agenda

The Committee will at least annually review these terms of reference. The agenda for meetings will be circulated to all Board members who have requested to receive papers. Full papers will be sent to members of the Committee at least 5 clear days before the meeting.

Version Control

Version	Date	Author	Comments	Status
0.1	December 2008	Wayne Preston	Considered by Charitable Funds Committee and approved for Board	Draft
1.0	January 2009	James Bufford	Approved by Board	Approved
1.1	March 2010	Maria Wogan	Minor amendments recommended to Board 24.03.10	For approval
1.2	March 10	Maria Wogan	Annual Review by the Board	Approved
1.3	April 2012	Michelle Evans-Riches	Review of Committee Structure By Finance and Investment Committee	For approval
1.4	September 2012	Michelle Evans-Riches	Implement changes from Charitable Funds Committee 27 September 2012	For approval
2	August 2013	Michelle Evans-Riches	Annual Review and changes to Committee Structure	For approval
2.1	November 2013	Jonathan Dunk	Updated to reflect new charitable funds approval guidance	For approval
3	June 2014	Michelle Evans-Riches	Review following changes to Terms of Reference template	For approval
4	October 2017	Ade Kadiri	Annual Review	For approval
5	February 2019	Ade Kadiri	Annual review and changes to the procedure for bid applications	For approval
6	October 2019	Ade Kadiri	Annual review (continued) including replacement of the charitable order form	For approval
7	November 2020	Julia Price	Annual review by Trust board	Approved
8	Aug 2021	Kwame Mensa-Bonsu	Annual Review	Draft
8.1	27 Aug 2021	Haider Husain	Review & mark-up of draft	Draft
9	10 September 2021	Kwame Mensa-Bonsu	Review Completed	Draft
10	November 2021	Kwame Mensa-Bonsu	Annual Review by the Board	Approved
11	November 2022	Kwame Mensa-Bonsu	Annual Review by the Board	Approved

Finance and Investment Committee
TERMS OF REFERENCE

1. CONSTITUTION

The Board of Directors hereby resolves to establish a sub - committee of the Board to be known as the Finance and Investment Committee. The Finance and Investment Committee is a committee of the Board and has no executive powers other than those specifically delegated in these terms of reference.

The Finance and Investment Committee is constituted under paragraph 41 of the Constitution and under Standing Order 5 of the Annex 7 of the constitution.

2. ACCOUNTABILITY

The Finance and Investment Committee is a committee of the Board of Directors of the Trust and accountable to them.

Following each meeting, the Chair of the Committee will provide a written report to the next available meeting of the Trust Board meeting in public, drawing the Board's attention to any issues requiring disclosure or Board approval.

The Committee will annually review its own effectiveness and report the results of that review in an annual report to the Board~~The Committee will also make an annual report to the Board~~.

The Chair of the Committee will, based on the Trust Secretariat's schedule, provide written reports to the Council of Governors~~The Committee will make a written report to the Council of Governors~~.

3. PURPOSE:

The Finance and Investment Committee will provide assurance to the Board on:

- the effectiveness of the organisation's financial management systems
- the integrity of the Trust's financial reporting mechanisms
- the effectiveness and robustness of financial planning
- the effectiveness and robustness of capital investment management
- the robustness of the Trust's cash investment strategy
- business case assessment and scrutiny (including ensuring that quality and safety considerations have been taken into account)
- the management of financial and business risk
- the capability and capacity of the finance function

- the administration, investments and financial systems relating to all charitable funds held by the Trust
- the effectiveness of the Trust's health informatics and information technology strategies and their implementation
- decisions for future investment in information technology
- the effective implementation and management of the Trust's estates strategy, ensuring that this is in line with the Trust's overall strategy.

The Finance and Investment Committee will review the findings of other assurance functions where there are financial and business implications.

4. MEMBERSHIP, ATTENDANCE AND QUORUM

Membership

The Membership of the Finance and Investment Committee shall be as follows:

- A Non-Executive Director who is not the Chairman, or Chair of another Board Committee will be appointed by the Chair of the Trust to Chair the Finance and Investment Committee
- Two other Non-Executive Director, who should not be the Chair of the Audit or Quality and Clinical Risk Committees. One of these Non-Executive Directors can chair a meeting in the absence of the Committee's Chair.
- The Chief Executive or the Deputy Chief Executive
- The Director of Finance or appointed Deputy
- The Chair of the Trust (ex-officio)
- Medical Director or appointed Deputy
- The Director of Operations.

Other Non-Executive Directors of the Trust may substitute for members of the Finance and Investment Committee in their absence and will count towards achieving a quorum.

Members of the Finance and Investment Committee are expected to attend all meetings of the Committee.

Attendance

The following should attend Finance and Investment Committee meetings:

- The Deputy Director of Finance
- Trust Secretary or nominated representative

Quorum

A quorum of the Committee shall be three members at least two of whom shall be a Non-Executive Director. Other Non-Executive Directors of the Trust, including associate Non-Executive Directors, who are substituting for members can be counted in the quorum.

5. MEETINGS AND CONDUCT OF BUSINESS

Frequency

The Committee will meet regularly as agreed by the Chair of the Committee and the Board.

Calling of additional meetings

An additional meeting may be called by the Chair of the Committee or any two of the other Members of the Committee.

In exceptional circumstances where an urgent capital investment decision is required which cannot wait until the next meeting of the relevant authorising group e.g. essential medical equipment which has failed, the approval of the Chairman and one other member of the Group may be sought. Where approval is sanctioned, the decision must be recorded and formally reported at the next meeting of the relevant authorising group where the decision would have been made

Committee Administration

The Committee will at least annually review these terms of reference.

Committee administration will be provided by the Trust Secretariat. The agenda for meetings will be circulated to all Board members who have requested to receive particular papers. In line with Standing Order 3.4, full papers will be sent to members of the Board so that they are available to them at their normal electronic address 5 clear days before the meeting. Draft minutes of meetings should be available to the Chair for review within fourteen days of the meeting.

Responsibilities of Members

Members of the Committee are expected to attend at least 75% of meetings. In the event that they identify any items for consideration by the Committee, these should be brought to the attention of the Chair at least 14 days before the meeting. Members must declare any conflicts of interest or potential conflicts of interest at the start of each meeting in accordance with the Trust's Conflicts of Interests Policy (even if such a declaration has previously been made).

6. DUTIES OF THE FINANCE AND INVESTMENT COMMITTEE

Financial Management

- To ensure a comprehensive budgetary control framework that accords with guidance and legislation.
- To review financial plans and strategies and ensure they are consistent with the overall Trust Strategic Planning process.
- To approve budget setting timeframes and processes and recommend budgets to the Board of Directors.

- To monitor business performance against planned levels and hold to account for corrective action planning, including finance, activity, workforce, and capacity.
- To scrutinise and assess business cases.

Financial Reporting

- To review the content and format of financial information as reported to ensure clarity, appropriateness, timeliness, accuracy and sufficient detail.

Performance Management

- To review the potential or actual financial impact of operational performance against a defined set of indicators, such indicators to be subject to on-going review.

Business and Financial Risk

- To consider business risk management processes in the Trust.
- To review arrangements for risk pooling and insurance.
- To consider the implications of any pending litigation against the trust.

Value for Money and Efficiency

- To ensure at all times the Trust receives value for money and operates as efficiently as possible.

Capital Investment

- To ensure robust capital investment plans are in place, kept updated, and progress monitored. (reporting arrangements as per Appendix 1)

Cash

- To act as the Investment Committee in line with approved Investment Policy.
- Ensure cash investments are monitored and give best returns.
- Ensure cash balances are robust, and continue to be so, on a 12-month rolling basis.

Technology

- To ensure that the Health Informatics strategy is implemented effectively and to review decisions for future investment in technology
- To oversee the implementation of the Trust's information technology strategy and ensure that this is developed in line with best practice within the sector and in accordance with the Trust's overall strategy.

Estates

- To oversee the implementation and development of the Trust's estate strategy in line with the Trust's overall strategy.

7. RELATIONSHIP WITH AUDITORS AND AUDIT COMMITTEE

The auditors interact with the Trust through the Audit Committee, neither internal nor external audit are therefore included as members of the Finance and Investment Committee. However, both parties can, if required, request an invitation to attend.

The Audit Committee is distinct and separate from the Finance and Investment Committee, and as such areas of overlap should be minimised. The Finance and Investment Committee should specifically exclude itself from:

Audit

- Review of audit plans and strategies.
- Review of reports from auditors.
- Review of the effectiveness of the internal control framework and controls assurance plans.
- Any recommendations or plans on auditor appointments.

Annual Accounts

- Consideration of the content of any report involving the Trust issued by the Public Accounts Committee or the Controller and Auditor General and the review of managements proposed response.

SFI's and SO's

- Examinations of circumstances when waivers occur.
- Review of schedules of losses and compensations.
- Monitoring of the implementation on standards of business conduct for members and staff.

Fraud

- The review of the adequacy of the policies and procedures for al***l*** work related to fraud and corruption as set out in the Secretary of State Directions and as required by the Directorate of Counter Fraud Services.

Version Control

Version	Date	Author	Comments	Status
0.1	5 January 2009	Wayne Preston	Approved for Board	Draft
1.0	January 2009	James Bufford	Approved by Board	Approved
1.1	11 Sept 2009	James Bufford	Added requirement for annual review of these terms of reference	Draft for Finance Cttee
1.2	March 2010	Maria Wogan	Additional amendments from Finance Director re: meeting frequency	Draft for approval by Board
1.3	March 10	Maria Wogan	Annual Review by the Board	Approved
2.0	Nov 2011	Geoff Stokes	Annual review by the Board	Approved
2.1	Aug 2012	Michelle Evans-Riches	Financial Reporting triggers included as appendix	Approved
3.0	Mar 2013	Michelle Evans-Riches	Review by Committee and Trust Board	Approved
4.0	Sep 2013	Michelle Evans-Riches	Annual Review	Draft for approval by Board
5.0	Oct 2013	Michelle Evans-Riches	Annual review by the Board	
6.0	March 2015			
7.0	October 2017	Ade Kadiri	Annual Review	Draft for approval by Board
8.0	October 2018	Ade Kadiri	Annual Review	Draft for approval by the Board
9.0	November 2020	Julia Price	Annual Review by the Board	Approved
10.	November 2021	Kwame Mensa-Bonsu	Annual Review by the Board	Approved

11	November 2022	Kwame Mensa-Bonsu	Annual Review by the Board	

Milton Keynes University Hospital NHS Foundation Trust

Quality and Clinical Risk Committee
TERMS OF REFERENCE

1. CONSTITUTION:

The Quality and Clinical Risk Committee (QCRC) is a sub-committee of the Board of Directors and has no powers other than those specifically delegated in these terms of reference.

The QCRC is constituted under Paragraph 5.8 of Annex 7 to the constitution. The Terms of Reference will be reviewed annually.

1.1 Authority

The QCRC is authorised by the Board to investigate any activity within its terms of reference. It is authorised to request the attendance of individuals from inside or external to the Trust with relevant experience and expertise if it considers this necessary. All employees are directed to co-operate with any request made by the Committee.

2. PURPOSE:

The QCRC is charged by the Board with the responsibility for providing assurance to the Board that the Trust is providing safe, effective and high quality services to patients, supported and informed by effective arrangements for monitoring and continually improving the safety and quality of care, and the patient experience. It will receive information from the CSUs and Divisions via the Trust Executive ~~Group~~ Committee and will, where necessary, escalate issues to the Board.

3. MEMBERSHIP, ATTENDANCE AND QUORUM:

3.1 Membership

The Membership of the QCRC shall be as follows:

- A Non-Executive Director who is not the Chairman, Deputy Chairman or Chair of another Board committee will be appointed by the Chair of the Trust to chair the QCRC
- Two other Non-Executive Directors
- The Chair of the Trust Board (ex-officio)
- The Chief Executive (ex-officio)
- The Director of Patient Care and Chief Nurse (or Deputy)
- The Medical Director (or Deputy)

- The Director of Operations (or their representative)
- The Director of Corporate Affairs

Other Non-Executive Directors of the Trust may substitute for members of the QCRC in their absence and will count towards achieving a quorum.

Members of the QCRC are expected to attend all meetings of the Committee.

3.2 Attendance

The following posts shall be invited to attend routinely meetings of the QCRC in full or in part but shall neither be a member nor have voting rights:

- Head of Clinical Governance and Risk
- Senior members of Divisional Management will be invited to attend meetings as required.

3.3 Quorum

A quorum of the Committee shall be two NEDs and one Executive Director. Other Directors of the Trust, including Directors who are substituting for members can be counted in the quorum. Ex-officio members of the Committee also count for quorum but are not required to attend every meeting

4. ACCOUNTABILITY:

The QCRC is a committee of and accountable to the Board of Directors.

A minute of each meeting will be taken and approved by the subsequent meeting.

Following each meeting, the Chair of the Committee will provide a written report to the next available meeting of the Trust Board meeting in public, drawing the Board's attention to any issues requiring disclosure or Board approval.

The Chair of the Committee will, based on the Trust Secretariat's schedule, provide written reports to the Council of Governors

~~Once the draft minutes have been approved by the Chair of the Committee, these approved minutes will be submitted to the next private meeting of the Board of Directors. They will also be submitted to the Audit Committee. An action log will be maintained by the meeting secretary.~~

~~The Chair of the Committee shall present a written report to the Public Board meeting immediately following each Committee meeting.~~

The Committee will annually review its own effectiveness and report the results of that review in an annual report to the Board~~The Committee will also make an annual report to the Board~~.

5. MEETINGS AND CONDUCT OF BUSINESS:

5.1 Frequency of Meetings:

The Committee will meet at least on a quarterly basis, with the possibility that additional meetings may be scheduled as necessary at the request of the Committee Chair.

5.2 Agenda

The Agenda for meetings will be circulated to all Board members who have requested to receive particular papers.

In line with Standing Order 3.4, full papers will be sent to members of the Committee so that they are available to them **5 clear days before the meeting**.

There will be an expectation for information from the Committee to be cascaded to front line staff by managers.

6. DUTIES OF THE QUALITY AND CLINICAL RISK COMMITTEE:

- To define the Trust's approach to ensuring the quality of its services as part of its overall strategic direction and organisation objectives.
- To promote clinical leadership so that the culture of the Trust reflects a strong focus on quality, clinical effectiveness, safety and patient experience.
- To ensure appropriate structures and systems are in place to support and deliver quality governance including clinical effectiveness, patient safety and patient experience.
- To assure the Board that systems operate effectively within each Division and to report any specific problems as they emerge.
- To receive reports on serious incidents, incidents and near misses, complaints, inquests, claims and other forms of feedback from patients, ensuring learning from all clinical risk management activity, identifying trends, comparing performance with external benchmarks and making recommendations to the Board as appropriate.
- To identify serious unresolved clinical and non-clinical risks to the Audit Committee and the Board.
- To oversee the effective management of risks, as set out within the Board Assurance Framework (BAF) as appropriate to the purpose of the Committee.
- To ensure that the views and experience of patients and staff are heard and acknowledged in the work of the Committee and by the Board, and that this drives the delivery of the Trust's services.
- To monitor strategies and annual plans for quality governance, clinical audit and effectiveness, research and development, public and patient engagement and equality and diversity. To oversee the production of the Trust's annual Quality Accounts, ensuring compliance with national guidance.
- To ensure that effective consultation with stakeholders takes place, and to monitor the delivery of the quality targets.

- To agree and submit annual quality governance assurance report to the Board.
- To receive relevant reports from internal reviews and external bodies and assurance regarding the implementation of associated action plans.
- To commission, as appropriate, internal and external audits and reviews of services to assure the Board that the Trust is compliant with statutory and regulatory requirements.
- To approve and monitor the Trust's clinical audit programme ensuring it is aligned with Trust priorities, responds to trends in complaints and incidents and is led by and involves staff from all disciplines, liaising with the Audit Committee as appropriate.
- To monitor compliance with the terms of the Trust's CQC registration and NHS Resolution Risk Management Standards.

Version Control

Version	Date	Author	Comments	Status
1.0	26.05.10	Maria Wogan Trust Secretary	Final draft approved by the Board of Directors	Approved
2.0	Aug 2011	Geoff Stokes	Annual review by the Board	Approved
3.0	May 2012	Michelle Evans-Riches	Review by Quality Committee following Committee Review by Board	Approved
4.0	March 2013	Michelle Evans-Riches	Review by Quality Committee recommended to Board	Approved
5.0	April 2017	Adewale Kadiri	Review by Quality and Clinical Risk Committee recommended to Board	Approved
6.0	November 2018	Adewale Kadiri	Review by Quality and Clinical Risk Committee recommended to Board	Approved
7.0	November 2020	Julia Price	Annual Review by the Board	Approved
8.0	November 2021	Kwame Mensa-Bonsu	Annual Review by the Board	Approved
9.0	November 2022	Kwame Mensa-Bonsu	Annual Review by the Board	

Milton Keynes University Hospital NHS Foundation Trust

REMUNERATION COMMITTEE
TERMS OF REFERENCE

1. CONSTITUTION

The Committee is a sub-committee of the Trust Board and will report to the Trust Board on an annual basis.

The Committee is authorised by the Trust Board on the matter of remuneration to obtain outside legal, remuneration or other independent professional advice to secure the attendance of individuals and authorities from outside the Trust with the relevant experience and expertise if it considers it necessary for or expediant to the exercise of its functions.

2. ACCOUNTABILITY

The Remuneration Committee is accountable to the Board of Directors of the Trust.

A minute of each meeting will be taken and approved by the subsequent meeting. Once the draft minutes have been approved by the Chair of the Committee, these unapproved minutes will be submitted to the next meeting of the Board of Directors.

The Chair of the Committee shall make a verbal report to the Board immediately following each Committee meeting, drawing Board's attention to any issues that require disclosure to the full Board or Board approval.

3. PURPOSE:

The purpose of the Committee is:

- The Committee will have delegated authority from the Trust Board to set the remuneration, allowances and other terms and conditions of office for the Executive Directors and to recommend and monitor the structure of remuneration including setting pay ranges.

4. MEMBERSHIP, ATTENDANCE AND QUORUM

Membership

The membership of the Committee shall comprise:

- All Non-Executive Directors
- The Trust Chairman
- The CEO and Director of Workforce shall normally be in attendance except when issues regarding their own remuneration is discussed

Attendance

Members of the Remuneration Committee are expected to attend all meetings of the Committee.

Quorum

The Comittee shall be quorate when the Chair and at least three Non Executive Directors are present.

5. MEETINGS AND CONDUCT OF BUSINESS

Frequency

Annually, or more freqeuently should it be necessary

Agenda

The Agenda for meetings will be circulated to all Board members who have requested to receive particular papers.

In line with Standing Order 3.4, full papers will be sent to members of the Committee so that they are available to them at their normal address 5 clear days before the meeting.

The Committee will at least annually:

- review these terms of reference

DUTIES OF THE REMUNERATION COMMITTEE:

The main duties of the Committee are to:

- To agree and keep under review the overall remuneration policy of the Trust.
- To set the individual remuneration, allowances and other terms and conditions of office (including termination arrangements) for the Trust's Executive Directors
- To recommend and monitor the structure of remuneration, including setting pay ranges.
- To monitor and evaluate the performance of the Trust's Chief Executive and Executive Directors against objectives for the previous year and note forward objectives. Performance of other senior managers will be monitored and evaluated by their line managers.
- To ratify decisions taken between meetings by the Chair of the Committee.
- In determining remuneration policy and packages, to have due regard to the policies and recommendations of the Department of Health and Social Care and the NHS, and to adhere to all relevant laws, codes and regulations.
- To keep abreast of executive level remuneration policy and practice and market developments elsewhere in the NHS and in other relevant organisations, drawing on external advice as required.
- To agree those Compromise Agreements, Settlements and Redundancy Payments which require final approval by HM Treasury as well as any proposed termination payment to the Chief Executive or an Executive Director.

- To receive regular reports on other Compromise Agreements, Settlements and Redundancies approved in accordance with Trust policies.
- Receive an annual report on the outcome of the employer-based (local) Clinical Excellence Awards round.
- To undertake any other duties as directed by the Trust Board.

Version Control

Version	Date	Author	Comments	Status
1.0	October 2013	Norma French	Separated the functions of the Combined Terms of reference of Remuneration and Workforce Committee	Approved
1.1	October 2021	Danielle Petch	Annual review by Committee – updated to reflect amended terminology/practice	Approved
1.2	September 2022	Danielle Petch	Annual review – no changes	

Workforce and Development Assurance Committee
TERMS OF REFERENCE

1. Constitution

1.1 The Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the Workforce and Development Assurance Committee (known as 'the Committee'). The Committee is a non-executive chaired committee and as such has no delegated authority other than that specified in the Terms of Reference.

1.2 The Committee has been established by the Trust Board to:

1.3 Ensure that the workforce has the capacity and capability to provide high quality, effective, safe patient care in line with the Trust's strategic objectives and values;

1.4 Monitor the governance of the Trust's workforce strategy, ensuring accountability for the continuous improvement of quality and performance.

1.5 The Committee is established under Standing Order 5 of Annex 7 of the Trust's Constitution.

2. Delegated Authority

2.1 The Committee has the following delegated authority:

2.1.1 The authority to require any officer to attend and provide information and/ or explanation as required by the Committee;

2.1.2 The authority to take decisions on matters relevant to the Committee;

2.2 The Committee does not have the authority to commit resources. The Chair may recommend to the Board that resources be allocated to enable assurance in relation to particular risks or issues.

3. Accountability

3.1 The Committee is accountable to the Trust Board. Any changes to the Terms of Reference must be approved by the Trust Board.

3.2 The Chair of the Committee is accountable to the Board and to the Council of Governors.

4. Reporting Lines

4.1 Following each meeting, the Chair of the Committee will provide a written report to the next available meeting of the Trust Board meeting in public, drawing the Board's attention to any issues requiring disclosure or Board approval.

4.2 The Chair of the Committee will, based on the Trust Secretariat's schedule, provide written reports to the Council of Governors~~The Committee will report back to the Council of Governors through a regular written report~~.

4.3 The Committee will annually review its own effectiveness and report the results of that review in an annual report to the Trust Board of Directors.

4.4 The Committee will receive regular reports from the Workforce Board on specific initiatives, business cases and activities that support the delivery of the Trust's Workforce Strategy.

4.4~~.~~5 The Committee will receive formal reports from directors and other Trust staff, covering the breadth of the workforce agenda, including statutory requirements.

4.5~~6~~ The Committee will receive at each meeting, either via the attendance of a member or members of staff, or a representation made on their behalf, an account of their experience of working in the Trust, taking account of relevant workforce strategies, initiatives and activities.

4.6~~7~~ The Committee will receive at each meeting, or as they become available, quarterly reports from the Trust's Guardian of Safe Working Hours to confirm compliance with the relevant terms and conditions relating to trainee doctors and dentists.

5. Duties

5.1 To promote the Trust's mission, values, strategy and strategic objectives.

5.2 To keep under review the development and delivery of the Trust's workforce strategy to ensure performance management is aligned to strategy implementation and promote this across the organisation.

5.3 To hold the executives to account for the delivery of the Trust's strategic objectives to improve workforce effectiveness.

5.4 To review progress on clinical and non-clinical training, development and education for Trust employees.

5.5 To ensure that the Trust meets its statutory obligations on equality, diversity and inclusion.

5.6 To monitor the progress of the Trust's plans to improve staff engagement.

5.7 To ensure that processes are in place to understand and improve staff health and wellbeing.

5.8 Provide assurance to the Board that there are mechanisms in place to allow staff to raise concerns and that these are dealt with in line with policy and national guidance.

5.9 The Committee will provide **assurance** to the Trust Board in relation to the following:

5.9.1 Ensure all workforce indicators are measured and monitored;

5.9.2 Ensure that all key performance indicators of a well-managed workforce are regularly reviewed and remedial action is put in place as necessary

5.9.3 Ensure that legal and regulatory requirements relating to workforce are met.

5.9.4 Review and provide assurance on those elements of the strategic risk register/board assurance framework are identified, seeking where necessary further action/assurance

6. Membership

6.1 A Non-Executive Director will be appointed by the Chair of the Board of Directors to Chair the Workforce and Development Assurance Committee.

6.2 The Committee will comprise the following members:

- Two other Non-Executive Directors
- Director of Workforce

6.3 Other Non-Executive Directors of the Trust, but not including the Board Chair, may substitute for members of the Committee in their absence, to achieve a quorum.

6.4 The meeting is deemed quorate when at least two members are present. The attendance of other Non-Executive Directors of the Trust who are substituting for members, will count towards achieving a quorum.

7. Attendance

7.1 The following posts shall be invited to attend routinely meetings of the Committee in full or in part but shall neither be a member nor have voting rights:

- Trust Board Chair

- Deputy Director of Workforce
- Assistant Director of HR
- Director of Patient Services & Chief Nurse (or deputy)
- Director of Operations (or deputy)
- Medical Director (or Associate Medical Director)

Other Directors and Trust staff may be invited to attend at the discretion of the Chair.

8. Responsibilities of Members

8.1 Members of the Committee are required to

7.1.1 Attend at least 75% of meetings,

7.1.2 Identify any agenda items in addition to those included on the Committee's workplan, for consideration by the Chair at least 14 days before the meeting;

7.1.3 Submit papers to the Trust Secretary by the published deadline (at least 7 days before the meeting);

8.2 Members should bring to the attention of the Committee any relevant matters that ought to be considered by the Committee that are within the scope of these terms of reference, but have not been included on the agenda

8.3 In the event that Committee members are unable to attend a meeting they must send apologies to the Trust Board Secretary and where appropriate seek the approval of the Chair to send a deputy if unable to attend in person;

8.4 Members must maintain confidentiality in relation to matters discussed by the Committee;

8.5 Members must declare any actual or potential conflicts of interest at the start of each meeting in accordance with Milton Keynes University Hospital NHS Foundation Trust policy (even if such a declaration has previously been made);

9. Frequency of Meetings

9.1 Meetings will normally take place quarterly and at least 14 days prior to the Trust Board to allow a Committee report to be submitted. Meetings may take place more frequently at the Chair's discretion;

9.2 The business of each meeting will be transacted within a maximum of two hours.

10. Committee Administration

10.1 Committee administration will be provided by the Trust Secretariat;

10.2 Papers should be distributed to Committee members no less than five clear days before the meeting;

10.3 Draft minutes of meetings should be made available to the Chair for review within 14 days of the meeting.

11. Review

11.1 Terms of Reference will normally be reviewed annually, with recommendations for changes submitted to the Trust Board for approval.

Version Control

Version	Date	Author	Comments	Status
1.0	Nov 2019	Adewale Kadiri Trust Secretary	Final draft approved by the Board of Directors	Approved
2.0	Nov 2020	Julia Price	Annual review by the Board	Approved
3.0	November 2021	Kwame Mensa-Bonsu	Annual Review by the Board	Approved
4.0	November 2022	Kwame Mensa-Bonsu	Annual Review by the Board	

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
Escalation items for Board attention	Workforce Report
AOB	Board Assurance Framework
Forward Agenda Planner	Trust Seal
	Summary Reports from Board Committees
	Significant Risk Register Report
	Serious Incident Report
	Patient Experience Report
	Maternity Assurance Group Update

Additional Agenda Items

Month	Assurance Reports/Items
January	Objectives Update
	Antimicrobial Stewardship - Annual Report
	Declaration of Interests Report
	Green Plan Update
	Maternity Patient Survey 2022 interim report
	Infection Prevention and Control Annual Report
March	
May	Freedom to Speak Up Guardian Annual Report
	Quality Priorities
July	Annual Claims Report
	Falls Annual Report
	Pressure Ulcers Annual Report
	Safeguarding Annual Report
	Green Plan Update

September	Research & Development Annual Report
	Emergency Preparedness, Resilience and Response Annual Report
November	Annual Complaints Report
	Annual Patient Experience Report
	CNST Maternity Incentive Scheme and Board Assurance Framework Sign Off
	Update on quality priorities (electives, diagnostics, emergency care and outpatients)
	Freedom to Speak Up Guardian Report
	Accountability and support for theatre productivity