Bundle Trust Board Meeting in Public 4 July 2024

0 10:00 - Agenda
Item 0 Agenda Board Meeting in Public - 04.07.24

1 10:00 - Apologies
Chair
Item 1.0 Placeholder Apologies

2 10:01 - Declarations of Interest
Chair
Item 2.0. Placeholder Declarations of Interest

3 10:02 - Staff Story
Chief Nursing Officer
Item 3.0 Placeholder Staff Story

4 10:22 - Minutes of the Last Meeting
Chief Nursing Officer
Item 4.0 Minutes Trust Board Meeting in Public 02.05.24 HT

5 10:24 - Matters Arising and Action Log
Chair
Item 5.0 Board Action Log 02.05.24

6 10:26 - Chair's report
Chair
Item 6.0 Placeholder Chair’s Report

7 10:31 - Chief Executive's Report
Chief Executive
Item 7.0 Placeholder Chief Executive’s Report

8 10:36 - Serious Incident and Learning Report
Chief Medical Officer/Chief Corporate Services Officer
Item 8.0 Trust Board Paper 4 July 2024

9 10:41 - Chief Nursing Officer Update
Chief Nursing Officer
Item 9.0 Chief Nursing Officers Report - Cover Sheet
Item 9.1 Bi-Annual Staffing Paper May 2024 - Cover Sheet
Item 9.2 Bi-Annual Nursing Midwifery and Allied Health Staffing Report June 2024
Item 9.3 Midwifery Workforce paper for board cover page
Item 9.4 MKUH midwifery workforce updateapril 2024
Item 9.5 Falls Report Coversheet
Item 9.6 Annual Falls Report 2023-24

Item 9.7 MKUH HAPU Annual Report Cover page
Item 9.8 HAPU ANNUAL Report 2023-24 QCRC

10 10:46 - Maternity Assurance Group Update
Chief Nursing Officer
Item 10 MKUH MAG Update Jun 24
Item 10.1 MAG Minutes 2024-04-25 IR
Item 10.2 MAG Minutes 2024-05-23 HT

11 10:51 - Performance Report
Chief Operating Officer
Item 11 2024-25 Executive Summary M2 Coversheet
Item 11.1 2024-25 Executive Summary M2
Item 11.2 2024-25 Board Scorecard M02
Item 11.3 M02 Board Performance Report - Objective O
Item 11.4 M02 Board Performance Report - Objective 1
Item 11.5 M02 Board Performance Report - Objective 2
Item 11.6 M02 Board Performance Report - Objective 3
Item 11.7 M02 Board Performance Report - Objective 4
Item 11.8 M02 Board Performance Report - Objective 5
Item 11.9 M02 Board Performance Report - Objective 7
Item 11.10 M02 Board Performance Report - Objective 8

12 10:56 - Finance Report
Chief Finance Officer
Item 12 Public Board Finance Report Month 2

13 11:01 - Workforce Report
Chief People Officer
Item 13 Workforce Report M2 202425 BOARD PAPER

14 11:06 - Freedom to Speak Up
Chief People Officer
Item 14 FTSU MKUH Annual Report 2023-24

15 11:11 - Risk Register Report
Chief Corporate Services Officer
Item 15 Trust Board - July 2024 - Risk Management Cover Sheet
Item 15.1 Trust Board - Risk Management Report - 4th July 2024
Item 15.2 Significant Risk Register - as at 19th June 2024
Item 15.3 Corporate Risk Register - as at 5th June 2024

16 11:16 - Board Assurance Framework
Chief Corporate Services Officer

Item 16 Board Assurance Framework July 24

17 11:21 - Board Committees Assurance Reports
Chairs of Board Committees
Item 17.0 Placeholder Board Assurance Report 1 QCRC
Item 17.0 Placeholder Board Assurance Report 2 Workforce
Item 17.0 Placeholder Board Assurance Report 3 Finance & Investment Committee

18 11:26 - Use of Corporate Seal
Chief Corporate Services Officer
Item 18 Cover Page - Use of Corporate Seal
Item 18.1 Use of Corporate Seal 4.7.2024

19 11:31 - Modern Slavery and Human Trafficking Statement 2024
Chief Corporate Services Officer
Item 19 Modern Slavery Statement 2024

20 11:36 - Integrated Quality Governance Report
Chief Corporate Services Officer
Item 20 Integrated Quality Governance Report July 2024

21 11:41 - Forward Agenda Planner
Chair
Item 21 Trust Board in Public Forward Plan 2024-25

22 11:46 - Questions from Members of the Public
Chair
Item 22.0 Placeholder Questions from Members of the Public

23 11:51 - Motion to Close the Meeting
Chair
Item 23.0 Placeholder Motion to Close the Meeting

24 11:54 - 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."

25 11:57 - Next Meeting in Public
Thursday, 05 September 2024

TRUST BOARD MEETING IN PUBLIC

Thursday 04 July 2024, 10:00-12:00noon
Conference Room at the Academic Centre

AGENDA

Item No.	Timing	Title	Purpose	Lead	Paper
Introduction and Administration					
1	10:00	Apologies	Note	Chair	Verbal
2		Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda • 2024/25 Register of Interests – Board of Directors - Register of Interests - Milton Keynes University Hospital (mkuh.nhs.uk)	Note	Chair	Verbal
3		Staff Story	Discuss	Chief Nursing Officer	Presentation
4		Minutes of the Trust Board meeting held in public on 02 May 2024	Approve	Chair	Attached
5		Matters Arising and Action Log	Note	Chair	Attached
Chair and Chief Executive Updates					
6	10:20	Chair's Report	Note	Chair	Verbal
7	10:25	Chief Executive's Report • Update on EDI work • Health and Safety Executive Update	Discuss Discuss	Chief Executive Chief Corporate Services Officer	Verbal To Follow
Patient Safety					
8	10:30	Serious Incident and Learning Report	Discuss	Chief Medical Officer/Chief Corporate Services Officer	Attached
9	10:35	Chief Nursing Officer Update • Bi-annual Staffing Report	Discuss	Chief Nursing Officer	Attached

Item No.	Timing	Title	Purpose	Lead	Paper
		• Midwifery Staffing Report • Falls Annual Report • Pressure Ulcers Annual Report			
Patient Experience					
10	10:40	Maternity Assurance Group Update	Discuss	Chief Nursing Officer	Attached
Performance					
11	10:45	Performance Report Month 2	Discuss	Chief Operating Officer	Attached
Break 10:50 (10 mins)					
Finance					
12	11:00	Finance Report Month 2	Discuss	Chief Finance Officer	Attached
Workforce					
13	11:05	Workforce Report	Discuss	Chief People Officer	Attached
14	11:15	Freedom to Speak Up	Discuss	Chief People Officer	Attached
Assurance and Statutory Items					
15	11:20	Risk Register Report	Discuss	Chief Corporate Services Officer	Attached
16	11:25	Board Assurance Framework	Discuss	Chief Corporate Services Officer	Attached
17	11:30	Board Committees Assurance Reports • Quality & Clinical Risk Committee • Workforce & Development Assurance Committee • Finance & Investment Committee	Note	Chairs of Board Committees Chair – Dev Ahuja Chair – Heidi Travis Chair – Gary Marven	Verbal
18	11:35	Use of Corporate Seal	Note	Chief Corporate Services Officer	Attached
19	11:40	Modern Slavery and Human Trafficking Statement 2024	Approval	Chief Corporate Services Officer	Attached
20	11:45	Integrated Quality Governance Report	Discuss	Chief Corporate Services Officer	Attached
Administration and Closing					

Item No.	Timing	Title	Purpose	Lead	Paper
21	11:50	Forward Agenda Planner	Note	Chair	Attached
22		Questions from Members of the Public	Discuss	Chair	Verbal
23		Motion to Close the Meeting	Approve	Chair	Verbal
24	11:55	Resolution to Exclude the Press and Public The Chair to request the Board pass the following resolution to exclude the press and public and /move into private session to consider private business: "That representatives of the press and members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted."	Approve	Chair	
12:00		Close			
Next Meeting in Public: Thursday, 05 September 2024					

Quoracy: This meeting shall be deemed quorate with not less than 3 voting Executive Directors (one of whom must be the Chief Executive or acting Chief Executive) and 3 voting Non-Executive Directors (one of whom must be the Chair or Deputy Chair).

	MEMBERS	
1	Heidi Travis	Non-Executive Director - Acting Chair
2	Joe Harrison	Executive Director- Chief Executive Officer
3	Gary Marven	Non-Executive Director
4	Haider Husain	Non-Executive Director
5	Dev Ahuja	Non-Executive Director
6	Mark Versallion	Non-Executive Director
7	Sarah Whiteman	Non-Executive Director
8	Jason Sinclair	Associate Non-Executive Director
9	Precious Zumbika-Lwanga	Associate Non-Executive Director
10	Ganesh Baliah	Associate Non-Executive Director
11	John Blakesley	Executive Director - Deputy Chief Executive
12	Ian Reckless	Executive Director - Deputy Chief Executive
13	Emma Livesley	Executive Director
14	Helen Beck	Executive Director
15	Danielle Petch	Executive Director
16	Steven Beaumont	Executive Director
17	Kate Jarman	Executive Director
18	Jonathan Dunk	Executive Director

TRUST BOARD IN PUBLIC

Virtual/Teams

Thursday, 04 July 2024

Apologies

Heidi Travis
Chair

Receive

TRUST BOARD IN PUBLIC

Virtual/Teams

Thursday, 04 July 2024

Declarations of Interest

- Any new interests to declare.
- Any interests to declare in relation to open items on the agenda.

Heidi Travis
Chair

Verbal/Information

TRUST BOARD IN PUBLIC

Virtual/Teams

Thursday, 04 July 2024

Staff Story

Steve Beaumont
Chief Nursing Officer

Receive/Discuss

BOARD OF DIRECTORS MEETING

Minutes of the Trust Board of Directors Meeting in Public held on Thursday, 02 May 2024 at 10.00 hours in the Academic Centre, Milton Keynes University Hospital Campus and via Teams

Present:

Heidi Travis (Chair)	Acting Trust Chair	(HT)
Joe Harrison	Chief Executive Officer	(JH)
John Blakesley	Deputy Chief Executive	(JB)
Gary Marven	Non-Executive Director	(GM)
Mark Versallion	Non-Executive Director	(MV)
Dev Ahuja	Non-Executive Director	(DA)
Dr Ian Reckless	Chief Medical Officer	(IR)
Danielle Petch	Chief People Officer	(DP)
Steve Beaumont	Interim Chief Nursing Officer	(SB)
Emma Livesley	Chief Operating Officer	(EL)
Jonathan Dunk	Chief Finance Officer	(JD)

In Attendance:

Kate Jarman	Chief Corporate Services Officer	(KJ)
Jason Sinclair	Associate Non-Executive Director	(JS)
Precious Zumbika-Lwanga	Associate Non-Executive Director	(PZL)
Andy Forbes	Public Governor	(AF)
Rachel Medill	Public Governor	(RM)
Tom Daffurn	Public Governor	(TD)
Tracy Rea	Staff Governor	(TR)
Caroline Kintu	Staff Governor	(CK)
Janet Page (for item 3)	Lead Dementia Nurse	(JP)
Nicholas Mann	Business Leaders Representative	(NM)
Kemi Olayiwola	Trust Secretary	(KO)
Timi Achom	Assistant Trust Secretary	(TA)
Amanda Godden	Committee Secretary	(AG)
Oli Chandler	Head of I.T. Technical Services	(OC)

1 Welcome and Apologies

1.1 HT welcomed all present to the meeting. There were apologies from Haider Husain (Non-Executive Director), Sarah Whiteman (Non-Executive Director) and Ganesh Baliah (Associate Non-Executive Director). Apologies were also received from Keith McLean (Representative Governor, Milton Keynes Council) and Andrea Vincent (Public Governor).

2 Declarations of interest

2.1 IR declared that this was his first attendance at the Public Board since joining the team at Bedfordshire, Luton, and Milton Keynes Integrated Care Board (BLMK ICB) as a Chief Medical Officer

3 Patient Story

3.1 Janet introduced David's case. David, a local resident lived with his wife, had two children, and two grandchildren. In May 2022, David began investigations for dementia, with a diagnosis confirmed in October 2022. Throughout 2023, he experienced aggressive behaviours at home.

3.2 The community provided support during this time. His condition escalated into a hypoactive delirium state, characterised by significant lethargy and confusion. Interventions included mental health consultations and prescribed antipsychotic medications, with efforts to manage his care in the community. Security measures and mental health interventions were periodically necessary.

3.3 In response to IR's question about the assessment of the level of dementia support available in the community in Milton Keynes, including the benefits of respite care and experiences managing patients with dementia using virtual care methods, JP stated that there was a significant need to enhance community services for dementia, as Milton Keynes still encountered cases where patients reached crisis points and required hospital intervention.

3.4 It was noted that Milton Keynes needed to improve how it managed dementia care across various age groups, suggesting that a more developed and comprehensive approach is necessary.

3.5 On behalf of the Board, HT thanked JP for the presentation.

4 Minutes of the Trust Board Meeting in Public held on 7 March 2024

4.1 The minutes of the Trust Board Meeting in Public held on 7 March 2024 were **reviewed** and **approved** by the Board

5 Matters Arising and a

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

Action 32 Council and Community Mental Health provider's update
On the agenda – Closed.

Action 35 Update on review of maternal women admitted to ICU during 2023
The review did not reveal any particular issues with the care provided. The findings, generally positive, included recommendations for Level 2 care such as the adoption of cell salvage technology to reduce blood loss. The report was presented to the Clinical and Risk Committee at the end of March 2024, and copies would be circulated among Board members. Closed.

There were no matters arising.

6 Chair's Report

6.1 HT provided a verbal report on a range of topics crucial for the operational and strategic management of the hospital. Emphasis was placed on the necessity for papers to be published and circulated within five working days prior to meetings to ensure all members have sufficient time to review and absorb the content.

6.2 Due to HT's new role as the Acting Chair, there was a need to reallocate certain Sub-Committee Chair roles for better governance. Discussions about this were planned for a private session later in the day and will be noted at next public Board.

6.3 A "GovernWell" session for Non-Executive Directors and Governors was planned for 30th May to enhance understanding and assurance of their roles in hospital governance and discussion was ongoing around organise site visits for Board members and Governors to foster closer relationships and understanding of hospital operations.

6.4 It was noted that Non-Executive Directors and Governors would increase the joint visits to site over the coming months.

6.4 JB provided updates on new infrastructure projects including the construction of a multi-story car park, which would temporarily reduce available parking spaces, potentially increasing pressure on parking facilities for about 12 months. Alternative parking would be provided during this time.

6.5 JB stated that due to the demolition of the Education Centre as part of new hospital works, there was a discussion on managing office space and possibly implementing hot-desking to accommodate non-patient facing roles.

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

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

7.1 Health and Safety Executive Inspection Update
KJ reminded the Board of the Health and Safety Executive (HSE) inspection, which was conducted in February 2024, which resulted in two improvement notices. The Board had previously reviewed these notices. A compliance deadline had been set for April 19, 2024, by which the organisation must submit an assurance plan and action plans addressing the required improvements. These documents were to be reviewed by the Audit Committee and then the Health and Safety Committee on May 13, 2024. The HSE has expressed satisfaction with the progress made so far and has requested additional documentation, which would be provided.

7.1.1 A new interim head of Health and Safety had been appointed and would be supporting programs aimed at reducing violence and abuse and improving manual handling.

7.2 The Emergency Department recently experienced an unannounced inspection by the Care Quality Commission (CQC). In response, the Trust provided the required data to the CQC. The results of this inspection would be formally presented to the Board at a later date. Ongoing communication with the CQC continues, particularly regarding the focused approach of the recent inspection. The hospital was among the first to undergo the new style of CQC inspection, which is still in its initial stages of implementation. The implications and effectiveness of this new inspection format are currently under assessment. Efforts were being made to better understand the new inspection parameters and their application.

7.3 Updates were provided on internal matters, including the announcement of the Staff Awards shortlist, which received almost 1000 nominations - the highest ever recorded. The traditional '*Event in the Tent'* would be replaced by the 'MKUH Expo,' a two-day event set for July 2024. This expo will feature several distinguished speakers. Specific dates for the MKUH Expo would be provided to the Board in due course, and Board members were encouraged to attend.

7.4 Virtual Wards Update
IR discussed the concept of the virtual wards, highlighting their purpose to manage patients who would typically require hospitalisation, but instead receive care at their residences which included comprehensive support from doctors, nurses, therapists, and the provision of medicines typically associated with in-hospital care.

7.4.1 Challenges associated with NHS England's initial targets and the non-recurrent, uncertain funding for virtual wards were noted. The current formula stipulates 124 virtual beds per population, but local adjustments have focused on 40 real virtual patients, termed 'heart patients', prioritising quality of care over meeting numerical targets.

7.4.2 Updates on the operational status of virtual wards were provided, including staffing levels of 33 whole-time equivalents and patient numbers generally around the 50 mark, slightly above the target of 40. A detailed information and case studies would be presented to the Quality committee, highlighting the effectiveness and value for money of the virtual ward system.

7.4.3 Further discussions revolved around the operational and financial aspects of the virtual ward, comparing costs and staffing needs to those of traditional hospital wards. It was noted that the

running costs of a 28-bed ward could be around £2.5 million, while the current expenditure on the virtual ward was approximately £2.2 million.

7.4.4 Questions were raised about the rate of readmissions from the virtual ward to the hospital and whether this would be viewed as a “failure”. The Board consensus was that occasional readmissions should not be seen as negative.

7.4.5 The funding and financial oversight of the virtual wards were discussed, including the origin of funds and how expenditures were monitored. It was mentioned that funding for the virtual wards had transitioned from being solely NHS-based to include council grants, indicating a shift towards more localised management. The management of the virtual ward, including patient admissions and staffing levels, is being overseen by the Improving System Flow Steering Group, which reports to a Joint Leadership Team.

7.4.6 Finally, it was suggested that updates on the virtual ward should be provided to the Board, but not necessarily on a monthly basis, given the proportion of the total trust expenditure it represents. The focus should be on maintaining appropriate oversight through the Quality Committee to ensure effective management and accountability.

7.5 BLMK ICB May 2024

7.5.1 The Board noted the reported which summarised the key items of business from the BLMK Integrated Care Board (ICB) and BLMK Health and Care Partnership and the NHS in Bedfordshire, Luton and Milton Keynes) that are relevant to Milton Keynes University Hospital NHS Foundation Trust.

7.6 The Board **noted** the Chief Executive’s update

8 Serious Incident and Quality Improvement Report

8.1 IR presented the report outlining the management of processes/systems in relation to serious incidents and quality improvement in the Trust.

8.2 The transition from the old style of incident reporting and investigation process to the new PSIRF approach, which was implemented on May 1, 2024, was highlighted. This new approach would prioritise daily triaging of incidents, allowing for more strategic allocation of resources towards incidents that require in-depth investigation. Recent serious incidents were noted, including the maternal death of a patient known to Mental Health Services and the death of a patient under a Deprivation of Liberty Safeguard (DOLS) which was falls related. Additionally, the potential for harm from gentamicin errors was noted, although no serious harm had occurred in the recent incident.

8.3 The report also addressed upcoming changes in the format of serious incident reporting and the integration of quality forms into the Quality Governance Board. This shift aims to enhance the Board's oversight on regulatory compliance and to focus more effectively on thematic learning across quality domains. The Board was informed that future reports would be presented differently, starting from the next meeting on 14 July, to better integrate learning and audit findings into broader quality and safety discussions.

8.4 The Board **noted** the Serious Incident and Quality Improvement Report.

9 Maternity Patient Survey 2024 interim report

9.1 SB presented the 2024 interim report for the Maternity Patient Survey, noting significant concerns in maternity services such as pain management, feelings of isolation, and lack of decision-making support from midwives. He highlighted that the report did not showcase any positive outcomes, which he aims to address in the next report.

9.2 The Board **noted** the Maternity Patient Survey 2024 interim report

10 Performance Report Month 12 (March 2024)

10.1 EL presented the Performance Report for Month 12 highlighting achievements and challenges against key performance indicators.

10.2 It was noted that the percentage for the 4-hour target for ED attendances that were admitted, transferred, or discharged exceeded the threshold with 78.1%. This was well above the national performance of 74.2%. Concerns were raised about the number of stranded and super stranded patients, indicating a need for improved patient flow and discharge processes.

10.3 The elective care pathway was also discussed. The year-end forecast indicated significantly fewer breaches than anticipated; however, challenges persist, especially with the 65-week waiting lists, which were expected to be reduced by September 2024. Additionally, issues related to capacity, notably in CT delivery and non-surgical services, were identified as critical areas requiring attention.

10.4 The Board emphasised the importance of strategic financial and operational planning for the upcoming year to align hospital operations with financial goals effectively. Future plans include revisiting performance targets and operational strategies, with a focus on sustainable and efficient hospital operations.

10.5 The Board **noted** the Performance Report for Month 12

11 Finance Report Month 12 (March 2024)

11.1 JD reported a small surplus position (on a Control Total basis) to the end of March 2024. This surplus largely depended on non-recurrent financial mitigation and additional income from the Elective Recovery Fund (ERF). While the Trust had met its annual efficiency targets, these were significantly bolstered by non-recurrent, high-value schemes. ERF performance had exceeded the 102% target, resulting in a £15.5 million income that was above expectations as of month 12.

11.2 Regarding capital expenditures, spending had exceeded the initial plan by £6.6 million due to nationally approved schemes that were not included in the original budget. Furthermore, the Trust had secured an additional £5 million for the 2023/24 ICS CDEL allocation following approval.

11.3 In terms of operational expenses, a significant mention was made of a £9 million pension adjustment for nationally funded pension contributions which was offset by income. Additionally, there were discussions on significant dividends, efficiency in product delivery, and the challenges anticipated for the upcoming year

11.4 The Board **noted** the Finance Report for Month 12

12 Workforce Report

DP presented key highlights from the workforce report:

- Temporary staffing usage has seen a reduction to 12.2%, with a 3.1% improvement in costs since the start of the fiscal year. Bank usage is under review to ensure that requests for Nursing and Healthcare Support Workers are thoroughly vetted by senior nursing staff before approval on the Health Roster.

- The Trust has reported an increase in total employees, now totalling 4,402. The vacancy rate has reached its lowest in over a year at 3.7%, with notable improvements observed across Nursing and Midwifery, Healthcare Scientists, and Professional Scientific and Technical staff groups.

- Compliance with statutory and mandatory training remains high at 94%, and appraisal compliance is at 9%, both contributing to overall workforce stability.

- The Freedom to Speak Up Annual Report has been completed and is scheduled for submission to the Workforce and Development Assurance Committee in May, followed by presentation at the subsequent Board meeting.

The Board **noted** the Workforce Report

13 Quality Priorities 2024/25

13.1 KJ presented the report highlighting the three quality priorities approved by the Council of Governors during their meeting on April 17, 2024. The Council of Governors selected Priorities 1, 3, and 5 as the focal areas:

1. Continued focus on sepsis management improvements (particularly as Martha's Rule is introduced to support parents' right to a second opinion and the Trust continues its sepsis management quality improvement programme in ED).
3. Reducing the number of complaints citing poor communication.
5. Reducing the number of falls.

The Board was requested to note these priorities as outlined.

13.2 The Board **noted** the 2024/25 Quality Priorities

14 Declaration of Interests Report

14.1 The Board reviewed the Declaration of Interests Report, which provided an update on the submissions of interest declarations for the fiscal year ending 2023/24. The report covered both conflicts of interest and a register of gifts and hospitality, with all individuals required to make declarations, even if there was nothing to declare. Compliance across the Board was strong however variability existed among other groups. Efforts were underway to improve compliance to achieve 100%.

14.2 The Board **noted** the Declaration of Interests Report

15 Risk Register Report

15.1 KJ presented a report analysing all risks listed on the Risk Register as of March 2024. Compliance was emphasised, with a proposal to address any gaps to ensure 100% compliance.

15.2 It was noted that the Risk Register was regularly addressed in different operational meetings, including the Quality and Risk Committee and Audit Committee meetings.

15.3 The Board acknowledged the need to revisit and refresh the risk management strategies and commitment to continued education and adjustment to enhance risk management across the organisation.

Action: Paul Ewers, Senior Risk Manager, to attend the next Trust Board Seminar Meeting.

15.4 The Board **noted** the Risk Register Report

16 Board Assurance Framework (BAF)

16.1 The Board reviewed the Board Assurance Framework which included two new risks proposed for inclusion on the BAF for 2024/25 and the current progress on completing the Board Assurance Framework for 2024/25.

16.2 The Board **noted** the Board Assurance Framework

17 (Summary Reports) Board Committees

17.1 Nothing to report.

18 Forward Agenda Planner

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

19 Questions from Members of the Public

19.1 There were no questions from the public.

20 Any Other Business

20.1 None

The meeting closed at 11:49am

Updated:02/05/24

Milton Keynes University Hospital NHS Foundation Trust

Trust Board Action Log

Action No.	Date added to log	Agenda Item No.	Subject	Action	Owner	Completion Date	Update	Status Open/ Closed
36	05-May-24	15	October Board Seminar: Risk Development Programme	Revisit and refresh the risk management strategies and commitment to continued education and adjustment to enhance risk management across the organisation.	Paul Ewers/KJ	03-Oct-24		**Open**

TRUST BOARD IN PUBLIC

Virtual/Teams

Thursday, 04 July 2024

Chair's Report

Heidi Travis
Chair

Verbal/Information

TRUST BOARD IN PUBLIC

Virtual/Teams

Thursday, 04 July 2024

Chief Executive's Report

Joe Harrison

Verbal/ Receive/Discuss

Meeting Title	**Trust Board**	**Date: 4th July 2024**
Report Title	Patient Safety Update	**Agenda Item Number: 8**
Lead Director	*Ian Reckless*	
Report Author	*Anna O'Neill and Anna Costello*	

Introduction	Assurance		
Key Messages to Note			
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)*	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*

Report History	*This is the first of this report following the transition to PSIRF.*
Next Steps	
Appendices/Attachments	

Section 2: Executive Summary

The Patient Safety Incident Response Framework (PSIRF) was launched at Milton Keynes University Hospital (MKUH) on 1st May 2024. This paper aims to give a brief overview of the purpose of PSIRF, how this is being implemented at MKUH and the initial data from having transitioned to PSIRF 7 weeks ago. Much of this information has been shared in other forums locally and is shared today for information and feedback from the Board.

Section 3: Main body

Background

PSIRF represents a significant shift in the way the NHS responds to patient safety incidents. It supports Trusts to focus their resource and time into reviewing patient safety incidents where there is an opportunity to learn and to avoid repetition. This requires a considered and proportionate approach to triaging and responding to patient safety incidents.

The introduction of PSIRF is a major step to improving patient safety management and will greatly support MKUH to embed the key principles of a patient safety culture which includes:

- Using a system-focused approach to learning (*Appendix 1*)
- Focusing on continuous learning and improvement
- Promoting supportive, psychologically safe teamwork
- Enabling and empowering speaking up by all

Patient safety incidents at MKUH are reviewed in a 2-stage triage process; a daily Trust wide triage panel and a weekly locally led triage panel. Trust wide triage includes a broad membership with representation from all key clinical areas, e.g. patient safety, corporate nursing, medical, pharmacy, maternity, paediatrics, radiology, pathology, safeguarding and IT. The local triage groups are smaller and include representation from patient safety, operations, medical and nursing at either divisional or clinical support unit (CSU) level. Both panels are responsible for appropriately grading all patient safety incidents using the 4 MKUH response levels *(Appendix 2)* based upon national criteria. The 2 stages allow for both Trust wide and local oversight and learning.

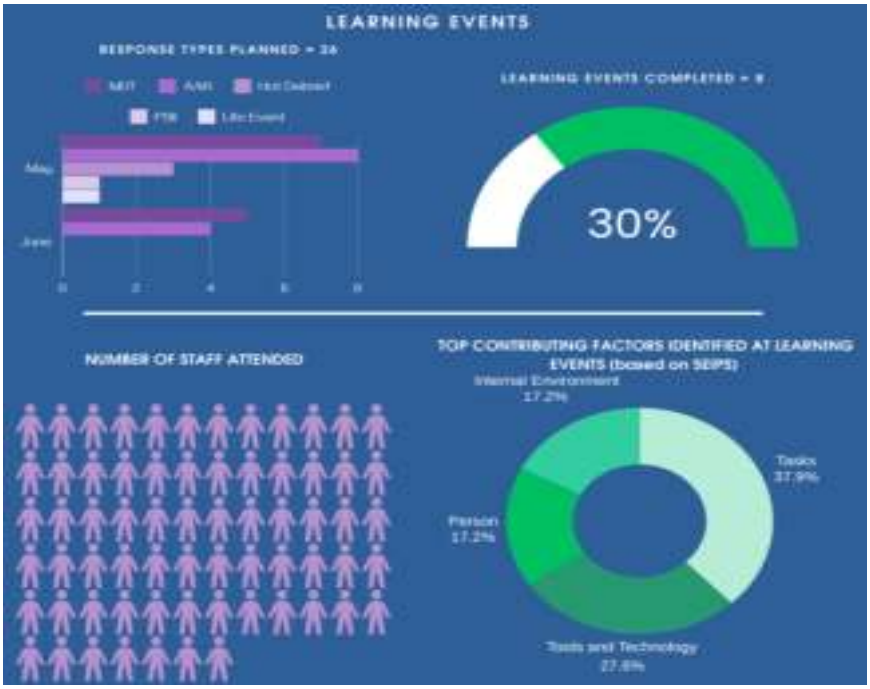
Other processes exist for the review of non-patient safety incidents or for patient safety incidents where robust improvements strategies are already in place. Any complaints which may have a significant patient safety component are discussed at Trust wide triage.

Depending on the response level allocated to any given incident, a learning event may be suggested. The details of different types of learning events are described in *Appendix 3.* Broadly these events have replaced local investigations, 72-hour reports and root cause analysis (RCA).

The Trust wide triage panel formally reports to the Patient Safety Incident Review Group (PSIRG), weekly, and the Patient Safety Board monthly, for oversight. In addition, a daily update is sent to key members of the executive group for their information.

Outcomes (learning and actions) from learning events are shared in several different forums including local safety huddles, team newsletters, notice boards, in 'Spotlight on Safety' in the CEO newsletter as well as at the Trust wide learning forums such as PSIRG. Additional forums for sharing learning such as podcasts, drop-in sessions, Schwartz style meetings, 'lunch and learn' and simulation are being developed and will be launched in the coming months.

PSIRF Data from 1st May to 21st June 2024



Key Learning and Actions Identified from Learning Events

- New procedure in main x-ray to ensure that all children aged 3 and under have a nominated chaperone.
- The Paediatric Register to attend the rapid response evening huddle to discuss any high dependency paediatric patients. This will offer Trust wide support and oversight of high dependency paediatric patients.
- Paediatric vital signs machines and eCare to be updated to allow for the adult national early warning score (NEWS) to be used for the monitoring of children over 16 years old.
- Importance of emergency equipment being checked and maintained by the relevant teams in theatres. A new process is now in place for the neonatal team to bring an emergency grab bag to all neonatal emergencies.
- Maternity patients are not always aware of the risks of blood clots during and after pregnancy and how to prevent them. The RCOG leaflet is to be shared with all antenatal and postnatal women at risk of blood clots.
- Checking of sterile equipment packs in theatre prior to patients being anaesthetised. This was after an incident where an operation had to be postponed when the pack was found to have a hole in, and no spares were available.
- Interventional radiology procedures are only to commence when all medications have been prescribed on eCare by the radiologist. A WOW is being purchased for the intervention suite and this new step has been added to the local checklist.

Staff feedback from Learning Events

"It felt that the incident report, and what I had considered to be the issue was the tip of the iceberg. This helped us look at the ice underneath and get to the real issue"

"This gave me the opportunity for closure"

"I now have a deeper understanding of my colleague's perspectives"

"We were able to share excellent practice to help us all learn"

"I travelled in on my day off, and I feel that this was not wasted, I met colleagues I would never have otherwise met and heard about how their systems work"

"I am not sure what happens at the learning events, but the team always come back buzzing"

"Really useful to use the SEIPS model, helps me think about all of the contributing factors and consider things I wouldn't normally have thought about"

"So useful to have the full MDT here for example the pharmacy team, the junior doctors and consultant colleagues"

Ongoing Level 1 Patient Safety Incident Investigations (PSIIs)

INC number and description	Progress
INC-24255 - Point of care blood sugar machines used in paediatric diabetic clinic providing inaccurate readings	Initial investigations are being undertaken by the paediatric and pathology teams. MDT to follow to review systems and agree learning and actions
INC 24659 – Uterine rupture and neonatal death	PSII approved at PSIRG Hot Debrief completed 21.05.24 AAR completed 18.06.24 Wider MDT planned

There have been no PSIIs or level 2 learning events identified for any of the four trust patient safety priorities *(appendix 4).*

Emerging Patient Safety Themes

Category	Source	Plan / next steps
Capacity and efficiency in obstetric ultrasound scanning (USS)	Incidents	Appreciative inquiry session held with sonographers 20.06.24 MDT with sonographers, midwives, obstetrics and USS admin team planned
Care of patients with learning disabilities	Incidents Complaints Section 42 reviews	Joint project with patient safety, QI and safeguarding team MDT learning event planned Once learning event has been completed, further scoping may be required to inform Trust wide QI project
Medications discharge errors including dispensary	Incidents	Patient safety team meeting with Associate Director of pharmacy to develop a robust process of incident review and improvement
Completion of blood transfusion forms and blood bottle labelling	Incidents	MDT planned with blood transfusion team and ward managers. Collaboration with IT

Measuring success of PSIRF

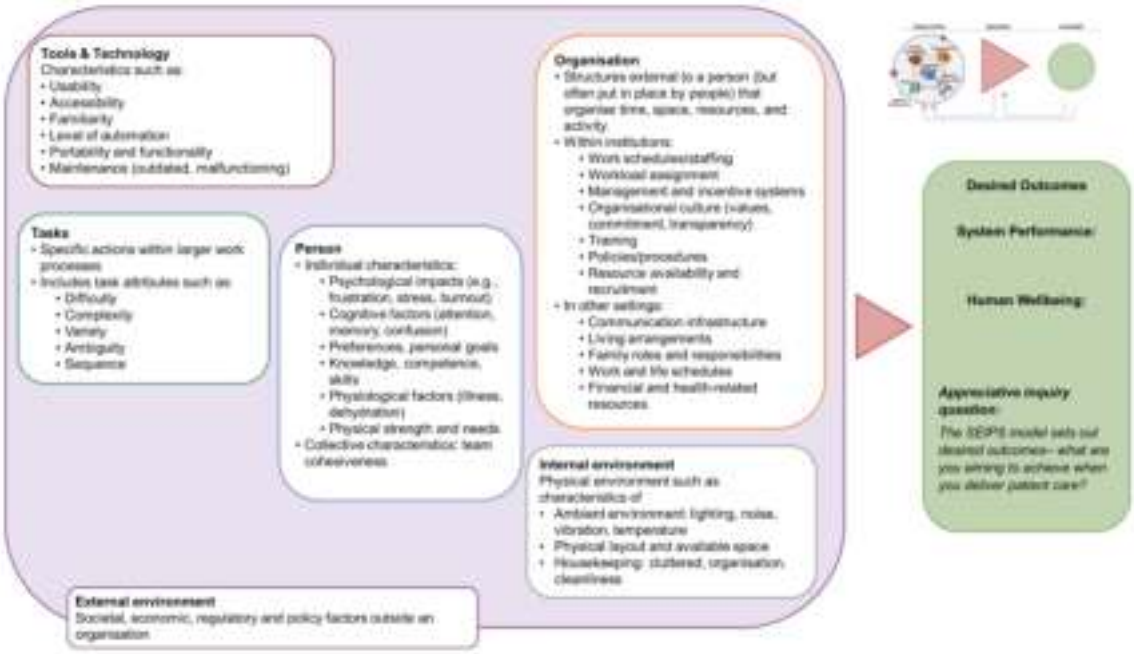
Success will be measured in a number of ways:

- Increase in incident reporting (as a marker of staff recognising that reporting will result in change)
- Reduction in the number of incidents relating to the MKUH local safety priorities (*Appendix 4*)
- Increased attendance at learning events

- Staff reporting feeling safe to raise concerns and speak up
- Qualitative staff feedback about incident reporting, triage, learning events and application of meaningful actions
- Patient and family feedback
- Feedback from the Integrated Care Board (ICB)
- Longer term: reduction in the number of complaints, reduction in staff sickness relating to mental health concerns or burn out, improved staff retention

Section 5: Appendices

Appendix 1 – The SEIPS model



Appendix 2 – Four response levels

Appendix 3: Types of Investigation and Learning Response Types

Response Type	Level	Description
Patient Safety Incident Investigation (PSII)	1	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how. These are led by the central patient safety team to ensure standardisation of high-quality system focused reports in collaboration with experts in the relevant fields.
Hot Debrief	2	A psychologically safe meeting with those involved to summarise a critical event, hear from those affected and identify immediate learning. These are locally led events by skilled facilitators.
After Action Review (AAR)	2	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the those involved and can be used to discuss both positive outcomes as well as incidents.
Multidisciplinary Team review (MDT)	2	An MDT review supports care teams to learn from patient safety incidents that have occurred. the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion, systems analysis and other techniques to understand 'work as done', to agree the key contributory factors and system gaps that impact on safe patient care. These can be useful to learn from clusters of similar events.
Learning and Innovation From Events (LIFE) session	2	LIFE sessions aim to take stories/accounts from everyday events and incidents and promote discussions that help people to use these stories/accounts as a prompt to collaboratively talk about what stood out for them, what there is to celebrate, what we are curious about and what are the ideals and practical ideas that can be taken forward to benefit those who live, work in or visit the care setting. LIFE sessions adopt a relational approach to learning and improvement, as they create space for multiple perspectives to be heard. LIFE sessions can be used to discuss stories/accounts from patients, family members or staff.
Rapid Review	4	A simple locally led review based upon national criteria. This determines whether the incident requires a level 1 or 2 learning response or can be closed. These are reviewed weekly at the local triage meetings.

Other level 2 response types can be considered such as audit, observational studies, and local learning forums.

Appendix 4 – MKUH Patient Safety Priorities

Sepsis in the Emergency Department	Delay, or failure, to recognise and manage any adult patient presenting to the Emergency Department with signs of sepsis.
Surgical Inpatients	Delay, or failure, to recognise the deteriorating surgical patient resulting in: • Change of lead speciality team • Unexpected further surgery • Unplanned admission to ICU • Death Adult patients under surgical specialities or inpatients on wards 20, 21, 23 or 24.
Diagnostics Delays	Incidents relating to diagnosis, specifically delay or failure to follow up on abnormal scan/test results resulting in: • Unexpected progression or worsening of disease • Delay in surgical intervention • Need for additional tests or procedure
Inpatient Diabetes	Incidents relating to the prescribing and administration of insulin resulting in a patient's blood glucose of >20 mmol/l (on two consecutive readings) or < 4 mmol/l. Adult patient under acute medical care (ED, Ward 1 and ward 2)

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Meeting Title	**Trust Board**	**Date: 4th Jul 24**
Report Title	**Chief Nursing Officers Report**	**Agenda Item Number: 9**
Lead Director	Steven Beaumont	
Report Author	Emma Codrington, Associate Chief Nurse and Emma Thorne, Safe Staffing Matron	

Introduction	This report will summarise the following reports. The full reports are included where full details can be found: • Bi-annual Staffing Report • Maternity Staffing Report • Annual Falls Report • Annual Tissue Viability Report
Key Messages to Note	1. <u>Bi- Annual Staffing Report</u> The bi-annual staffing report is required to be presented to the board twice a year. Vacancies across Registered Nurses, Midwives and therapist continue to reduce, and there is a good RN fill rate. A review is being undertaken with regards to the paediatric nurse staffing and our responsibility and funding of paediatric HDU beds is being discussed with commissioners. Nurse staffing on ICU is being reviewed. Business cases for nurse staffing uplifts in the emergency department has been supported. A band 8C nurse will be recruited to enhance the ED nursing leadership team. There remains a 21% HCA vacancy in April 24. However, the number of HCA vacancies may fall following rebalancing of the RN to HCA levels on some of the wards and there are several potential employees undergoing pre-employment checks. Therefore, it is envisaged that the vacancy rates for HCAs will reduce significantly in the next 6 months. 2. <u>Maternity Staffing</u> The Divisional Chief Midwife is required to provide a six-monthly staffing paper to board. The data is based on the PWR data and gives and oversight of the last six-month Birthrate + data. A vacancy rate of 9.9% was recorded in Mar 24. The supernumerary status of the labour Ward coordinator was achieved between 99.3% to 100% from Oct 23 to Mar 24. There has been an increase in the funded establishment for 23/24 and 24/25 in line with the Birthrate+ which has included an 8a and 8b post. A review of the data shared via the PWR is underway and compliance with the BR+ acuity App will be improved to over 85% compliance. A rebuild of the rosters is also underway. 3. <u>Annual Falls Report – Apr 23 – Mar 24</u> MKHU recorded 1,041 inpatient falls during the reporting period of which 96.9% were no or low harm event and 3.1% were moderate and above. 79.6% involved patients over the age 65 who are classified as high risk. Of the incidents, 420 incidents were unwitnessed falls accounted for 40%

	of the total falls. However, this represents a 27% reduction compared to the previous year. Overall, there has been a 1% reduction in falls. Falls prevention is a quality priority for 2024/25 with an aim to reduce unwitnessed falls which with a focus on: • Digitalised Multifactorial Risk Assessment • Focused education on Post Fall Assessment • Falls prevention and management training. • Alignment of falls incidence with PSIRF process. 4. Hospital Acquired Pressure Ulcers (HAPU) Report Apr 23 – Mar 24 Between the reporting period, there were 213 reported HAPUs across all categories. This represents a 51.5% reduction compared to the previous year. However, the number of Moisture Associated Skin Damage (MASD) incidents has seen a steady increase. A quality improvement programme has been initiated to address this. The incident review process for pressure ulcers has been reviewed to align it with the PSIRF process. The End PJ Paralysis initiative has been revitalised.

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)*	*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*

Report History	
Next Steps	
Appendices/Attachments	*n/a*

Meeting Title	**Trust Board**	**Date: 4th Jul 24**
Report Title	**Bi-annual Nursing, Midwifery and Allied Health Professionals Safe Staffing Report**	**Agenda Item Number: 9**
Lead Director	Steven Beaumont	
Report Author	Emma Codrington, Associate Chief Nurse and Emma Thorne, Safe Staffing Matron	

Introduction	This report provides an overview of the Nursing, Midwifery and Therapy staffing for the previous 6 months November to April 2024. The report details key safe staffing metrics, including vacancies, fill rates, and Care Hours Per Patient Day.		
Key Messages to Note	1. The vacancy rate for Registered Nurses, Midwives and Therapists continues to reduce. 2. Healthcare Support Worker vacancies remain at 21% in April 2024. With the recommended adjustments to ward skill mix and the number of candidates in pre-employment, it is expected that HCSW vacancies will reduce significantly in the next 6 months. 3. The staffing fill rate for Registered Nurses continues to be greater than 90%. Health Care Support Worker fill rates have dropped from 95% during the day to 85% over the 6-month period whilst the night shift is consistently over 90%. 4. Inpatient nurse establishment reviews have taken place with the recommended changes included in this paper.		
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)*	*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*

Report History	
Next Steps	
Appendices/Attachments	*n/a*

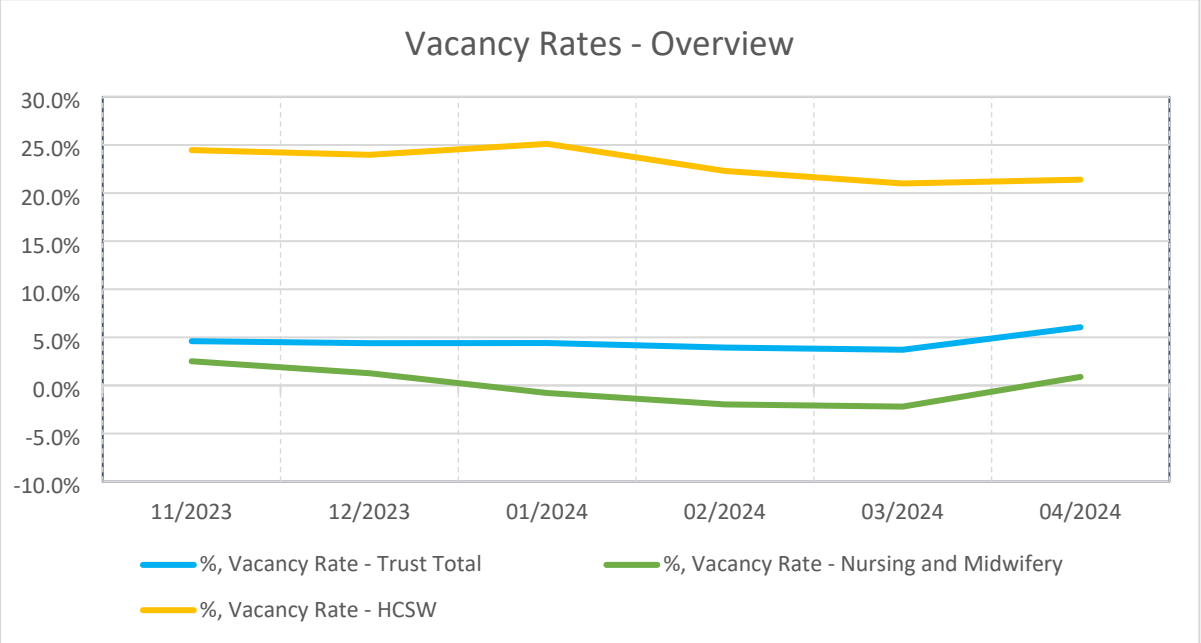
Nursing and Midwifery Bi-Annual Safe Staffing and Inpatient Establishment Review

Introduction

This report provides an overview of Nursing, Midwifery, and Allied Health Professionals (AHP) staffing at Milton Keynes University Hospital (MKUH) over the last 6 months. This report provides details of vacancies, fill rates, Care Hours Per Patient Day, Midwife Birth Ratio, inpatient establishment reviews and a summary of improvement actions and activities.

Nursing and Midwifery Vacancies

Registered Nurse (RN) and Registered Midwife (RM) vacancies have continued to decline over the past six months. The vacancy rate for RN has reduced from 1.7% (17wte) in November 2023 to 0.3% (2.7wte) in April 2024. Midwife vacancies have reduced from 8% (12.3wte) to 5.1wte (8wte) in April. Healthcare Support Worker (HCSW) vacancies have decreased from 24.5% (108wte) to 21.4% (101.3wte) in April 2024.



Nursing, Midwifery and HCSW Vacancies (November 2023 – April 2024)

% Vacancy Rate - Nursing and Midwifery (Nov 2023 – April 2024)					
Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024
2.5% (29wte)	1.3% (14.9wte)	-0.8% (-9.2wte)	-2% (-23.2wte)	-2.2% (-26.1wte)	0.9% (10.7wte)

% Vacancy Rate - Nursing (Nov 2023 – April 2024)					
Nov	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024
1.7% (17wte)	0.4% (4.1wte)	-1.8% (-17.8wte)	-3% (-30.8wte)	-3.2% (32.9wte)	0.3% (2.7wte)

% Vacancy Rate - Midwifery (Nov 2023 – April 2024)					
Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024
8% (12.3wte)	7% (10.8wte)	5.7% (8.7wte)	5% (7.6wte)	4.4% (6.9wte)	5.1% (8wte)

% Vacancy Rate – Healthcare Support Worker (Nov 2023 – April 2024)					
Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024
24.5% (108wte)	24% (105.9wte)	25.1% (111.9wte)	22.3% (99.3wte)	21% (93.9wte)	21.4% (101.3wte)

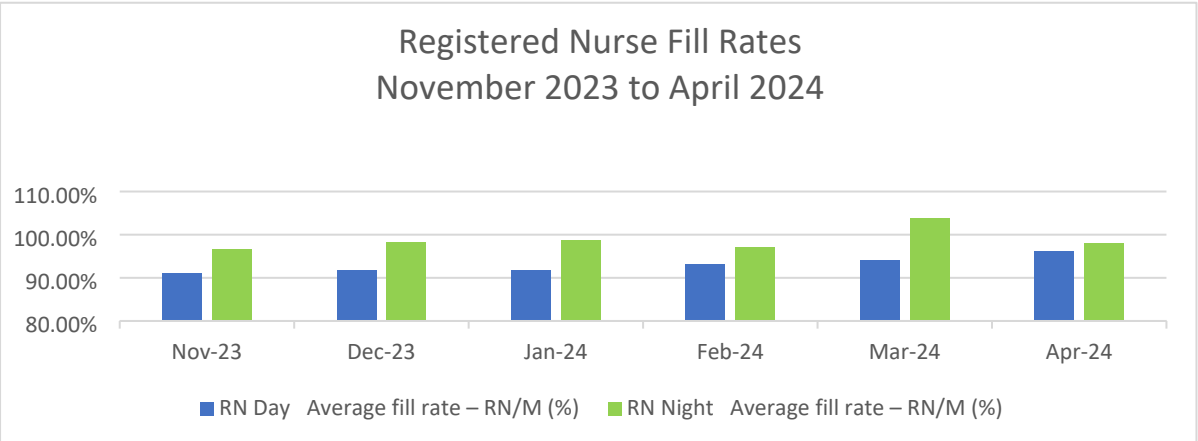
The figures above do not include current candidates in pre-employment, of which there are 40 HCSW, 29 Registered Nurses, 1 Midwife, 19 student midwives due to qualify in the coming months.

The current vacancy position reflects the success of the Trusts internationally trained nurses who have all passed their OSCE and are working as registered nurses.

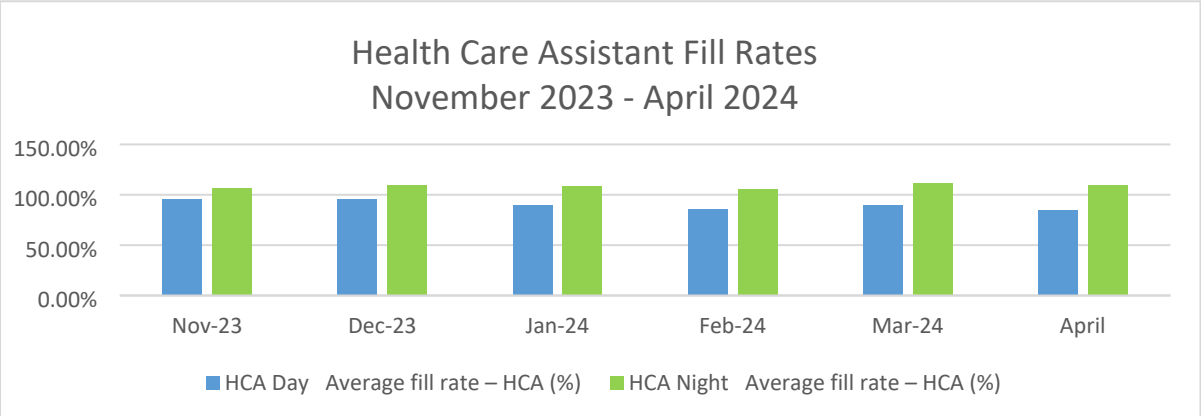
Planned Versus Actual Staffing and Care Hours per Patient Day (CHPPD)

Planned versus actual staffing fill rate is calculated by the percentage of actual staff on duty (including the temporary workforce) against the established staffing. Over the last six months, there has been an improvement in the overall fill rate for registered nursing during the day, from 90% in November 2023 to 96% in April 2024. Fill rates on nights have also increased from 96.5% to 98%.

Planned versus Actual Fill Rates for Registered Nurses



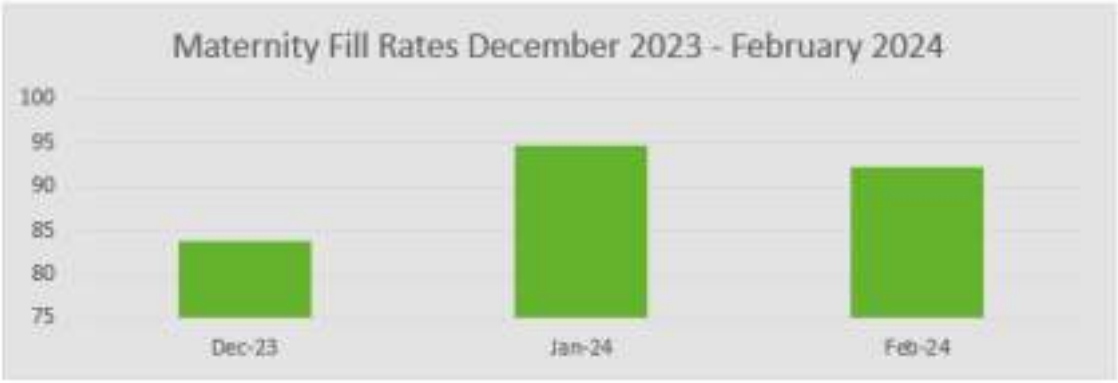
Planned versus Actual Fill rates for Healthcare Support Workers



The fill rate for HCSW's during the day has decreased from 95.7% in November 2023 to 85% in April 2024. The decrease in HCSW fill rates is likely to be associated to the vacancies held trust wide and the increase of escalation beds open during this reporting period, as staff regularly move from wards to support escalation areas.
The additional staffing requirements for the current escalation areas are 14 Registered Nurses and 11 HCSW's during the day and 12 Registered Nurses and 9 HCSW's at Night.

Maternity Fill Rates

In Maternity, the fill rate is calculated based on exact shift requirements month on month across the service – which are changeable depending on the community midwifery requirements. The midwifery staffing across all in-patient and outpatient areas dynamically adapts to meet the service needs, supported by the maternity escalation plan and midwifery business contingency plan. It is, therefore, necessary to review the midwifery staffing fill rate across the service instead of by area.

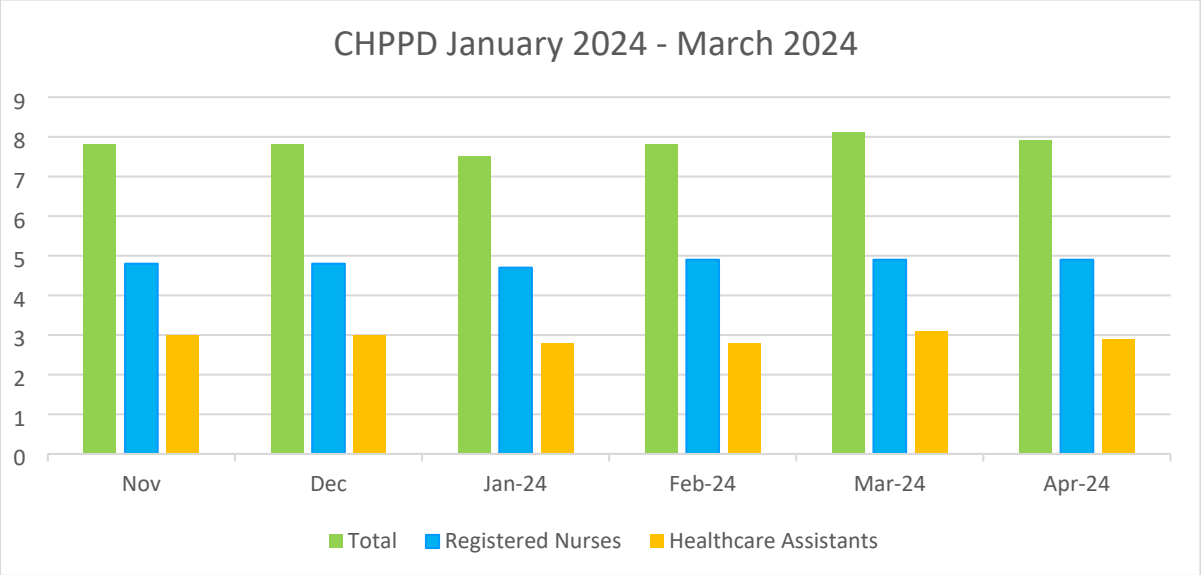


The graph above demonstrates Maternity fill rates from December 2023 to February 2024, other months within the 6-month timeframe have not been included due to potential inaccuracies within the data. Work is ongoing to ensure accurate data can be collected via Healthroster as currently the data is being collated manually. Following the shortfall in December where the fill rates dropped to 84% there has been

a successful revised approach to proactive maternity and study leave management to ensure fill rates stay above 90%.

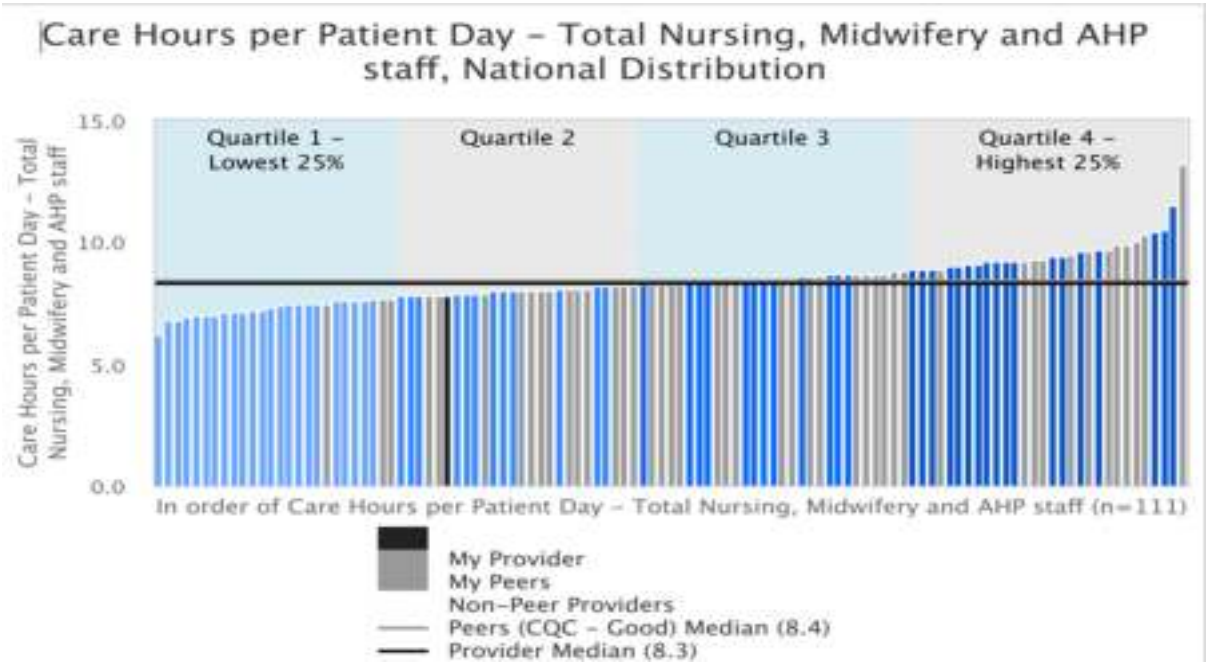
Care Hours Per Patient Day (CHPPD)

Care Hours Per Patient Day (CHPPD) is a key metric for recording nursing and HCSW staff deployment on inpatient wards. CHPPD is calculated by adding together the hours of registered and unregistered staff and dividing the total number of patients in beds at midnight. This calculation provides a value of actual nursing care hours spent with patients a day. Low levels of CHPPD could indicate inadequate staff in proportion to patient numbers and high rates could indicate inefficient rota practice or incorrect shift plans. While there is no nationally set figure for CHPPD the national average is recognised as approximately 8.3 (Model Hospital, February 2024) The Trust's CHPPD has consistently ranged between 7.5 and 8.1 in the last 6 months.



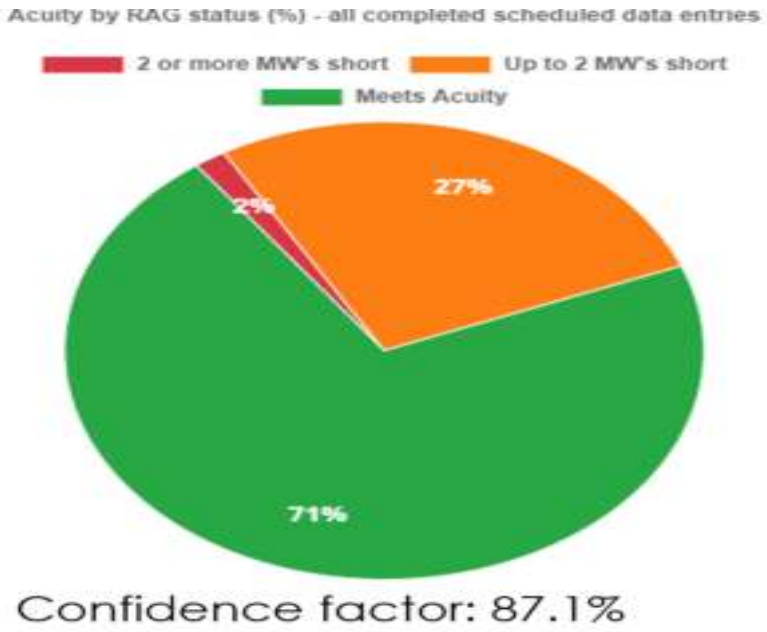
	Nov	Dec	Jan-24	Feb-24	Mar-24	Apr-24
Total CHPPD	7.8	7.8	7.5	7.8	8.1	7.9
Registered Nurses	4.8	4.8	4.7	4.9	4.9	4.9
Healthcare Assistants	3	3	2.8	2.8	3.1	2.9

The Table below illustrates the Trusts current position against the latest national picture using Model Hospital. The Graph shows that as an organisation we sit in Quartile 2 for CHPPD. Provider Median is 8.3 (Quartile 3).



Midwife-to-Birth Ratio

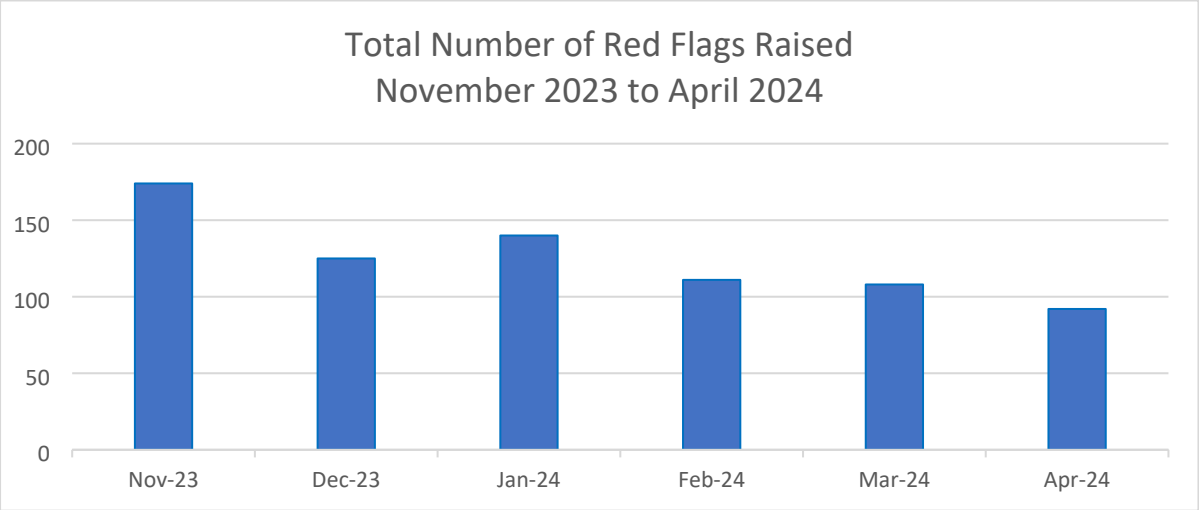
Birthrate Plus is a methodology used to determine maternity staffing levels based on an assessment of clinical risk and the needs of women and babies during the periods of labour, delivery and immediately post-delivery. The Birthrate Plus (BR+) confidence factor has improved over the last 6 months –currently reporting 87%. Improvements continue to be a focus of the maternity teams with the next BR+ workplace assessment planned for next quarter.



Safe Staffing Red Flags

Red Flags are NICE-recommended reportable events warranting immediate staffing and patient acuity review. Any Red Flag raised will initiate a senior nursing review, and necessary mitigations are actioned to minimise the risk.

Red flags form part of the safe staffing escalation process and as such Ward leaders have been educated on the importance of raising red flags where risks are identified and when staffing falls below plan. The graph below demonstrates the number of red flags that were raised on Safe Care in the last six months.

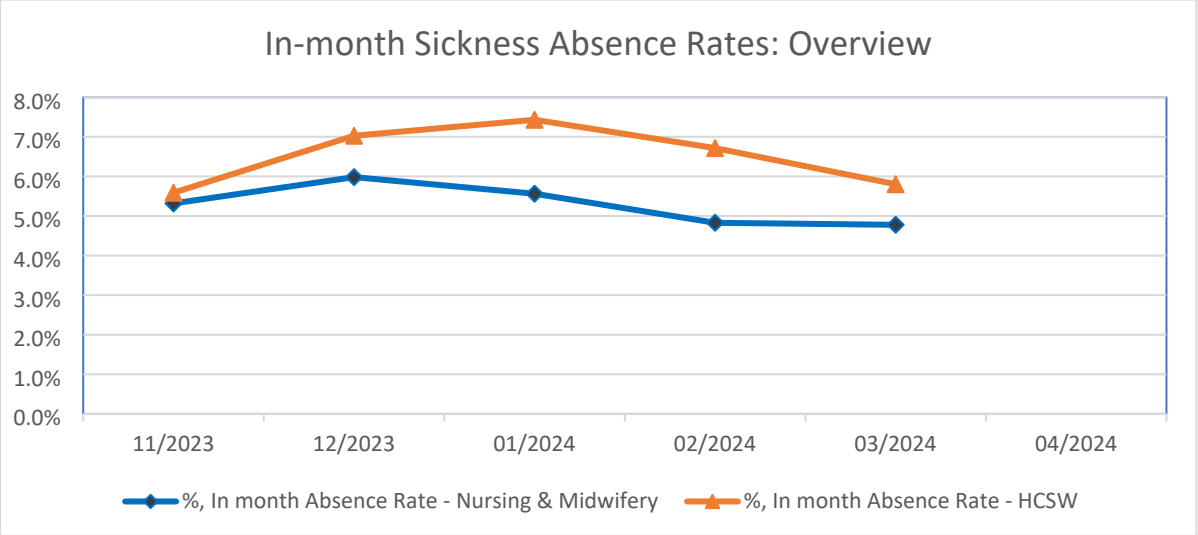


The decrease in the reporting of Red Flags is likely to be reflective of the improved vacancy position for registered nurses. The top reporting themes for Red Flags were a shortfall in registered nurse time and skills deficit (whereby a ward feels that they do not have the required skill mix to manage the needs of the patients).

In maternity there is some overlap with BR+ and NICE red flags as actions taken are often dependant on acuity and causality, e.g. maternity escalation causing elective activity being paused to maintain overall safety as opposed to delays with elective work due to staff shortfalls.

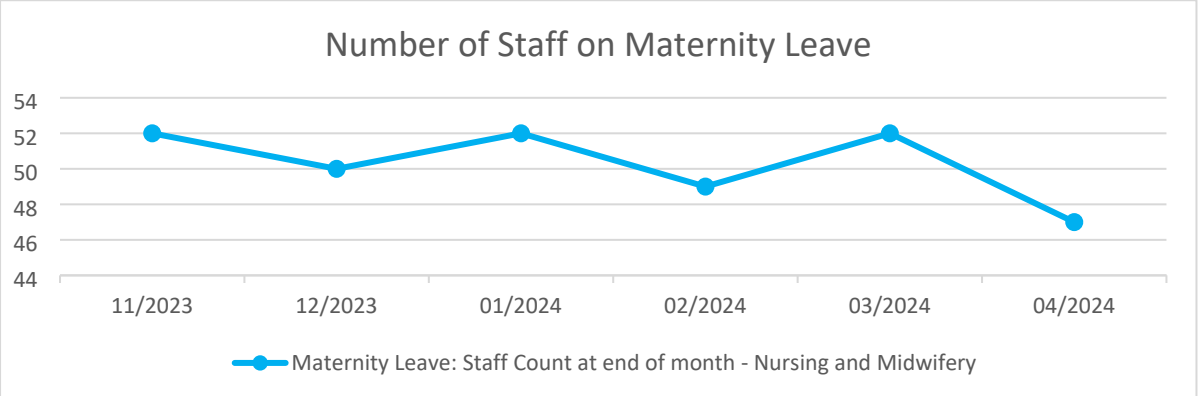
Sickness Absence

The rates of sickness absence have been variable over the past six months and have ranged between 4.8% and 6% for registered nurses/midwives. HCSW sickness absence has also fluctuated ranging from 5.6% to 7.4%. Efforts continue to reduce sickness absence involve flexible working arrangements, training and development opportunities, supportive management, and regular engagement and communication that seeks feedback from staff and target interventions with the Divisional Chief Nurses/Midwife to reduce sickness absence below 4%.



Maternity Leave

The graph below demonstrates the number of Nursing and Midwifery staff on maternity leave has ranged from 52 to 47 over the past six months.



Nursing and Midwifery Agency Usage

Agency use for registered staff has increased over the past six months from 353 in November to 415 in April 2024. Ad hoc agency shifts continue to be requested and raised on a shift-by-shift basis requiring ‘Gold’ approval to ensure that this resource is only used when necessary.

Long line approval remains in place for Theatres, Paediatrics, and the Macmillan Department/Cancer Services. All these areas have an exit strategy to reduce their agency usage over the coming months.
The main reason for other agency staff usage was covering the skill deficit in specialised areas such as ICU and ED. The graphs below illustrate the Agency Nurse/Midwives over the last 6 months, there have been no agency staff used to backfill HCSW shifts.

Allied Health Professional Staffing

Inpatient OT vacancies have reduced over this period from 6wte to 1.55wte. Inpatient Physiotherapy vacancies continue to decrease from 9wte to 5.61wte. Frailty Band 6 (OT) and complex Medicine (PT) positions remain difficult positions to recruit into.

Staff Group	Vacancies (WTE)	Current Vacancy rate %	Newly Appointed	Hard to recruit posts
Inpatient Occupational Therapist (OT)	1.55	8%	1.0	Frailty Band 6
Inpatient Physiotherapist (PT)	5.61	19%	0	Oncology Band 6 Complex Medicine Band 6
Therapy Support Workers (Band 3/4)	4.76	17%	0	
Total	11.93	16%	1.0	

The staff turnover in inpatient therapy has reduced from 15% in December 23 to 13% in April 2024, however a lot of the gaps including maternity leave and vacancies continue to be covered by offering internal secondments. Whilst this provides potential opportunities to retain and develop staff, their substantive posts are often being covered by temporary staffing such as agency and bank. Locum spend therefore remains at 10% including cover for escalation areas. Exit strategies are being expedited to ensure that we are supporting the overall challenges faced by the Trust to achieve the necessary savings and efficiency targets.

Since December, inpatient therapy has appointed to the hard to recruit Band 6 OT in Oncology and all the additional ward 14 posts (1 x OT and 4.0 band 3 Therapy assistants).

Sickness remains above 5% at 6.53% hitting a peak of 7.48% in February 24, at least 3 staff are on long term sickness management. All appropriate measures have been taken to support staff on absence in line with Trust policy and procedures.

Therapy Service Developments - Keeping you active initiative

Since November 2023 Therapy inpatients have led on a 'Keeping you active' initiative which introduced 8 Therapy HCSW and 1 Assistant Practitioner across Wards 15, 16, 18 and 19. Feedback has confirmed that the Therapy HCSW supported patients to remain active during their hospital stay using reablement approaches. The initiative is due to end in June 2024, further funding is being explored via the Improving System Flow (ISF) workstream.

Inpatient Establishment Reviews

The National Quality Board (NQB, 2016) and Developing Workforce Safeguards (2018) report require NHS Trusts to conduct establishment reviews twice a year using an evidence-based tool. These reviews aim to ensure that existing establishments meet patient needs and help address changes in acuity and patient demographics. In January 2024, data was collected using the Adult Inpatient, Adult Assessment Unit Safer Nursing Care Tool (SNCT) and Emergency Department SNCT methodology. Data was gathered once daily for 20 days in adult areas and twice daily for 12 days in the Emergency Department as per the SNCT guidance. Multi professional establishment review meetings were held for all inpatient areas, to assess if the current establishments align with SNCT recommendations. professional judgment and national guidance. A summary of all inpatient ward establishments can be found in Appendix 1.

1. Adult and Pediatric Inpatient Wards

Overall, the adult inpatient ward establishment review indicates that in the main wards have the correct establishment. The current funded establishment allows nurse-to-patient ratios to remain below the 1:8 (day) and 1:10 (night) except for Ward 14 which works to a re-enablement model. Of note, current national research recommends 1:6 or 1:7 registered nurse to patient ratio as having more favourable patient outcomes. The review identified that some skill mix adjustments are required to optimise safety particularly at night.

All areas were reviewed triangulating the evidence with professional judgement, red flags raised, staff satisfaction, patient acuity and outcomes alongside dependency to indicate a revised skill mix to meet patients' needs.

1.1 Medical Division

The Medical Division requires revisions to Wards 3, 7, 8, 16, 18 and 19. The proposed changes to these establishments are summarised in the tables below. The proposed increase reflects the complexity of patients cared for in these areas and the SNCT requirement to work towards a 65%/35% RN split to optimise safety and reduce mortality.

Ward 3	Registered Nurse	Healthcare Support Worker
Current skill mix (Day)	4	4
Recommended skill mix	5	3
Current skill mix (Night)	3	3
Recommended skill mix	4	3
Change	***+ 1 RN per 24 hours***	***-1 HCSW per day***

Ward 7	Registered Nurse	Healthcare Support Worker
Current skill mix (Day)	5	4
Recommended skill mix	5	4
Current skill mix (Night)	3	3
Recommended skill mix	4	3
Change	***+ 1 Registered Nurse per night***	***0***

Ward 8	Registered Nurse	Healthcare Support Worker
Current skill mix (Day)	4	3
Recommended skill mix	5	2
Current skill mix (Night)	3	2 + 1 Twilight
Recommended skill mix	4	2
Change	***+ 1 RN per 24 hours***	***-1 HCSW per 24 hours***

Ward 16	Registered Nurse	Healthcare Support Worker
Current skill mix (Day)	4	4 on an early 3 on a late
Recommended skill mix	5	3
Change	***+ 1 RN per day***	***-1 HCSW per early***

Ward 18	Registered Nurse	Healthcare Support Worker
Current skill mix (Day)	4	4 early 5 on a late duty

Recommended skill mix	5	4
Current skill mix (Night)	3	3
Recommended skill mix	4	3
Change	***+ 1 RN per 24 hours***	***-1 HCSW per late***

Ward 19	**Registered Nurse**	**Healthcare Support Worker**
Current skill mix (Day)	4	5 on an early 4 on a late
Recommended skill mix	5	4
Current skill mix (Night)	3	3
Recommended skill mix	4	3
Change	***+ 1 RN per 24 hours***	***-1 HCSW per early***

Acute Assessment Areas (Ward 1 and Ward 2A)

Acute Assessment areas are recommended to operate to the nurse-to-patient ratio of between 1:6 -1:7. Ward 1 runs on a nurse-patient ratio of 1:5 during the day and night, a HCA uplift is recommended for the night duty to support the acuity of patients and patients that are cared for during the SDEC transition hours. In relation to Ward 2A, the establishment review supports the June 2023 review to increase the number of Registered Nurses at night, thus increasing the Nurse to patient ratio in this area. Therefore, the change below should be made to the funded nursing establishment.

Ward 2A	Registered Nurse	Healthcare Support Worker
Current skill mix (Day)	5	4 on an early 3 on a late
Recommended skill mix (Day)	5	3
Current skill mix (Night)	4	3
Recommended skill mix (Night)	5	3
Change	***+ 1 RN per night***	***-1 HCSW per early***

1.2 Surgical Division

Ward 20

Ward 20 requires one amendment to the establishment to ensure appropriate registered nurse support at night to meet patients' acuity and dependency needs. The proposal would be to increase the skill mix by one HCA in the day, reduce by one at night, and increase an RN at Night to align with safe staffing recommendations. This can be achieved within current funding.

Ward 20	Registered Nurse	Healthcare Support Worker
Current skill mix (Night)	3	3
Recommended skill mix	4	2
Change	***+ 1 RN per night***	***-1 HCSW per night***

Ward 23

The SNCT tool indicates a review of the skill mix on Ward 23 with an increase of 7 RNS and reduction of 8 HCAs. Taking into consideration clinical judgment and complexity of the patient group the manager and matron propose an increase of 1 HCA night only in the first instance. There is also recognition that that Ward 23 has two Band 7s to support the unit in which 1 Band 7 will be clinical at anyone time to support the needs of the clinical environment. Geographically Ward 23 layout provides challenges in how staff can adequately supervise and observe patients at risk. The additional HCA would support the observation of patients also.

Ward 23	Registered Nurse	Healthcare Support Worker
Current skill mix (Night)	5	4
Recommended skill mix	5	5
Change	***0***	***+1 HCSW per night***

1.3 Women and Childrens Division

The Women and Children Division requires an amendment to the staffing establishment in Ward 5, inpatient Paediatric Ward. The Royal College of Nursing 'Defining Staffing Levels for Children and Young People Services' outlines the recommended safe staffing ratios for children of all ages. The RCN guidance on nurse-to-patient ratios is as follows:

Under 2 years	1:3
Over 2 years (Day)	1:4
Over 2 years (Night)	1:5

Based on the under and over 2 recommendations the proposal is to increase the number of Registered Nurses over the next two years as outlined in the Table below.

Ward 5	Current RN Model	Proposed RN Uplift 2024/25	Proposed RN Uplift 2025/26	Required RN Model
Long Day	6	1	0	7
Night	4	1	2	7

An increase in acuity has been identified as part of the establishment review and the Division will be working collaboratively with Paediatric Critical Care Operational Delivery Network on how this increase should be supported from a staffing and service perspective.

A separate paper has been taken to Trust Board to outline the investment required to ensure the provision of safe care across paediatric services, in line with the national guidance.

1.4 Emergency Department

The Emergency Department (ED) Safer Nursing Care Tool (2021) was used to calculate nurse staffing requirements for ED based on patient needs (acuity and dependency). The Emergency Department (ED) establishment review was underpinned by:

- The ED Safer Nursing Care Tool evidence
- Professional judgement
- Benchmarking against other Type 1 Emergency Departments
- Application of the recommendations from the RCN/RCEM (2020)
- Patient and workforce metrics and outcomes

The Emergency Department has sought additional investment and amendments to the current nurse staffing establishment to strengthen the skill mix, headroom and leadership structure. The buisness case submitted has been approved with a phased approach.

Next Steps

The Trust is planning to undertake a further establishment review in June 2024. Data is collected twice a year to compare seasonal variance and benchmark staffing establishments against peers of similar size. The Trust will work towards the

recommended 65% registered nurse to 35% HCSW ratios, as recommended by the Safer Nursing Care Tool. The decisions regarding ratios are made on a ward-by-ward basis, with professional judgment and evidence-based practice being applied.

Safe Staffing Improvement Actions and Activities

- **Safe Staffing Meetings and SafeCare**

Safe Staffing Meetings continue to be held three times daily. During these meetings, the live SafeCare system is utilised to ensure that Red Flags raised are reviewed, mitigated, or escalated and that wards/departments at risk receive the support required to provide safe and effective care. The Safe Staffing Matron chairs the meeting, and attendance is required from all Divisions. Wards must input patient acuity and staffing data into the live system three times daily to provide an overarching picture of the ward's safety. Data entry compliance now sits at 90% Trust-wide.

- **Safe Staffing Escalation Policy and Procedure**

A Safe Staffing and Escalation Policy is now in place. The policy outlines the escalation process when staffing falls below plan, how staff can escalate and raise concerns and how to mitigate risk, ensuring safe care.

- **Check and Confirm Roster Efficiency**

Monthly Check and Confirm meetings continue to optimise workforce efficiency and ensure that staffing is spread evenly across the breadth of the rota. This process ensures wards create and publish safe and effective rosters per national guidelines and working time directives. By doing so, the Trust can ensure that appropriate staff are available at the necessary times to provide patient care.

- **Nursing and Midwifery Recruitment and Retention**

Over the last six months, the rate of vacant positions for Registered Nurses/Midwives (RNs/RM) across the Trust has consistently decreased. Two hundred and twenty-five internationally educated nurses have passed their OSCE exams and are officially registered with the NMC. To support our internationally educated nurses, the Trust has recruited a career coach to help with their development alongside the preceptorship programme. Core Skills development days have also been developed and implemented in addition to those offered in the preceptorship programme.

- **HCSW Recruitment and Retention**

The HCSW Recruitment and Retention Steering Group continues to work on reviewing and improving the HCSW recruitment process from advertisement to induction.

Introductory welcome letters and information booklets about the wards and departments are being developed to ensure those new to care have an improved understanding of the areas they will work in and what skills are involved.

The group is also working on the HCSW Band 2 to Band 3 programme to ensure HCSW roles and responsibilities match the national profile.

Conclusion

In conclusion, significant progress has been made in reducing nursing and midwifery vacancies at MKUH over the past six months although healthcare support worker vacancies remain a challenge. The Trust has collaborated with BLMK on a regional healthcare support worker recruitment campaign, undertaken Recruitment evenings and events to address this. With the recommended adjustments to ward skill mix and the number of candidates in pre-employment, it is expected that HCSW vacancies will reduce by at least 40% in the next 6 months.

The inpatient nurse establishment review provides an updated position on the nursing workforce requirements to achieve optimal staffing levels in inpatient areas, the emergency department, and children's and young people's services. The review proposes changes to the nursing establishment on Wards 1,2,3,7,8,16,18,19, in the Medical Division, Ward 20 and 23 in the Surgical Division, and Ward 5 in the Women and Children Division. The Emergency Department has also sought investment to enhance the skill mix, headroom, and leadership structure. The Trust will initiate data collection for a further nursing establishment review in line with the national guidance in June 2024.

Recommendation

The Trust Board is asked to receive this report and note the ongoing plans to provide safe staffing levels within nursing, midwifery, and AHP disciplines.

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Appendix 1: January 2024 Adult Inpatient Establishment Review Data

DIVISION	WARD	BED No.	CURRENT PATIENT FACING ESTABLISHMENT WTE					JUNE 2023 SAFER NURSING CARE TOOL DAILY AVERAGE (BASED ON 65% RN RATIO & 22% HEADROOM)						SNCT PROPOSED TOTAL RN	SNCT PROPOSED HCA	JANUARY 2024 SAFER NURSING CARE TOOL DAILY AVERAGE (BASED ON 65% RN RATIO & 22% HEADROOM)						SNCT PROPOSED TOTAL RN	SNCT PROPOSED TOTAL HCA	CURRENT DAY		RN TO PT RATIO	CURRENT NIGHT		RN TO PT RATIO
			RN	B6	Total RN	HCSW	TOTAL	Level 0 patients	Level 1a patients	Level 1b patients	Level 2 patients	Level 3 patients	TOTAL			Level 0 patients	Level 1a patients	Level 1b patients	Level 2 patients	Level 3 patients	TOTAL			RN	HCSW		RN	HCSW	
MEDICINE	Ward 1	26	27.04	6.57	33.61	12.2	45.81	15	3.2	7.8	0.1	0	26.1	28.5	12.2	8.45	8.2	9.1	0.45	0	26.2	31	13.3	5	3	**5.2**	5	2	**5.2**
MEDICINE	Ward 2	27	15.66	5.24	20.9	17.72	38.62	12	1.8	10.8	2.5	0	27.1	32.4	13.9	10.5	3.85	12.7	0.05	0	27.1	32.3	13.9	5	4	**5.4**	4	3	**6.75**
MEDICINE	Ward 3	26	17	5.24	22.24	22.44	44.68	13.1	0.1	14.9	0	0	28.1	25	13.5	13.65	0.35	14	0	0	28	24.7	13.3	4	4	**6.5**	3	3	**8.7**
MEDICINE	Ward 7	26	17.99	7.24	25.23	17.28	42.51	3.4	0.5	22	0.2	0	26.1	27.3	14.7	5.2	0.5	20.25	0	0	25.95	26.4	14.2	5	4	**5.2**	3	3	**8.7**
MEDICINE	Ward 8	25	18.45	5.24	23.69	17.45	41.14	9.3	2.75	12.65	0.25	0	24.95	22.9	12.3	8.6	0.35	16.2	0	0	25.15	23.9	12.9	4	3	**6.2**	3	2 (TW)	**8.3**
MEDICINE	Ward 14	24	8.96	0	8.96	17.92	26.88	15.5	0.05	8.4	0	0	23.95	19.4	10.4	12.2	0.35	11.45	0	0	24	20.9	11.3	2	5	**12**	2	4	**12**
MEDICINE	Ward 15	29	18.25	5.24	23.49	17.72	41.21	13.7	6.3	6.4	2.5	0	28.9	24.8	13.4	12.95	3	6.65	6.5	0	29.1	26.7	14.4	4	4 (3)	**7.25**	4	2	**7.25**
MEDICINE	Ward 16	29	17.88	5.24	23.12	17.72	40.84	16	2	10.1	0.2	0	28.3	23.4	12.6	10.7	2.55	12.6	2.85	0	28.7	26.9	14.5	4	4(3)	**7.25**	4	2	**7.25**
MEDICINE	Ward 17	26 (1)	20.79	5.24	26.03	13.89	39.92	12.5	5.8	4.8	3.6	0	26.7	23.1	12.4	9.2	6.1	5.2	6.45	0	26.95	25.4	13.7	5	3	**5.2**	4	2	**6.5**
MEDICINE	Ward 18	28	13.1	5.24	18.34	19.57	37.91	10.8	0.4	17.2	0	0	28.4	26.5	14.3	12.7	0.2	16.4	0.05	0	29.35	26.7	14.4	4	4	**7**	3	3	**9.3**
MEDICINE	Ward 19	30 (1)	13.54	5.24	18.78	19.42	38.2	15.6	0	14.4	0	0	30	26.1	14.1	14.5	0.2	15.7	0	0	30.4	27	14.6	4	5(4)	**7.5**	3	3	**10**
MEDICINE	Ward 22	21	14.06	5.24	19.3	16.69	35.99	8	0.4	12.6	0.1	0	21.1	19.6	10.5	14.3	0.9	5.8	0	0	21	16.5	8.9	4	4	**5.25**	3	3	**7**
MEDICINE	Ward 25	20 (4)	16.09	6	22.09	11.47	33.56	9.5	2.2	4.6	5.8	0.1	22.2	20.8	11.2	1.95	5.7	9.8	6.4	0	23.85	25.5	13.7	5	3	**4**	3	2	**6.66**
SURGERY	Ward 20	28 (1)	18	5.24	23.24	14	37.24	21.6	1.5	5.2	0	0	28.3	20.9	11.3	20.55	3.6	4.7	0	0	28.85	21.7	11.7	5	2	**5.6**	3	3	**9.3**
SURGERY	Ward 21	27	16.4	5.24	21.64	11.16	32.8	23.3	1.3	2.4	0	0	27	18.8	10.1	22.45	0.7	3.7	0	0	26.85	19.2	10.3	4	2	**6.75**	4	2	**6.75**
SURGERY	Ward 23	40	21.89	6.92	27.78	27.8	55.58	18.4	0.6	21.1	0	0	40.1	35.8	19.3	16.55	0.15	23.3	0	0	40	36.8	19.8	6	5	**6.66**	5	4	**8**
SURGERY	Ward 24	20	9.8	5.24	15.04	10.56	25.6	16.6	0.3	2.6	0.6	0	20.1	14.5	7.8	14.9	0.15	4.9	0.05	0	20	15.2	8.2	3	2	**6.66**	3	2	**6.66**
TOTAL					373.48	285.01	658.49							409.8	214							426.8	223.1						

Chief Executive: Joe Harrison
Chair: Alison Davis

Meeting Title	Trust Board	**Date: 4th Jul 24**
Report Title	Milton Keynes University Hospital Midwifery Workforce update	**Agenda Item Number: 9**
Lead Director	Steve Beaumont – Interim Chief Nursing Officer	
Report Author	**Elaine Gilbert Divisional Chief Midwife**	

Introduction	The purpose of this paper is to provide the trust board 6 monthly oversight of midwifery staffing/safety issues. NICE guidance requires a six monthly review at board level of the midwifery establishment. The oversight of board is also required to achieve compliance with the maternity incentive scheme recommendations (Safety Action 5).		
Key Messages to Note	The midwifery establishment is set and funded in line with Birthrate plus recommendations. Midwifery vacancies have been recorded on the PWR and the data held at trust level are identifying as not being a lined, with the trust currently identifying a 9.9% vacancy over the 5% reported on the regional report (appendix 1 February 2024). A recruitment trajectory has been included in the paper which will reduce the vacancy by October 2024 to 0.25%. Safe staffing flags are reported using the birth rate plus acuity tool and are included within the report for the past 6 months. The service has maintained for the period of October 2023 – March 2024 supernumerary status of the Labour ward coordinator of 99.3% to 100%. The suggested level of compliance with BR+ is over 85% is not currently achieved over this period and this is an area that requires improvement. Data for the ward acuity app is currently unavailable for this period due to ongoing develop of the app by the provider (BR+).		
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)*	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*

Report History	
Next Steps	• Improvement of data shared via the PWR with the regional and national teams in relation to midwifery staffing, ensuring that information is consistent. • Improve compliance with the BR+ acuity app to over 85% as a constant. • Rebuild of rosters in relation to the working pattern and the allocated midwifery hours. • Ensure that all midwifery hours are allocated to the clinical areas, using BR+ acuity app to inform allocation. • Monitor recruitment to ensure that it remains on Trajectory. • Review of data in relation to fill rates as roster builds - identifying areas of improvement that impact fill rates such as sickness rates and non-compliance to meet KPI in relation to roster management. • Undertake a full-service BR + review prior to October 2024, as the last BR+ review was October 2021. This to ensure midwifery workforce is assessed prior to FY 2024/2025-year end and within national guidance.
Appendices/Attachments	

Milton Keynes University Hospital Midwifery Workforce update

1 Context

1. NICE guidance in relation to safe midwifery staffing requires the Divisional chief Midwife to provide a six-monthly staffing paper to board.

2. The data reported is based on the trust PWR data, and the projection of recruitment in the next six months.

3. The staffing report will also provide an oversight of the last 6 months BR+ data.

4. This paper provides a summary of:
   - MKUH (Milton Keynes University Hospital) funded midwifery establishment, vacancy rate and recruitment trajectory
   - BR+ data in relation to safe staffing within maternity.

2 Midwifery Establishment

2.1 For this paper, the term midwifery establishment refers to whole time equivalent (wte) midwives between band 5 and 8b to align with PWR data. Data quality issues have been identified within the 23/24 PWR data set.

2.2 These have been discussed with the regional team to ensure that there is an alignment within the data held within the trust and that reported externally, previously band 8a and 8b have not been included in the PWR return.

2.3 Review of the data confirmed that the midwifery establishment reported on the PWR is tabled below:

Table 1

Year	NHSE (NHS England) midwifery establishment (Band 5-8b)
23/24	159.69

24/25	163.49

2.4 There has been an increased in the midwifery establishment in line with the BR+ report. The funded establishment for 23/24 and 24/25 in table one includes 8a and 8b post (to bring in line with regional and national reporting).

2.5 Although the midwifery establishment has been increased to reflect the BR+ report, there was not a review of the roster build or allocation to clinical areas in wte with 6.89 wte not allocated to a clinical area by 31.03.2024.

Maternity Establishment 23/24															
Current funded establishment		**8b**	**8a**	**7**	**6**	**5**	**4**	**3**	**2**	**Anc 2**	**A&C4**	**A&C 3**	**A&C 2**	**Total**	
Matrons	W73036	4.00	4.00											**8.00**	
Specialist Midwives	W73042			15.00	2.00						2.00			**19.00**	
ADAU/ Triage	W73051			1.20	12.86			5.46					1.00	**20.52**	
Ante-natal	W73053			1.00	1.62			3.00					1.00	**6.62**	
Labour ward	W73023			12.68	27.30			5.46	1.00	0.80			5.33	**52.57**	
Ward 9	W73009			2.00	22.84			10.92		1.00			1.64	**38.40**	
Ward 10	W73010			0.00	5.46		3.20							**8.66**	
Community	W73057			5.00	35.84			4.20	1.40					**46.44**	
Homebirth & CoC	W73033			0.00	0.00									**0.00**	
(Balance)	W73058				6.89									**6.89**	
		4.00	**4.00**	**36.88**	**114.81**	**0.00**	**3.20**	**29.04**	**2.40**	**1.80**	**2.00**	**0.00**	**8.97**	**207.10**	159.69

2.6 Rosters are built on a previous shift pattern of early Late and Nights, rather than the required long days which are the main shift pattern in all inpatient areas (Labour ward / Triage / ADAU and ward 9/10).

2.7 This impacts the data quality in relation to fill rates, hours that are worked demand within the clinical areas.

2.8 Rosters with community and outpatient settings have also not been reviewed.

3 Vacancy

3.1 In March 2024 the midwifery vacancy was 9.9% as tabled below:

Table 2

Band	Establishment	In post	Vacancy	
8b	4	4	0	
8a	5 (4 +1 externally funded till January 2025)	4	1	Recruited to due to start June 2024.
7	38.88	39.09	0	External funding for band 7 x2 posts (patient experience / retention) and one additional maternity leave cover.
5/6	114.81	99.50	15.31	
Total	**162.69**	**146.59**	**16.10**	

3.2 The band 8a and 8b have not all been recorded on the PWR and therefore the data Maternity Workforce Programme Trust view in 23/24 (Appendix 1 February 2024) is not reflective of the current midwifery vacancy at MKUH.

4. Provider Workforce Return Review

1. The total number of midwives recorded within the Maternity Workforce Programme Trust View are not reflective of the current midwives in post at MKUH.

Table 3

Band	Establishment	Recorded on Maternity Workforce Programme Trust View	In post	Comments
8b / 8a	9 + 1 externally funded till January 2025)	6	9	Coding of 8a /8b to be reviewed. Including secondment (externally funded) and secondment for maternity leave cover.
7	38.88	34	39.09	Difference of 4.88 wte from MWP data and over establishment to cover maternity leave.
5/6	114.81	88.0	99.50	Difference of 26.81 wte from MWP data. Vacancy overall in band 5/6 15.31 wte.

5. Recruitment Trajectory

5.1 Recruitment is continuously underway, and it is forecast that at least 18.02 wte midwives will start in post before the end of October 2024 (See Table 4)

Table 4

Estimated timeline	Starters	Leavers	Vacancy 5-8b	Comments
May	0	2.33	18.43	None planned
June	4.2	0	14.23	8a – labour ward matron / 2.4 band 6.

				0.8 wte at risk of failure to recruit due to on possible on-going fixed term role.
July	0	0	14.23	
August	1	0	13.23	None planned
September	12.82	0	0.41 (3.41)	Band 5 recruitment programme (3.0 wte are at risk of failure to recruit.)
October	0	0	0.41 (3.41)	

2. The forecast leavers rate is 1.33 known leavers (band 5-7) wte before the end of October 2024.
3. 2.0 wte band 8a/ 8b planned to leave in first quarter of 2024/2025. Recruitment for labour ward 8a successful and due to start at MKUH by quarter two of 2024/2025. The band 8a leaver was due to retirement.
4. Recruitment currently under way for 8b position and 1.0 8a secondment is due to commence to support maternity governance team. The band 8b leaver was due to promotion within another NHS Trust.
5. Based on this trajectory of forecast new starters and leavers, in October 2024 it is anticipated that there will be 162.28 wte midwives in post and that the vacancy will be 0.41 wte (0.25%).

Please note, this forecast may be subject to change as some midwives have expressed interest in increasing hours, student completion rates may vary, and development opportunities may arise.

6 Birthrate plus (BR+) overview.

6.1 The BR+ acuity app was implemented on MKUH labour ward in April 2022, and we have also commenced the use of the antenatal and postnatal ward acuity app in December 2023.

6.2 BR+ acuity app enables electronic collection of red flags, improved reporting of staffing and acuity metrics. The acuity app is completed every 4 hours on the labour ward and 6 hourly (4 times a day) on the ward acuity app.

6.3 The service has maintained the requirement that the labour ward coordinator is supernumerary as detailed below in table 5, for the past six months compliance has been achieved near 100%. Exceptions in 2 of 6 months are accounted for by allowances detailed in the guidance - CNST compliant – not regular (more than once a week) not providing 1:1 care in labour.

Table 5

Month	% Supernumerary (Labour ward coordinator)
October	100
November	99.37
December	100
January	100
February	99.3
March	100

6.4 The RAG rating for acuity on the labour ward is detailed in Table 6. The RAG rating within BR+ is classified as: **Red** – 2 or more midwives short, **Amber –** up to 2 midwives short, **Green** – Meets acuity.

Table 6

Month	Red %	Amber %	Green %
October	2	26	72
November	6	33	61
December	3	28	70
January	2	34	64
February	1	29	70
March	3	31	66

6.5 The compliance with completing the BR+ acuity tool for Labour Ward is detailed in table 7. Due to ongoing development work being undertaken by the BR+ team historical reporting forward areas is extremely limited to daily views.

Table 7

Month	Labour ward
October	84.5%
November	86.3%
December	82.7%
January	81.5%
February	79.5%
March	83.3%

6.6 The suggested level of compliance with BR+ is over 85%, this is to ensure that there is confidence in the data recorded. Over the past 6 months the BR+ acuity app on the labour ward has only achieved this threshold once in the 6months.
Data for the ward acuity app is currently unavailable for this period due to ongoing develop of the app by the provider (BR+).

7 Next Steps

7.1 The trust will continue with current recruitment strategy, to improve the overall staffing position in line with BR+.

7.2 Other areas of focus need to be:

- Improvement of data shared via the PWR with the regional and national teams in relation to midwifery staffing, ensuring that information is consistent.
- Improve compliance with the BR+ acuity app to over 85% as a constant.
- Rebuild of rosters in relation to the working pattern and the allocated midwifery hours.
- Ensure that all midwifery hours are allocated to the clinical areas, using BR+ acuity app to inform allocation.
- Monitor recruitment to ensure that it remains on Trajectory.
- Review of data in relation to fill rates as roster builds - identifying areas of improvement that impact fill rates such as sickness rates and non-compliance to meet KPI in relation to roster management.
- Undertake a full-service BR + review prior to October 2024 to ensure midwifery workforce is assessed prior to FY 2024/2025-year end.

8 Asks of the Board or of members present

The board is requested to take assurance

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

Chief Executive: Joe Harrison

Acting Chair: Heidi Travis

Meeting Title	**Trust Board**	**Date: 4 Jul 24**
Report Title	**Annual Falls Prevention and Management Report 2023/24**	**Agenda Item Number: 9**
Lead Director	Steven Beaumont- Chief Nurse	
Report Author	Deepa Austin - Associate Chief Nurse / Maria Munoz Vazquez- Falls Prevention Lead	

Introduction	*Purpose of the report e.g. Statutory/Assurance*		
Key Messages to Note	The Trust annual report on inpatient falls prevention and management highlights the importance of reducing the incidence of falls among patients. Falls can result in serious injuries, prolonged hospital stays, and increased healthcare costs, making fall prevention a critical component of patient safety. MKUH recorded 1,041 inpatient falls during the reporting period of which 1,038 (96.9 %) were no or low harm events and 27 (3.1 %) were moderate harm or above. The report outlines the various strategies employed by the Trust to prevent and manage inpatient falls. These include identifying patients at risk, assessing the patient's environment, implementing appropriate interventions, and educating patients, families, and healthcare staff. The report emphasizes the importance of conducting regular fall risk assessments and addressing environmental hazards promptly to prevent falls. The report concludes that by implementing a fall prevention quality improvement programme designed to reduce the incidence of falls, improve patient outcomes, and promote patient safety. Plan to refresh the Quality Improvement programme is also outlined in the report.		
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)*	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. *Spending money well on the care you receive* 7. *Employ the best people to care for you* 8. *Innovating and investing in the future of your hospital*

Appendices/Attachments	

Annual Inpatient Falls Report 2023/2024

Introduction

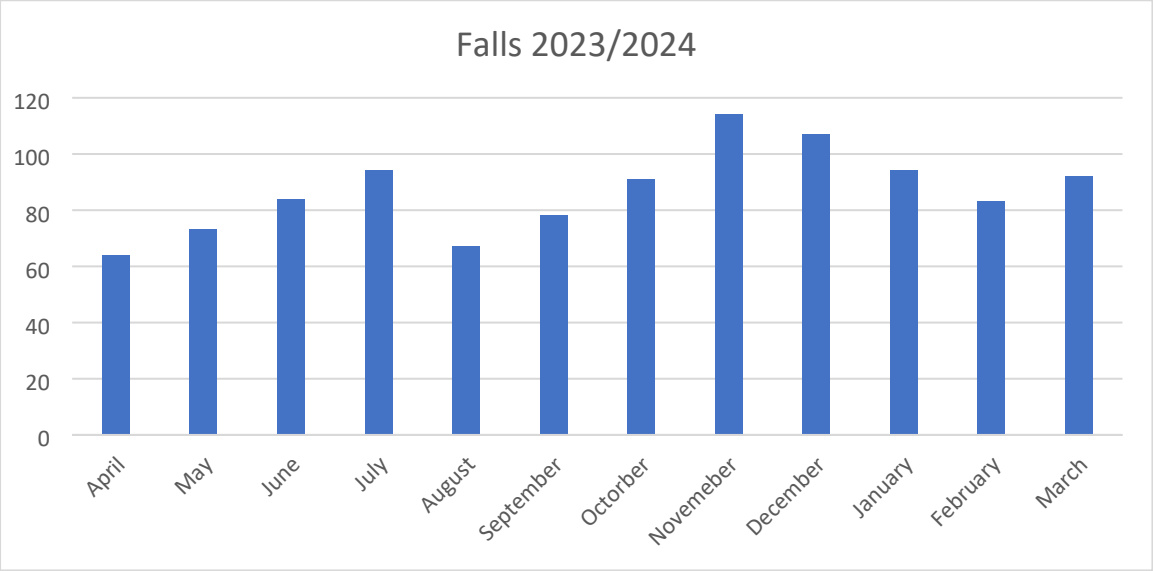
Inpatient falls are a significant concern, with potential outcomes including severe morbidity and, in extreme cases, mortality. Over the past year, the NHS has reported an increase in the incidence of falls, highlighting the urgent need for effective preventive strategies. By adopting a multifactorial approach to fall prevention, we can enhance patient safety and reduce the frequency of falls. At MKUH, we take patient safety seriously and continuously work to ensure that our facilities prioritise falls prevention measures.

The purpose of this report is to provide an annual analysis of inpatient falls at Milton Keynes University Hospital (MKUH). The report provides information on the number and location of falls, as well as the categories and levels of harm. The report summarises the work of the Trust-wide falls prevention and management programme.

Incidence of Inpatient Falls at MKUH

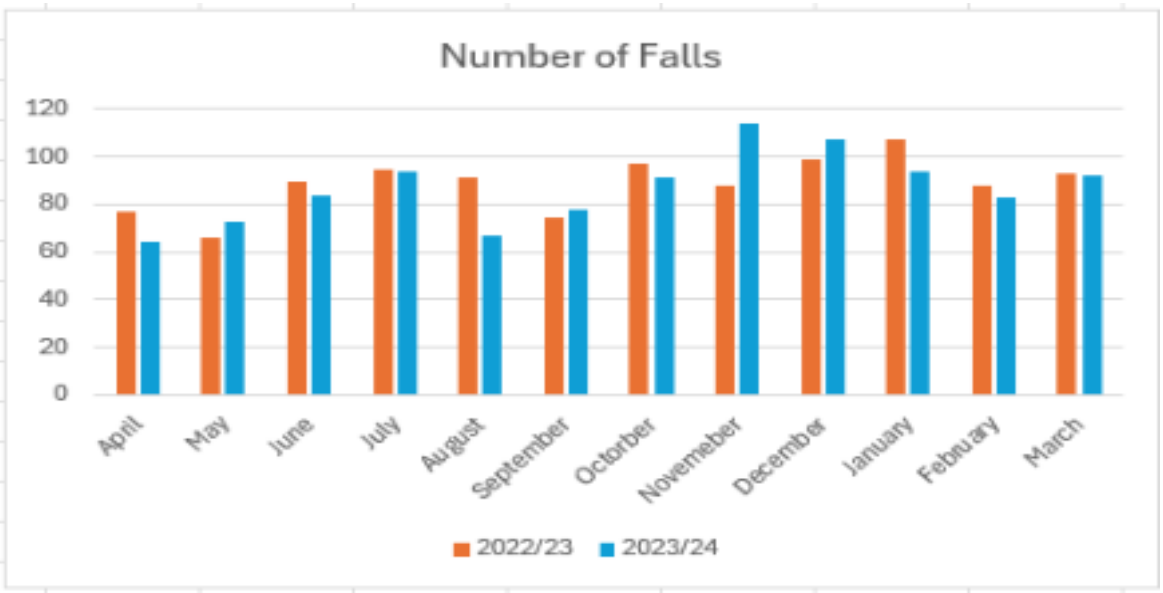
MKUH recorded 1,041 inpatient falls between April 2023 and March 2024 of which 1,038 (96.9 %) were no or low harm events and 27 (2.6 %) were moderate harm or above. Of the total falls reported, 829 (79.6%) involved patients over the age of 65,who are classified as high risk of falls.

Figure 1 below provides a breakdown of the number of inpatient falls by month. The highest number of falls were reported in November and December, reflecting the additional capacity opened during the winter period.

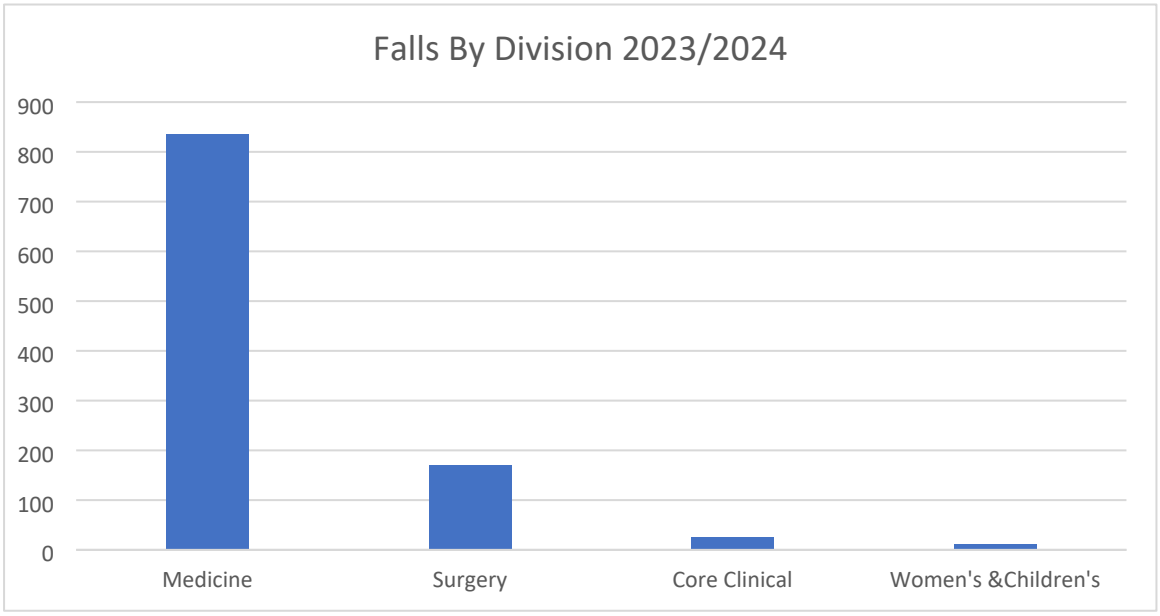


Below graph illustrates the inpatient falls per month in comparison to 2022/2023.

Figure 2

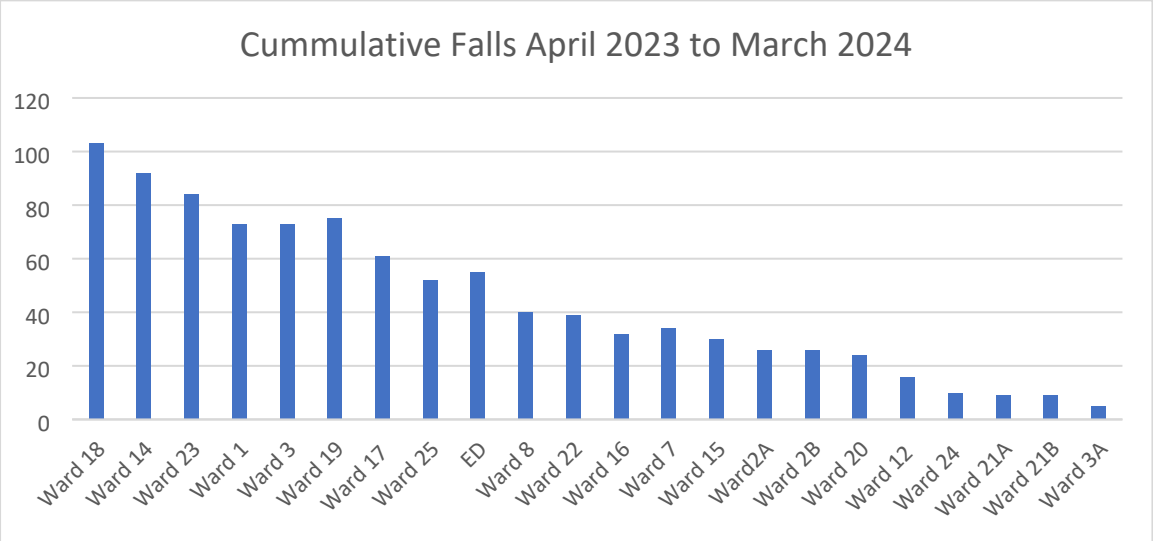


below provides a breakdown of the number of inpatient falls by Division. Medicine division reported the 835 inpatient falls.



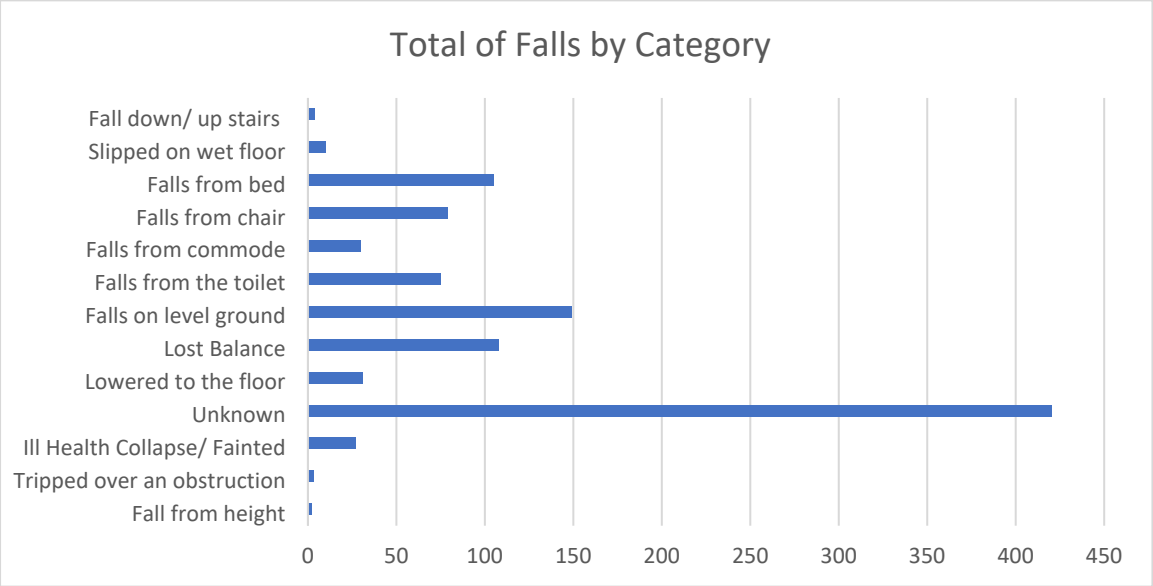
All falls regardless of the level of harm are reported through the Trust Radar reporting system. If in the event of a fall resulting in moderate harm or above a falls summit is undertaken and reported to the Serious Incident Review Group (SIRG). The aim of the summit is to assess whether the fall meets Serious Incident criteria and, more importantly, identifies and shares any lessons learned to improve future care.

Figure 3 below provides a breakdown of the number of inpatient falls by Ward in order of highest to lowest reporter.



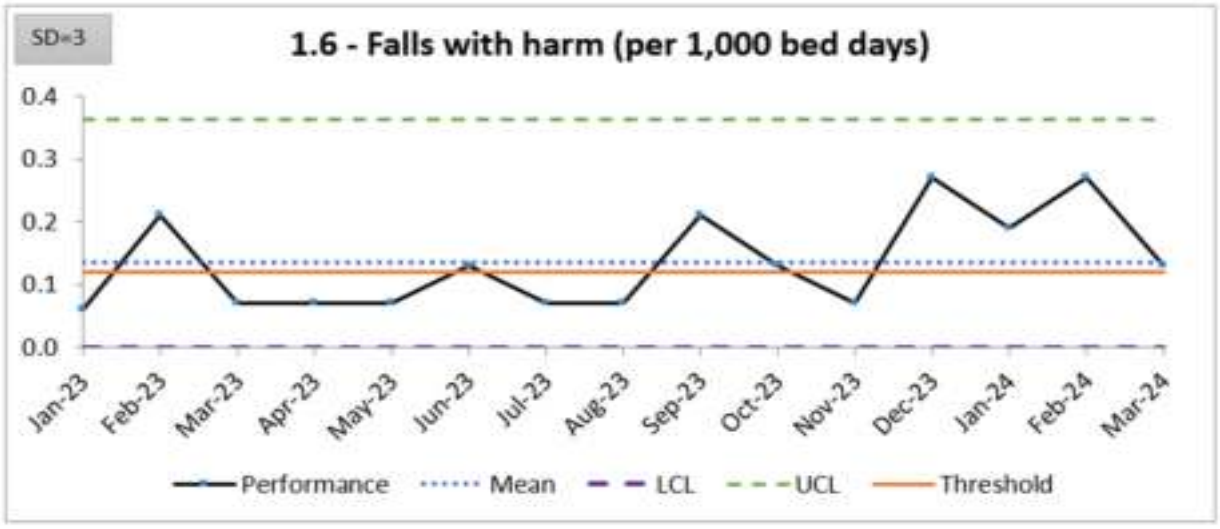
As demonstrated in the graph above, the wards with the highest incidence of patient falls are as follows: Ward 18 (a male general medical ward), Ward 23 (a Trauma and Orthopaedic ward), Ward 14 (a mixed-sex rehabilitation ward), Ward 19 (a mixed-sex general medical ward), and Ward 1 (a Medical acute admissions unit).These five wards collectively account for 40.1% of all falls that occurred during the period under review. It's noteworthy that each of these wards has a significant number of patients who are at an elevated risk of falls, attributable to factors such as limited mobility, cognitive impairment, and being over the age of 65. This information is crucial to target the interventions effectively.

Figure 4 below shows a breakdown of the number of inpatient falls by category. Among these, 420 incidents were reported as unknown, accounting for 40% of the total falls. These incidents were unwitnessed, and patients were unable to recall the mechanism of their falls. However, this represents a 27% reduction in unwitnessed falls compared to the previous year.



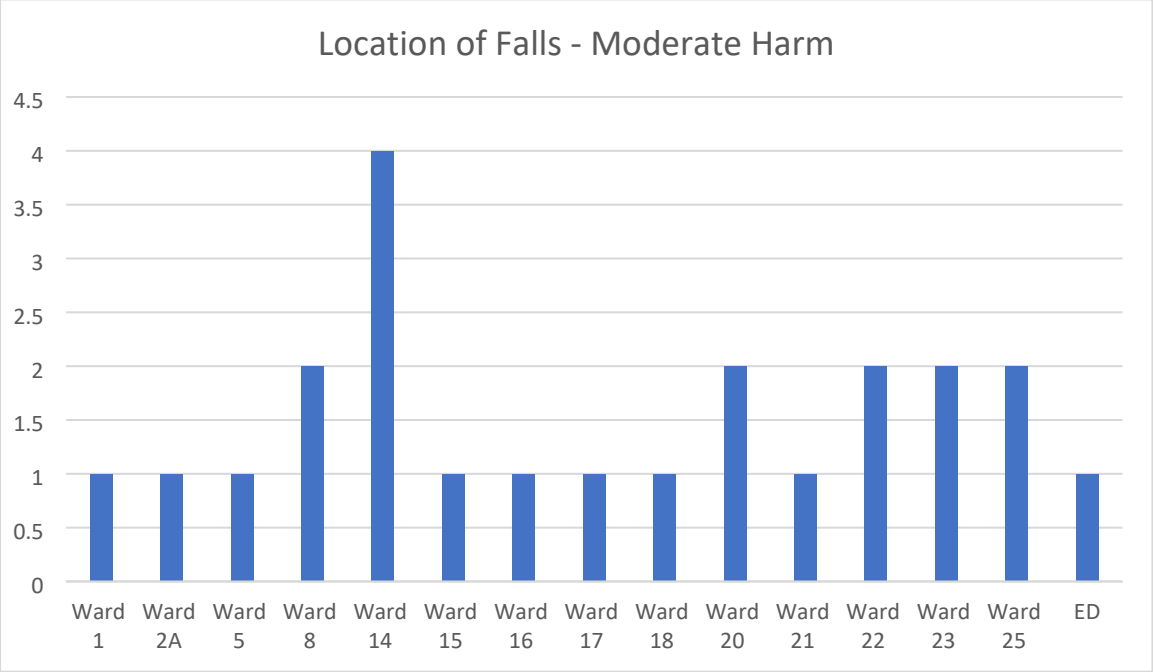
There is an ongoing focus to reduce the number of unwitnessed falls by implementing Bay-Based Nursing and strategically placing equipment such as Workstations on Wheels (WOWs) to maximize patient visibility. Additionally, a Baywatch Project was launched on Ward 14 to ensure constant supervision of high-risk patients.

Figure 7 shows SPC chart Falls with Harm per 1,000 bed days January 2023 to March 2024

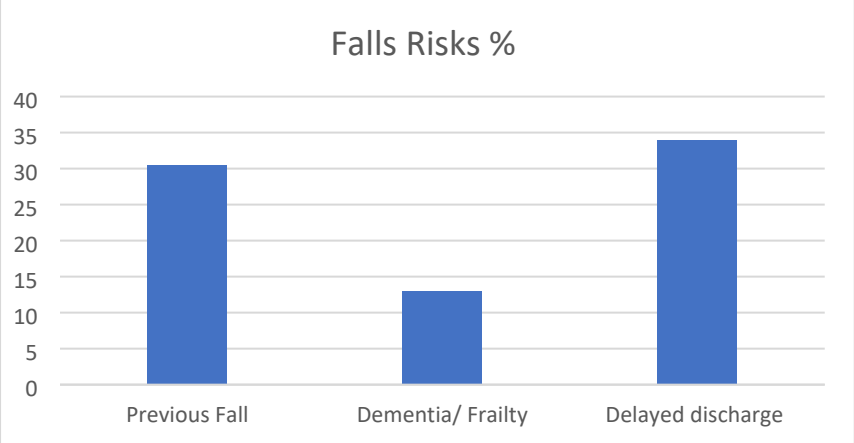


Number of falls with harm per 1,000 bed days have remained between 0.3 and 0.08 most months. The moderate/major harm incidents resulted in haemorrhage, fracture neck of femur, other fractures. There were 6 deaths associated with complications following the fall. All deaths following a fall at hospital are referred to Coroner to review the need for an inquest.

Figure 8 shows incident of Moderate level of harm by location



Analysis of Moderate falls – known risk factors



Note that some patients fulfil more than 1 risk factor.

- Of the patients who sustained moderate harm following an inpatient fall, 30.5 % had a diagnosis of having fallen previously. A history of falls is one of the strongest risk factors, a person who has fallen in the previous year has a significant risk of falling again.

- 13% of patients who sustained moderate harm from a fall in hospital were identified as having a cognitive impairment. Dementia and delirium are known to increase the falls risk with frailty also associated with a higher risk of falls and a risk of greater harm as an outcome from a fall.

- Patients who wait in hospital for a discharge plan to be arranged or commence are at greater risk of harms, one of which is decreased mobility and associated falls. 34% of those patients who sustained moderate harm from a fall were awaiting a package of care/discharge plan.

Key learning from Moderate incidents

- **Enhanced Care Policy:** all members of the clinical team should know the details of each patient under the care of this policy with a clear understanding of their behaviour profile and the action plan to reduce the risk of harm from falling, involving the family wherever possible. Baywatch is a patient safety initiative, and a MDT approach, recently implemented by MKUH to reduce the risk of inpatient falls. It involves continuous supervision of patients in a bay who are at high risk of falling, particularly those who have cognitive impairment, mobility issues or recovering from surgery. Dedicated staff members are assigned to watch over these patients, assist them with movement, and ensure their safety. The goal is to prevent falls and the patient experience by providing immediate support and intervention when necessary.

- **Patient acuity**: the combined acuity and dependency of all patients within a clinical area will impact on the capacity and availability of nursing and support staff – utilisation of SafeCare to ensure accurate analysis to inform staffing levels and skills.

- **Ward orientation:** patients should be orientated to the ward or clinical area to ensure they know the direct route to the nearest toilet. Improvement and implementation of signposting should be considered as a potential strategy to prevent falls on those with visual impairment and/or cognitive impairment.

- **Patient education:** patients and families should be given the falls prevention leaflet with a discussion on best practice to prevent falls during admission to hospital.

- **Clinical documentation:** contemporaneous documentation wherever possible will increase accuracy and improve the opportunity to identify learning.

- **Post-falls management:** completion of the post falls checklist supports systemic and comprehensive management of the patient and enhances the communication within the clinical team.

Serious Incident(SI)

Two of the incidents were reported as SI and the learning from the incidents were incorporated into the quality improvement programme.

Trust wide falls prevention Quality Improvement programme

The Quality Improvement programme is spearheaded by the Lead Nurse for Falls Prevention, who was appointed in February 2023 on a twelve-month fixed-term contract. This initiative is backed by the Associate Chief Nurse and quality improvement team. This team is dedicated to implementing strategies and measures to prevent falls and improve patient safety. Their work is crucial in our ongoing efforts to enhance the quality of care we provide**.**

Training and Education: e-learning package is accessible to all staff via ESR. This training is in the process of been revised. Further face- to-face Falls Awareness and Management training sessions and ward-based workshops have additionally been implemented by the Falls Prevention Lead across the Trust. There is also a university accredited frailty module available for nursing staff to attend that is designed and delivered by the frailty team, focusing on the prevention of deconditioning to support the independence of frail patients reducing their risk of harm, including falls.

Falls prevention measures: Ward performance against the completion of a Falls assessment and Falls Care Plan within 6 hours of admission is monitored in real time using Business Intelligence (BI) and audited via Tendable (audit tool) reporting into the Ward performance process. In order to comply with National Guidelines and National Audits the Falls Action Steering Group, which has recently been re-launched in February 2024, is working in the implementation of a Multi-Factorial Risk Assessment (MFRA) tool to facilitate the early identification of those at risks of falls at the Emergency Department as the first point of contact. This assessment must be reviewed on admission to the ward and re-assessed weekly, after an inpatient fall, patient's condition changes, or after ward transfers. The same process applies to the Falls Care and Management Plan and Post Fall Care Plan (on e-care). In addition, Lying and Standing Blood Pressure Project has been focusing on the early identification and intervention for those with orthostatic hypotension, one of the main risk factors for falls in the Trust.

Falls prevention policy and procedure: the falls prevention and management policy is currently under review (for approval at TEC in June 2024) by a multiagency group seeking to produce a policy that reflects national guidance and is fit for purpose.

Next Steps

Falls prevention is a quality priority for 2024/25. A refreshed Quality Improvement programme will aim to reduce the number of unwitnessed falls with a focus on:

- Digitalised Multifactorial Risk Assessment
- Focused education on Post Fall Assessment
- Falls prevention and management training.
- Alignment of falls incidence with PSIRF process

Conclusion

Reported inpatient falls at MKUH have slightly decreased by 1% compared to the previous year. The highest incidence of falls was in November and December. Moreover, the highest number of falls occurred after breakfast (09:00 to 12:00) and after lunch (14:00 to 15:00).

This paper has detailed the incidences of reported inpatient falls for the year 2023/2024, provided an analysis of the falls with moderate harm alongside the key learning and detailed the falls prevention programme and next steps. Overall, the report provides valuable information on the main mechanism of inpatient falls at MKUH to implement different measures to prevent and manage them. This progress report is an essential resource for those interested in the safety and well-being of patients at the hospital.

Recommendations

The Committee is asked to note the contents of this report.

Meeting Title	**Trust Board**	**Date: 4th July 2024**
Report Title	Hospital Acquired Pressure Ulcers Annual Report	**Agenda Item Number: 9**
Lead Director	**Steven Beaumont -Chief Nurse**	
Report Author	Deepa Austin- Associate Chief Nurse	

Introduction	*Purpose of the report e.g. Statutory/Assurance*		
Key Messages to Note	This provides an overview of the Pressure Ulcer Annual Report which highlights the prevalence, impact, prevention, and management of Hospital Acquired Pressure Ulcers (HAPU) at MKUH between April 2023 and March 2024. A total of 213 Hospital Acquired Pressure ulcers were reported this year. This represents a 51.5% reduction compared to 2023/24. Pressure ulcer prevention and management remained a key focus for this year. The data presented in this report provides valuable insights into the effectiveness of current prevention and management strategies and quality improvement activities. This report emphasises the collaborative approach involving a multidisciplinary team establishing a sustainable process in reporting and validating pressure ulcers, reviewing, and learning from incidents, resulting in a downward trend in the total number of pressure ulcers. By continuing to analyse and monitor care delivery and implementing evidence-based interventions, the Trust aims to sustain the improvement achieved so far with a refreshed Quality improvement programme. .		
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)*	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. *Spending money well on the care you receive* 7. *Employ the best people to care for you* 8. *Innovating and investing in the future of your hospital*

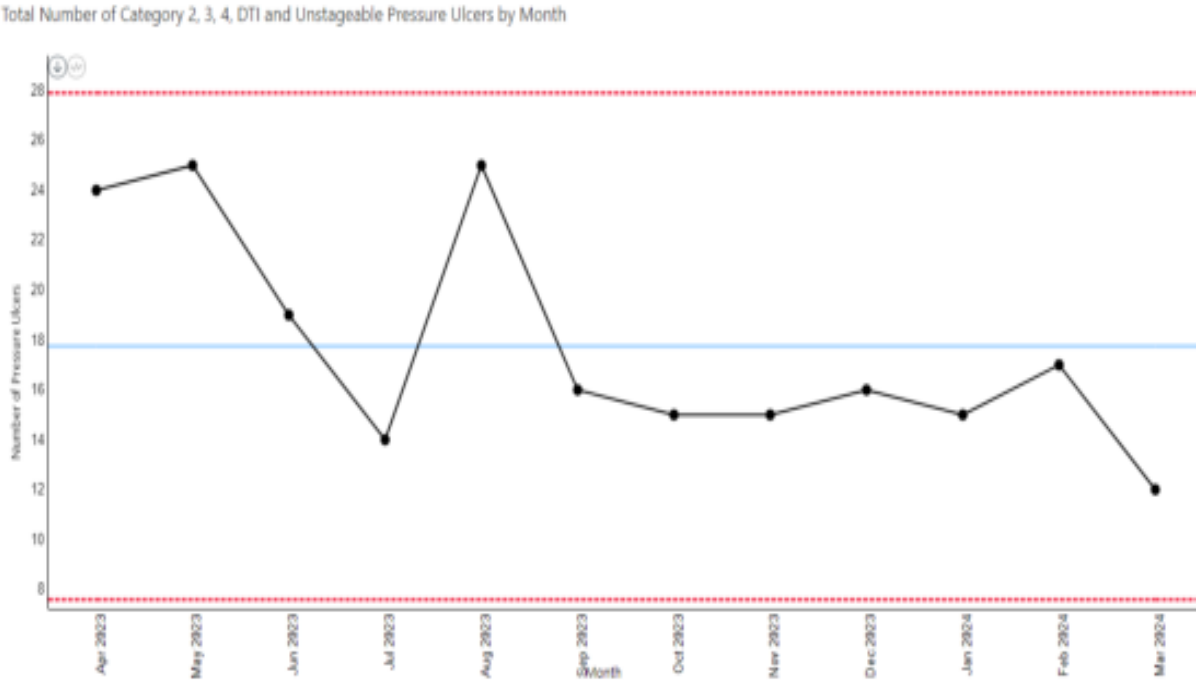
Appendices/Attachments	

Introduction

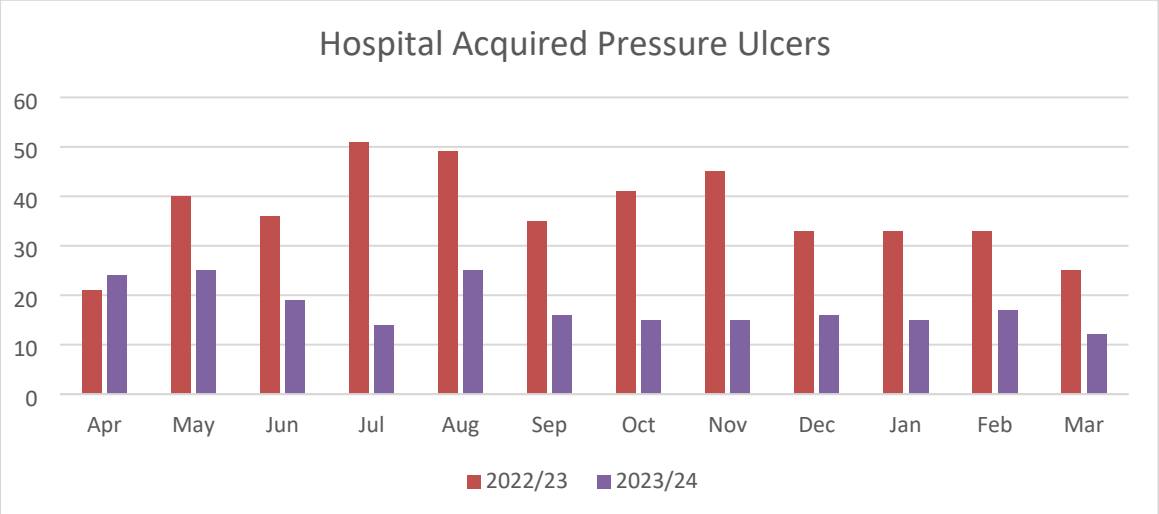
Milton Keynes University Hospital is dedicated to delivering high quality care to its patients. A crucial part of this dedication involves preventing and managing hospital-acquired pressure ulcers (HAPUs). These pressure ulcers are frequent in healthcare settings and can result in patient complications and higher healthcare expenses. This annual report reviews the incidence of pressure ulcers at the Trust from April 2023 to March 2024. It also emphasizes the advancements made in reducing, preventing, and managing HAPUs, and details the continuous efforts to further reduce hospital-acquired pressure ulcers.

Incidence of HAPU at MKUH

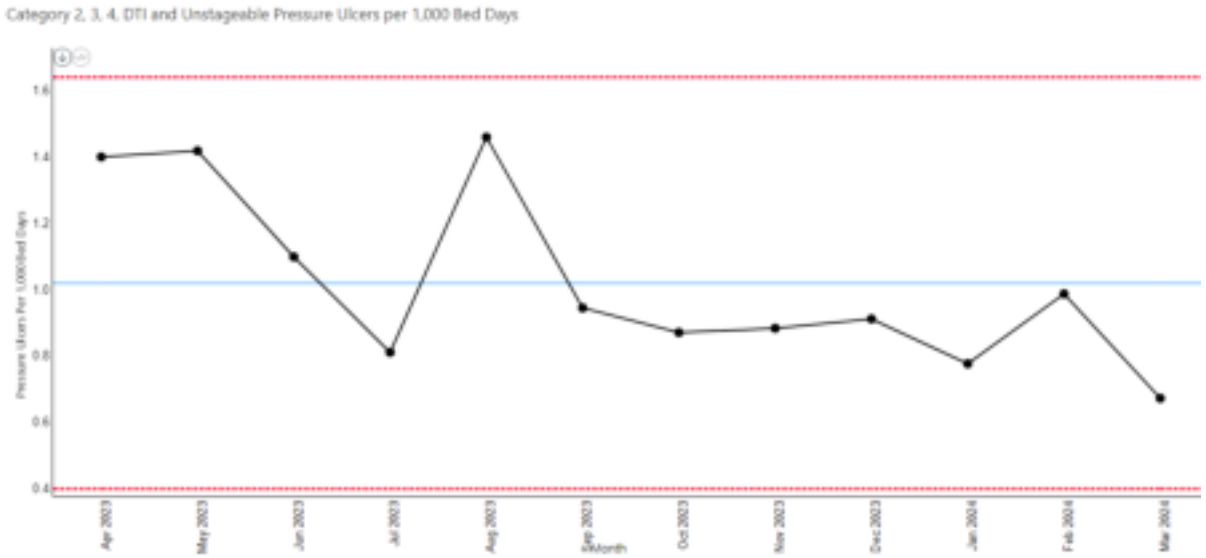
Between April 2023 and March 2024, there were 213 reported hospital-acquired pressure ulcers (HAPUs) across all categories, including categories 2, 3, and 4, Deep Tissue Injury (DTI), and unstageable ulcers. This represents a 51.5% reduction in HAPUs compared to the previous year. The graph below illustrates the total number of hospital-acquired pressure ulcers by month. As shown in the chart, the Trust has maintained a steady decline in the incidence of HAPUs.



The graph below shows the number of hospital acquired pressure ulcers by month in comparison to 2022/23.



The Trust has also experienced a decline in the number of HAPUs per 1000 bed days. Tracking pressure ulcers per 1000 bed days is a standard method to monitor the incidence of HAPUs, allowing for more accurate comparisons and benchmarking of performance despite fluctuations in the number of escalation beds. The graph below shows a steady decline from 1.5 HAPUs per 1000 bed days in August 2023 to 0.7 HAPUs per 1000 bed days in March 2024. Notably, this is a sustained reduction from 4 HAPUs per 1000 bed days in August 2022.

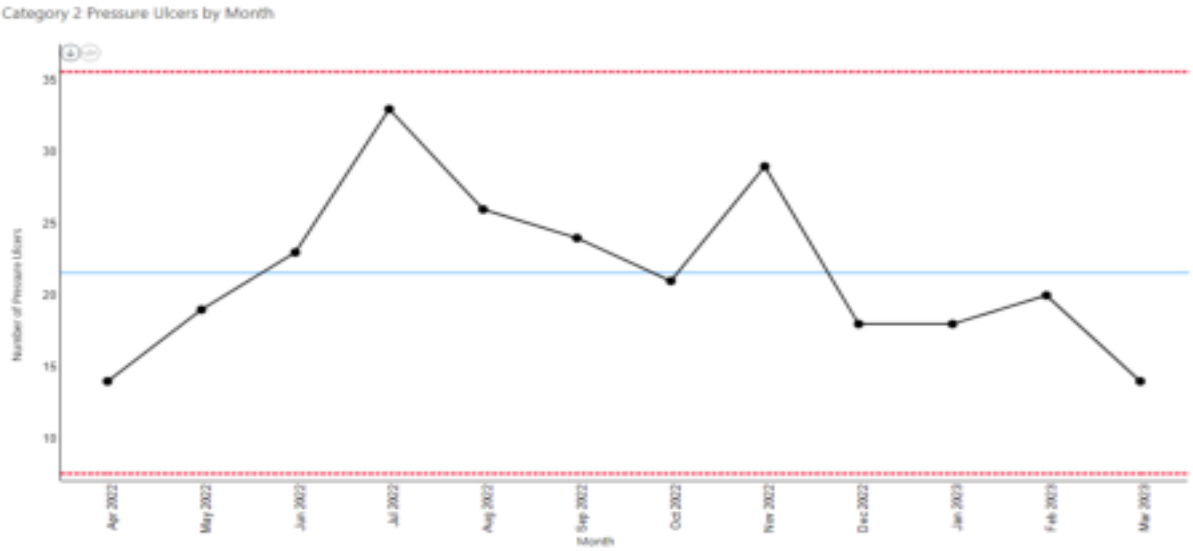


Incidence of Hospital-Acquired Pressure Ulcer by Category

Hospital-acquired pressure ulcers (HAPUs) are categorised on their severity based on the National Pressure Ulcer Advisory Panel (NPUAP) staging system.

Category 2

Category 2 pressure ulcers are the most frequently reported pressure damage. There were 126 hospital acquired category 2 pressure ulcers during the reporting period. This is a reduction of 51% in category 2 pressure ulcers in comparison to 2022/23.



Category 3 Pressure Ulcers

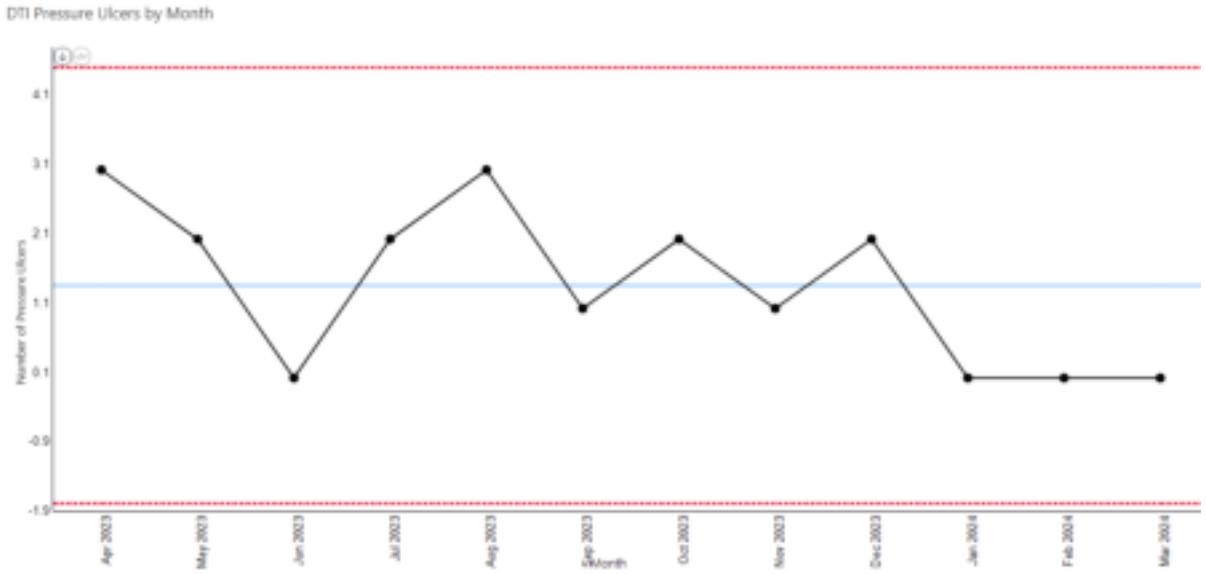
A Category 3 pressure ulcer involves full-thickness tissue loss. During the reporting period, there were 40 Category 3 pressure ulcers. This increase is attributed to more accurate categorization of pressure ulcers. After Action Reviews were conducted and discussed at the Care Review and Learning panel. The main issue identified from these reviews was a delay in recognizing the deterioration of the pressure ulcers. Wards with Category 3 pressure ulcers are holding quality summits to ensure that improvement actions are monitored and documented.

Category 4 Pressure Ulcers

There were no category 4 pressure ulcers reported this year.

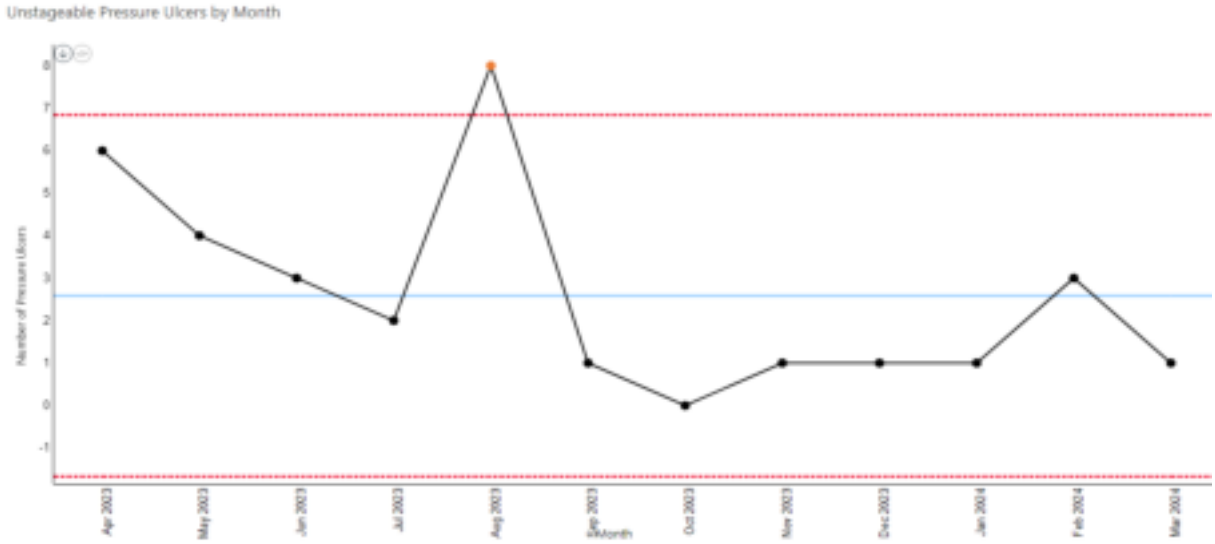
Deep Tissue Injury (DTI)

A deep tissue injury (DTI) is a type of pressure ulcer that starts beneath the skin's surface and progresses outward, often appearing purple or maroon. This year, there were 16 reported DTIs, marking an 89% reduction compared to the previous year.



Unstageable Pressure Ulcers

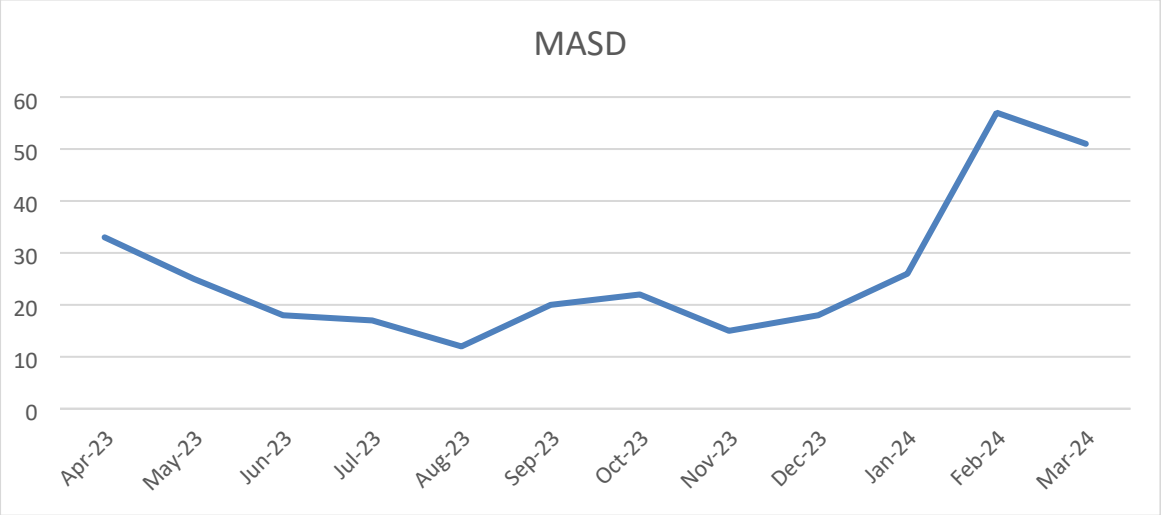
Unstageable pressure ulcers occur when the wound's depth cannot be determined. The Trust started the process of categorising unstageable pressure ulcers in December 2022.There were 31 unstageable pressure ulcers reported in 2023/24.



Moisture Associated Skin Damage

Below graph demonstrates the number of Moisture Associated Skin Damage (MASD). MASD can develop due to incontinence, intertriginous dermatitis caused by skin friction facilitated by moisture trapped in skin folds or wound moisture associated dermatitis.

There has been a steady increase in the number of MASD reported. A quality improvement programme has been initiated to reduce the number of MASD.

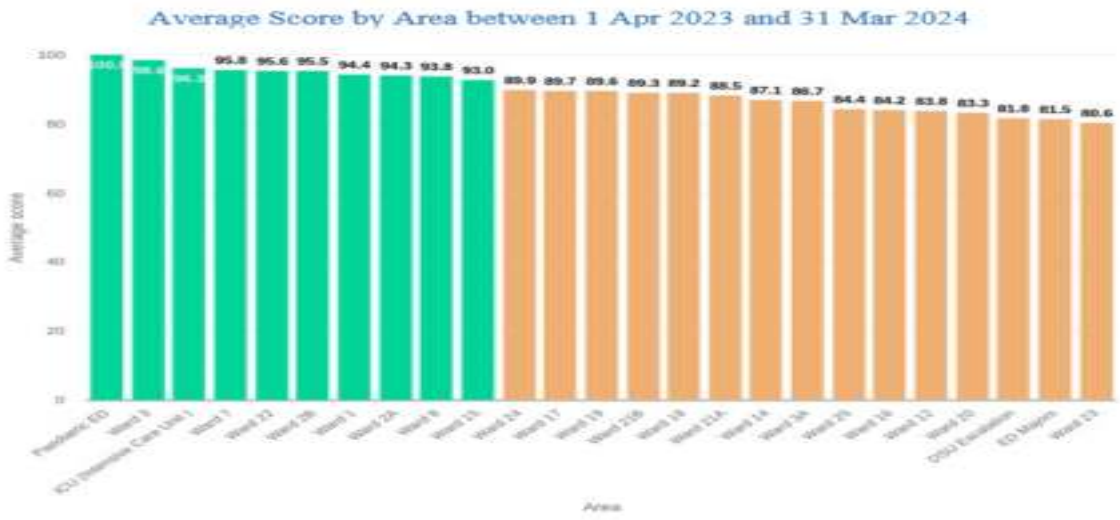


Safeguarding Referrals

There were eleven safeguarding inquiries regarding hospital-acquired pressure ulcers during the reporting period. Out of these four incidents were substantiated as safeguarding concerns due to gap in care and two were partially substantiated, The learning and actions from the investigation are being incorporated into the quality improvement actions.

Adult Inpatient Metrics: Pressure Ulcer Prevention and Management

Each inpatient wards are expected to complete 10 Pressure Ulcer Prevention and Management audits every month. 1702 inspections were completed during the reporting period and the average score was 89.8%.
The below graph demonstrates the average score for individual wards for the reporting period.



Individual area has action plans to improve the audit outcomes which is monitored at divisional level.

Pressure Ulcer Prevention Improvement Plan

The trust continues to focus on training on the prevention and management of pressure ulcers.

Education and Training

The trust continues to focus on training on the prevention and management of pressure ulcers.

- Compliance with E-learning- The overall compliance for Wound Care Essentials (Tissue Viability) is 95.8%
- The ‘Stop the Pressure’ campaign was conducted in November and captured 117 members of staff across the Trust during the week, with a mixture of trolley dash across the wards and a day of workshops in the Tent.
- The TVN link champion training programme launched in February and 30 champions have been appointed from different wards.
- Champions competency booklet has been devised.

Medstrom Aria Flex Bed Training

A training program has commenced on managing and using Aria Flex Bed and the advanced semi-dynamic support for all staff. To date, 1181 staff have been trained. Training on Medstrom beds will be included as part of the manual handling, as profiling and positioning on beds support pressure ulcer prevention.

Infrastructure and Culture

- **Improved Tissue Viability Triage and Diagnostic Support**

Tissue Viability Specialist Nurses validate all HAPUs to ensure consistent and reliable categorisation and early intervention and treatment. The Radar incident reporting system has also been adapted to record the pressure ulcer category after validation. All Category 3 and above pressure ulcers have joint review by tissue viability nurse and ward nurses to identify learning.

- **Care Review and Learning Panel**

A HAPU incident review process has been established. The new approach involves Ward Managers and Matrons conducting an after-action review (AAR) for rapid learning and identifying opportunities for improvement in all HAPUs. The AAR is discussed at the Care Review and Learning Panel and chaired by the Associate Chief Nurse. The themes and learning from the discussions are shared, and improvement actions are agreed upon. Work is ongoing on the Radar reporting system to simplify the process and evidence following the after-action reviews. Care Review and Learning Panel reports to Harm Prevention Group and Patient Safety Board. This process will be reviewed in line with implementing the Patient Safety Incident Response Framework (PSIRF).

- **HAPU Data Collection and Measurement**

Weekly and monthly data is now available on the Trust information portal, and it is reported on the Trust Board scorecard as the number of pressure ulcers per 1000 bed days. This facilitates more accurate benchmarking and comparison with peer organisations. All clinical areas receive a weekly update on the number and category of HAPUs. These reports provide information on trends and a weekly SPC chart indicating deterioration and improvement.

- **Pressure Area Care and Prevention Audit (Tendable)**

The pressure ulcer prevention and management audit tool has been implemented in all inpatient wards. These are in line with Nice Guideline, and these revised and more detailed audits will improve pressure ulcer care and prevention oversight and enable more effective ward-based and Trust-wide improvement actions.

Care Delivery and Standards

- **Incontinence Management**

Continence assessment and appropriate use of incontinence products are paramount to pressure ulcer prevention and management. Improved product selection, education, and training have been implemented and continue to be rolled out across all clinical areas. Continence assessment pathway have been developed in eCare.

- **Patient and Family Involvement**

A patient and family information leaflet on pressure ulcer prevention and management has been implemented trust wide.

Improved Tissue Viability Service

The Trusts Tissue Viability service provides clinical and non-clinical support services through Tissue Viability Specialist Nurses (TVN). The service received approximately 3000 referrals this year, including pressure ulcers, leg ulcers, and complex wound management. In addition to this, the service also provides support in:

- Education across the organisation on skin damage prevention and intervention.
- Education on complex wound management.
- Production and updating of wound formulary.
- Advice on clinical aspects of bed contract
- Coordination and delivery of national tissue viability programs.
- Expert advice on serious incidents (SI) investigations and outcomes.
- External network links – representing the Trust and educating on new initiatives.
- Management of Vacuum Therapy for the Trust

Next Steps

- Align pressure ulcer incidence review process with PSIRF.
- Refresh the Quality Improvement programme.
- Continue the focus on MASD.
- Standardise the pressure ulcer risk assessment and management in the Emergency Department.
- Revitalize the End PJ Paralysis initiative to prevent patient deconditioning.

Conclusion

In conclusion, preventing and managing hospital-acquired pressure ulcers (HAPUs) remains a priority for the organisation. While the Trust has made significant progress in reducing the incidence of pressure ulcers, there is still room for improvement. The data presented in this annual report provides valuable insights into the effectiveness of current prevention and management strategies and quality improvement activities. By continuing to analyse and monitor care delivery HAPU data and implementing evidence-based interventions, the Trust can further reduce the incidence of HAPUs and improve patient outcomes. The Trust remains committed to this important goal and will continue to work towards reducing the incidence of HAPUs over the next year.

Recommendations

The Committee is asked to note the progress with the improvement program outlined above.

Meeting Title	Trust Board	**Date: July 2024**
Report Title	Maternity Assurance Group	**Agenda Item Number: 10**
Lead Director	Ian Reckless/Steve Beaumont	
Report Author	Elaine Gilbert – Divisional Chief Midwife	

Introduction	The Maternity Assurance Group (MAG) was established in response to the publication of the Final Ockenden Report. Its purpose is to act as a reporting mechanism to the Trust Board and is responsible for overseeing, evaluating, and assessing the quality, safety, and effectiveness of maternity services.
Key Messages to Note	The areas discussed and reviewed at MAG for April 2024 and May 2024 are summarised below: Standing items included the following: • The Maternity Governance Report • Perinatal Quality Surveillance Model updates • Clinical Negligence Scheme for Trusts (CNST) - Maternity Incentive Scheme Year 6 • Ockenden Assurance • Workforce – obstetric / neonatal / midwifery / neonatal nursing MAG received the following reports: **1. Perinatal Quality Surveillance Model (PQSM)** The PQSM is a quality oversight tool that seeks to provide consistent and methodical oversight of maternity. The items summarised below were discussed as part of the PQSM report. a. There were 3 moderate harm incidents for the reporting (April 2024); 2 cases were awaiting review. One case was related to a gynaecological outpatient appointment and verbal abuse to staff. In May 2024 there were 2 moderate incidents (one was still awaiting review). b. The current status all ten actions for MIS were reported; 4 actions are currently on trajectory to be met, with 6 on track but key actions identified. c. MAG received an update on the levels of training compliance by staff group or the areas summarised below: I. Maternity Emergencies: 92% (Midwife 96%, Maternity support Worker /Maternity Care Assistant 95%, Obstetric staff 90%, Anaesthetists 75%). II. Fetal Monitoring: 98% (Midwives 99%, Obstetric staff 94%). III. iNeonatal Life Support: 94% (Midwife 92%, Paediatric Consultants 100%, Paediatric other 77%, Advanced Neonatal Nurse Practitioner 100% and Neonatal Nurses 28%).

IV. GAP GROW/Saving Babies Lives: 89% (Midwife 91%, Obstetric 81%)
V. PROMPT: MAG noted a further decrease in PROMPT cover in April 2024, with Anaesthetics dropping a further to 5% to 75%.

2. Perinatal Mortality Review Tool

The quarterly (January – March) PMRT report was presented in April 2024 MAG meeting. The quarterly reported identified that in January No Cases were reported.

In February two cases were reported; one which was a 24+2 Neonatal Death, placental abruption and extreme preterm birth. And the other was a 39+6 stillbirth with no clear clinical cause findings from the post-mortem waited and in March one case which was a 29+0 Neonatal death at 9 hours old, following a preterm birth complicated by established sepsis at birth. This case is a coroner's case.

The quarterly report also reported one Maternal Death in February due to suicide 4 at months post-natal.

The May 2024 PMRT report presented that is April there were no cases eligible for MBRRACE or PMRT in April, however there were 8 losses under 22 weeks

3. CQC picker action plan / CQC recommendations

The CQC action plan was presented in April 2024 MAG. The CQC Picker Maternity survey 2023 was reviewed with the MNVP to identify areas of improvement. The plan includes outstanding actions/ progress from the 2022 survey and any other actions related to service user experience in response to feedback/ complaints.

The 2023 survey identified areas for improvement including, pain management in labour and birth, support in labour when worried, infant feeding, personalised plans of care and awareness of information.

Since 2022 two areas were identified as areas that had seen a downward trend in user satisfaction and need some focused actions, these were accessing a midwife and feeling listened too.

Additional themes within the free text of the survey report were identified around inpatient care on ward 9.

The QIPP action plan has been updated to reflect the feedback from the survey, including the themes identified by the MNVP. The 2022 and 2023 actions are highlighted separately on the QIPP in addition to actions.

4. 60 steps regional Maternity review.

The Sixty Supportive Steps to Safety v2 tool (SSSSv2) has been updated, and is a tool intended to provide support to Trusts to feel confident that their maternity services are improving safety outcomes and experiences for women and birthing people. National reports have unfortunately

identified similar safety themes that still need focus and attention to improve maternity services in England.

The SSSSv2 objectives are to provide the Trust with an appraisal of their compliance with national reports and safety regulations.

The report identified 21 areas where there could be improvement.
The report has been shared with the ICB and LMNS.

For oversight and monitoring, all actions will be added to the QIPP. Some actions are outside the scope of maternity leads within the suitable clinical will be identified i.e. ED and Neonatal service. Monitoring of actions will be through CSU and MAG.

5. **FASP action plan**

In November 2023, the Trust participated in a quality assurance visit regarding fetal anomaly screening.

A possible increase in babies born with unexpected anomalies was identified, and a review of cases of babies born with unexpected anomalies was conducted, including the screening pathway. After a thorough examination and assessment of compliance with the national screening programme, it was determined that no cases met the criteria for a screening incident as set by the Screening Quality Assurance Services (SQAS). The quality assurance visit also made ten improvement recommendations to be completed within 3-12 months.

A meeting with SQAS in April confirmed that all 3-month (high) actions following evidence submission were closed. A further 2 actions (standard) were closed at this meeting (1 - 12months and 1 - 6 months),1 further action is only requiring one further evidence to be submitted prior to being closed.

A date is to be confirmed with SQAS to close 6 months' and provide update on 12-month actions in July 2024.

6. **Midwifery Workforce paper**

The six-monthly staffing report was presented.
The purpose of this update is to provide the Trust board a summary for the reporting period of April in line with maternity incentive scheme recommendations (Safety Action 5). Overview of KPIs is positive to date. Sickness absence has increased in the last month up to 10%. Further exploration of reasons needed to determine best course of action.

Birth Rate + (BR+) confidence factor has improved at 87%, but to ensure data confidence this is an area of ongoing monitoring. The next full BR+ workplace assessment is required to commence in the quarter to ensure that the 3 yearly review is compliance as required by MIS.

Staffing levels reported via the PWR data set are under review to ensure consistent reporting of the maternity PWR within regional guidance.

7. Avoiding Term Admissions to Neonatal Unit (ATAIN)

The quarterly report is produced to provide an overview of the cases of term admissions to NNU, the learning and actions. It is a NHSR (MIS) requirement that this report is discussed with the maternity and neonatal board level safety champions and submitted to the Trust Board. This review brings together the data over a period to demonstrate the themes, performance and actions taken to support the reduction in avoidable admissions to NNU.

The ATAIN action plan demonstrates the actions in progress to support improvements. The Term admission during January and February (3.9%/4.6%) rate were maintained below national target of under 6% with February rate being the lowest for the year. There was an increase of term admissions in March (6.9%).

Over quarter 4, 73% of admissions were unavoidable admissions, which is an increase from the previous quarter at 67%. There was a decrease in avoidable admissions 27% from the previous quarters 44%. 54% of avoidable admissions are babies that would have been suitable for transitional care.

The leading cause for admission continues to be respiratory, which is consistent with regional data. A deep dive identified that the secondary cause for respiratory admissions was infection.

There was an increased number of babies admitted to neonatal unit in March that met the criteria for transitional care 40% which impacted the ATAIN rate for the month

8. Triage / BSOTS audit and Quality Improvement Plan

MAG was advised that there has been increased feedback from service users regarding waiting times in the ADAU/Triage area, particularly for those experiencing delays, awaiting obstetric review and pain relief.

To reduce these waiting times, a review of the ADAU/Triage area is currently underway. This review aims to identify areas for improvement and includes reviewing the service user pathway, medical and midwifery staffing, and the estate. Additionally, feedback from complaints, Radar, and Maternity and Neonatal safety investigations will be taken into consideration during the review.

9. MNSI Final report summary

Ockenden 1 report recommends that Maternity Unit send their full serious Incident reports to Board for transparency. There were 3 MNSI reports finalised by MNSI in 2024. There were no safety recommendations in the first final report received. The second final report received had 5 safety recommendations related to fetal surveillance and Triage. The third final report received had 2 recommendations related to translation services use and telephone triage.

	All three reports have associated action plans that are being monitored for their progress and completion.		
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Review** [x]

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*

Report History	Maternity Assurance Group April and May 2024.
Next Steps	N/A
Appendices/Attachments	N/A

Maternity Assurance Group (MAG)

Meeting Date:	25th April 2024	**Meeting Time:**	08:00 – 09:00
Location:	Microsoft Teams		

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

In attendance:	Alexandra Godfrey, Superintendent Sonographer (AG) Charlie Nunn, Divisional Chief Nurse, Paediatrics (CN) Elaine Gilbert, Divisional Chief Midwife (EG) Jenny Barker, Interim Operations Manager, Women & Children (JB) Dr Lazarus Anguvaa, Clinical Director, Paediatrics (LA) Lila Ravel, Risk Management Midwife (LR) Nandini Gupta, Divisional Director (NG) Natalie Lucas, Maternity Matron (NL) Paula Robinson, Imaging Services Lead (PR) Roxanne Vidal, Deputy Head of Midwifery (RV) Dr Vicky Alner, Medical Director for Unplanned Services (VA)
Apologies:	
Minute Taker:	Nicky Peddle – EA to Chief Medical Officer (from recording)

Item	**Minute**	**Action**
	Welcome and Introductions	
	Apologies noted above.	
	Declarations of interest	
	None declared.	
1.	**Minutes of the last meeting**	
	The minutes of the meetings held on 29th February 2024 were accepted as an accurate record.	
1.1.	**Action log and matters arising**	
	Action 4: Maternity designated Patient Safety Specialist (PSS) EG reported that the agreed plan of action is to utilise PSS team resource, semi funded by Maternity. To be discussed further offline. MAG to be updated in May. **Action 27: PMRT (still birth data)** Summary paper required for assurance. **Action 28: QIS** Workforce action plan to come to next meeting for oversight. Paper deferred to May.	
2.	**Review findings / updates and action plans**	

a.	CQC Picker Survey action plan CQC recommendations (Pg 11) Paper taken as read. The following additional comments were highlighted and discussed: • Areas identified for improvement: o EG reported that post-natal elements will be the most challenging due to establishment and environmental issues. o Support around infant feeding has been identified as common trend. o EG gave MAG assurance that the elements around pain relief in labour and being left alone will be addressed quickly and effectively. 1:1 care in labour is not being breached. o Action plan is being drafted and will come to MAG and LMNS next month. Actions will be monitored monthly by the MVP and brought to MAG for assurance. To include EDI perspective to ensure MVP feedback mirrors CQC action plan.	
b.	60 Steps – regionally Maternity Review (Awaiting report): EG provided a verbal update of initial feedback: • Concerns around antenatal and post-natal estates. • Concerns regarding triage, assurance was given around action plan. • Challenge around reporting of delayed incidences and feedback, e.g. delayed inductions, caesarean sections. Triumvirate clarified that the unit is reporting in line with national guidance and NICE, i.e. 2 hours from failure to admit and then administer Prostin, or 24 hours delay of CS once decision made, or 24 hours delay transferring to labour ward. • EG gave assurance that there should not be anything unexpected in the report. Any actions will be aligned with existing action plans.	
3.	**Regional/National Reports and Publications (Recent papers and changes in national guidance i.e. NICE/ RCOG/ CQC / Maternity reviews**	
a.	FASP action plan update - planned meeting 23.04.2024: EG reported that extremely positive feedback was received from NHS England around our culture and acceptance of the FASP action plan. 5 of the 10 actions completed, some ahead of schedule. Planned meeting at 7 months to sign off 6-month actions and hopefully some of the 12-month actions. NHS England acknowledged that it was their decision to change from an informal conversation to a formal QA which created the need for an action plan. EG reiterated that there is a process for raising concerns to execs and service leaders, this was also acknowledged and will be followed in future. Assurance was given that the appropriate quality metrics will be monitored internally through the quarterly Trust Screening Assurance Board. Colleagues were thanked for their hard work.	
b.	ICU final report for noting – presented at joint audit half day:	

	Cover sheet (not included in combined papers) includes key actions: 003b. MAG_28032024_Obs_I The following additional comments were highlighted and discussed: • Move towards HDU trained midwives, upskilling existing workforce rather than changing establishment. • Review ad hoc drills and skills on labour ward and educate. • JB is leading a multi professional team review cell salvage for high-risk elective caesarean sections. 3 different models have been reviewed and site visit in the pipeline to look at preferred choice. IR advised that an invitation has been extended by the CMO at Bedfordshire to visit either Bedford or Luton where cell salvage is done without additional staffing. **Action** MAG requested an update in July 2024.	JB
4.	**Staffing**	
a.	**Obstetrics** Audit of compliance with Obstetric Consultant Staffing and Role/Responsibilities on Labour Ward (October and April): NG talked to the paper circulated. The following additional comments were highlighted and discussed: • For note, 3 middle grade posts have been interviewed and offered. Active discussions around pay scales etc. are ongoing. IR confirmed there may be some flexibility around relocation, to be discussed further outside this meeting.	
b.	**Neonates' medical workforce** Compliance with BAPM over any six-month period in line with the maternity incentive scheme safety requirements: LA gave a verbal update: • The 14th Consultant has allowed for adjustments to consultant's job plans to include at least 3 weeks per year on neonatal unit. Additional workforce required to achieve the recommended 4 weeks. • Bank costs have been incurred to cover middle grade gaps due to long term sickness.	
c.	**Neonatal Nursing** Nursing workforce review has been undertaken at least once annually in line with the maternity incentive scheme safety requirements: CN gave a verbal update: • Establishment review to be reviewed in line with new standards. • Approval has been given to recruit into the TC business case; uplift of Band 7s and nursery nurses. • RN establishment: all positions fully recruited into. • QIS update will be reported to MAG in May.	

d.	**Midwifery** Six monthly midwifery staffing report (April and October): EG talked to the following highlight report, full report circulated with papers:  004d. MAG Document Cover Shee The following additional comments were highlighted and discussed: • YC requested updates around fill rates for individual areas be included in future reports for oversight and assurance, following a query from the CQC. • Data quality issue identified around regional establishment data. Meeting scheduled to address. MAG requested a retrospective local version of vacancy rate data in case there are discrepancies.	
5.	**Perinatal Quality Surveillance Model**	
a.	Governance report Update on MIS Ockenden Litigation/Claims scorecard LR spoke to the report circulated. The following additional comments were highlighted and discussed: • Specified MNSI safety recommendations to be included in report going forward. Recommendations referred to in report to be circulated to MAG today. • Women's moderate harms: INC-21211 neonatal death 29 weeks – initial enquiry with coroner ongoing, full enquiry not requested. 72-hour report submitted, and action plan created. Does not meet criteria for MNSI. Presented at SIRG circumstances not deemed to be an SI, downgraded to moderate. • Risk register: Risk no. 486 – risk increased from 8 to 16 following feedback from regional team. Following the CQC focus on post-natal ward environments and experience, risks identified/actions to be reflected as an evidence source.	
b.	Perinatal Mortality Review Tool Quarterly PMRT (Perinatal Mortality Review Tool) report (January, April, July, and October): LR spoke to the report circulated. The following additional comments were highlighted and discussed: • For information, MBRRACE grading definitions: A = no learning B = no learning that would have made a difference to the outcome C = leaning that may have made a difference to the outcome	
6.	**Avoiding Term Admissions to Neonatal Unit**	
a.	ATAIN Action Plan annually (March) ATAIN Action Plan quarterly progress report (January, April, July, and October) Term admissions to neonatal unit and learning from reviews report (January, April, July, and October)	

	LR gave a verbal overview of the report circulated. The following additional comments were highlighted and discussed: • Medusa (Injectable Medicines Guide) out of date on intranet for the management of chorioamnionitis. **Action** IR to link LR with lead antimicrobial doctor and pharmacist for resolution.	IR / LR
b.	Safety Intelligence Data Complaints themes/trends (Monthly overview and Quarterly report March / June / September / December) Monthly action log of staff feedback from safety champion's walk rounds (previous month) EG gave a verbal overview of the report circulated. The following additional comments were highlighted and discussed: • MAG requested positive feedback from service users be reported as narrative and qualitative perfective rather than quantitative.	
7.	**Mat Neo Safety Collaborative**	
	Update on current projects (March and September) • LA reported that Mat Neo Safety Collaborative meetings have been diarised monthly. Update will be presented to MAG next month. • PREM 7 data and compliance summary report to MAG next month for Board oversight, including coversheet. • YC provided a verbal 'Safety Champion' update: Band 6s on Ward 9 key issues: o appreciate the inclusion of RNs into staffing numbers but would like to see them as part of their substantive staffing model rather than bank. o Redeployment to Labour Ward	
8.	**Trust IPR Metrics**	
	Maternity – Maternity dashboard - for noting. Neonates - NNAP dashboard (July, October, January, April) - for noting. • OASI Injury in Instrumental births – Upward trend in numbers from 3.8% up to 12.5%. Data to be examined in more detail outside this meeting.	
9.	**Transitional Care Monthly update** **(Quarterly Audit Findings (January, April, July, and October)**	
	Paper was taken as read.	
10.	**Score Survey and Cultural Survey Feedback and Action plan update.** **Cultural survey and SCORE survey findings once completed work stream – and monthly updates following development of SCORE action plan)**	
	RV spoke to the paper circulated. The following additional comments were highlighted and discussed: • NHS England recommended compliance rates not achieved for Score survey, the plan is to overlay information collated from the Maternity Cultural Survey for the purpose of data quality. Internal timelines to be established for feedback to staff.	

11.	**Maternity and Neonatal Service User Feedback** **(verbal updates/quarterly Maternity and Neonatal Voices Partnership Meeting)**	
	EG spoke to the paper circulated. The following additional comments were highlighted and discussed: • In addition to the report and in line with Trust objectives, EG advised that MNVP work will tie in with 'The Bletchley Way' project to ensure cohesion with the community.	
12.	**Triage / BSOTS audit and Quality Improvement Plan** **(Monthly Audit findings for BSOTS with action plans update and quarterly reports Feb / May/ August / November)**	
	NL spoke to the paper circulated. The following additional comments were highlighted and discussed: • Obstetric availability is a challenge. NG reported that the obstetric on call team has been reorganised to improve focus on ED reviews and improve flow. MAG requested that triage be made aware of which obstetric colleagues are 1st and 2nd on call to address issues in ADAU. If standards are not met, data captured by QR code could be used to demonstrate why.	
13.	**AOB**	
	• Obstetric Ultrasound CIG report carried forward to top of May agenda. • RV gave a verbal update around the Labour ward coordinator framework. Work is ongoing to in collaboration with other partners within the LMNS around setting a baseline standard for skills and education for labour ward coordinators, identifying gaps, and supporting needs. • For note, this is Alison and Yvonne's last MAG meeting as Alison has reached the end of her term as Chair and Yvonne is moving onto pastures new. IR extended thanks on behalf of MAG for the focus and dedication shown to maternity over a number of years.	EG
19.	**Date and time of Next Meeting**	
	Thursday 23rd May 2024 @ 08:00-09:00 via MS Teams	

Maternity Assurance Group (MAG)

Meeting Date:	23rd May 2024	**Meeting Time:**	08:00 – 09:00
Location:	Microsoft Teams		

Present:	**Name**	**Job title**	**Initials**
	Heidi Travis (Chair) Ian Reckless Steve Beaumont	Chair and Non-Executive Director Chief Medical Officer and Maternity Safety Champion Chief Nursing Officer and Maternity Safety Champion	HT IR SB

In attendance:	Charlie Nunn, Divisional Chief Nurse, Paediatrics (CN) Elaine Gilbert, Divisional Chief Midwife (EG) Erum Khan, Labour Ward Lead (EK) Georgena Leroux, Maternity Service User Experience Lead (GL) Jasmine Cajee, Maternity Compliance Assurance Technical Lead (JC) Jenny Barker, Interim Operations Manager, Women & Children (JB) Lazarus Anguvaa, Clinical Director, Paediatrics (LA) Lila Ravel, Risk Management Midwife (LR) Lisa Viola, Neo-natal Matron (LV) Marsha Jones, Deputy Chief Nurse (MJ) Nandini Gupta, Divisional Director (NG) Natalie Lucas, Maternity Matron (NL) Roxanne Vidal, Deputy Head of Midwifery (RV) Vicky Alner, Medical Director for Unplanned Services (VA) Zuzanna Gawlowski, Consultant Paediatrics (ZG)
Apologies:	Alexandra Godfrey, Superintendent Sonographer (AG)
Minute Taker:	Nicky Peddle – EA to Chief Medical Officer

Item	**Minute**	**Action**
	Welcome and Introductions	
	Heidi introduced herself to the membership and welcomed all to the meeting.	
	Declarations of interest	
	None declared.	
1.	**Minutes of the last meeting**	
	The minutes of the meetings held on 25th April 2024 were accepted as an accurate record.	
1.1.	**Action log and matters arising**	
	Action 4: Action carried forward to June. **Action 27:** The Maternity Governance team is currently reviewing and aligning the data to the current reporting periods used for PMRT and MIS. Action carried forward to June.	

	Action 28: Agenda item. Action closed. **Action 35:** Completed action plan to be presented next month. Action closed. **Action 36:** Thematic review of triage from current findings around birth down to complaints undertaken. Paper currently with EK for Obstetric overview and will be circulated for discussion. **Action 37:** Extraordinary guideline meeting scheduled to sign off. 2 remain outstanding and been allocated to consultants. **Action 38:** Standing item. Action closed. **Action 39:** Standing item. Action closed.	
2.	**Review findings / updates and action plans**	
a.	**Obstetric ultrasound CIG report** Report circulated. **USS capacity and workstream on demand and capacity** EG gave a verbal update: • Audit identified that 15% of women are not being booked on correct scan pathway. Currently undertaking audit of every single patient in workstreams to ensure they are on the correct pathway and scans have been requested. • There is a capacity issue with urgent scans and a need to improve data reporting and MDT oversight. Workstream ongoing to address these issues led by EG/NG/EK. • Demand is rapidly increasing with SBL3. • DNA rate significantly high. • Underreporting on Radar when not meeting requirements.	
b.	**CQC Picker Survey action plan CQC recommendations** NL provided a verbal update; progressing well with no concerns, on track to improve infant feeding. Update will be provided quarterly.	
c.	**60 Steps – regionally Maternity Review:** EG spoke to the report circulated. The following additional comments were highlighted and discussed: • Step 44 - There was mould in the bathrooms: Assurance was given that the mould in bathrooms is dealt with as part of tendable environmental audits, ongoing Estates work. • Step 27 – There is not a lead Obstetric physician for maternity: IR challenged the wording. NG reported that the Trust has 3 maternal medicine consultants, Anja Johansen-Bibby (lead), Erum Khan, and Swati Velankar.	

	• Step 11 - MEWS & NEWTS charts are currently not used within the ED, they will be implementing in a month: Machine for ED to be purchased. eCare switch from 'adult woman' to 'pregnant woman', to be discussed with Debbie Phillips and Laura Crump outside this meeting. **Action** Step 50 - What is the team structure of the care in community? MAG requested overview of current plan.	EG
d.	**FASP action plan update:** EG spoke to the report circulated. No further comments.	
e.	**QIPP update and progress:** JC spoke to the report circulated. The following additional comments were highlighted and discussed: • The unit has a large number of open actions on the quality improvement project plan, some of which are outdated or superseded. JC and EG are working with Jackie Stretton to review and streamline the actions and move them to radar.	
3.	**Regional/National Reports and Publications (Recent papers and changes in national guidance i.e. NICE/ RCOG/ CQC / Maternity reviews**	
a.	**Saving Babies Lives 2024: A report on Progress:** JC spoke to the report circulated. Paper for note.	
b.	**Listen to Mums: Ending the Postcode lottery on perinatal care:** EK spoke to the report circulated. No further comments.	
4.	**Staffing**	
a.	**Obstetrics** Audit of compliance with Obstetric Consultant Staffing and Role/Responsibilities on Labour Ward (October and April): NG gave a verbal update: • NG reported that the unit has some gaps in the middle grade and consultant rotas. Interviewed and offered 3 middle grade posts. • NG also updated on the assurance process for consultant attendance. SOP already in place. Nidhi Singh, new Clinical Director, to device QR code. Review in 3 months.	
b.	**Neonates' medical workforce** Compliance with BAPM over any six-month period in line with the maternity incentive scheme safety requirements: • LA spoke to the report circulated. No further comments.	
c.	**Neonatal Nursing** Nursing workforce review has been undertaken at least once annually in line with the maternity incentive scheme safety requirements: CN spoke to the report circulated. The following additional comments were highlighted and discussed: • NNU workforce action plan and tracker safety action 4 will be shared with MAG on a quarterly basis.	

	• Action plan in place to reduce QIS 49% gap in QIS.	
d.	**Midwifery** Six monthly midwifery staffing report (April and October): RV spoke to the report circulated. The following additional comments were highlighted and discussed: • Issues with PWR data have been identified as double recording. Work is in progress to resolve issues and restore data quality. • Midwifery safe staffing – assurance was given that 12% specialist midwife is in line with Birthrate plus recommendations.	
e.	**Progress update and Action Plan** **Update re Labour Ward Coordinator framework** RV spoke to the report circulated. The following additional comments were highlighted and discussed: • Link in with corporate education team. • Ensure diversity of skills sets being developed. **Action** MAG requested a progress report in 6 months.	RV
5.	**Perinatal Quality Surveillance Model**	
a.	**Governance report:** Update on MIS Ockenden Litigation/Claims scorecard 5a. MAG governance report Cover Sheet.dc LR spoke to the report circulated. The following additional comments were highlighted and discussed: ○ Pg 86 Ockenden 1 report recommend that Maternity Unit send their full serious Incident reports to Board for transparency – It has been previously agreed by MAG that full SI reports will not be submitted to public board. EG gave assurance that is reports are presented to MAG (board sub-group) the Ockenden requirement is met. ○ 3 MNSI reports with seven actions, mostly around communication and triage. Translation is an issue everywhere, SB suggested working with colleagues in network. ○ Pg 91-93 Risk Register: ○ Risk 486 - rating up from 8-16 due to a rise in incidents relating to space, including failure to bring in inductions, which is a NICE red flag and reportable outside of organisation. Risk being reworded to reflect. ○ Risk relating to triage – rating up from 16-20 due to increase in incidents and MNSI reports. Ongoing review of BSOTS pathway following an increased number of births in triage. • The unit has seen an increase in complaints, some of which are historic or related to Ward 9. EG and GL are reviewing the themes and the responses.	

b.	**Perinatal Mortality Review Tool:** N/A this month.	
6.	**Avoiding Term Admissions to Neonatal Unit**	
a.	N/A this month.	
b.	**Safety Intelligence Data:** Complaints themes/trends (Monthly overview and Quarterly report March / June / September / December) Monthly action log of staff feedback from safety champion's walk rounds (previous month) Papers for noting.	
7.	**Mat Neo Safety Collaborative**	
	Update on current projects (March and September) CN/LA spoke to the report circulated. The following additional comments were highlighted and discussed: • Mat Neo collaborative PREM 7 monthly report safety action 6 – review ongoing around data collection, particularly around antibiotic administration.	
8.	**Trust IPR Metrics**	
a. b. c. d. e.	Maternity – Maternity dashboard - for noting. Neonates - NNAP dashboard (July, October, January, April) – paper for noting. Transitional Care - N/A this month. Score Survey and Cultural Survey Feedback and Action plan update – paper for noting. Maternity and Neonatal Service User Feedback - EG reported that she is working with colleagues to ensure the MVP has a voice at the correct forums. Assurance was given that that the MVP report will be shared more widely with staff. Conversation is ongoing with the MVP to check that all information contained is physiologically safe. Triage / BSOTS audit and Quality Improvement Plan - deferred until next month.	
9.	**AOB**	
	• Agenda to be reviewed.	
10.	**Date and time of Next Meeting**	
	Thursday 27th June 2024 @ 08:00-09:00 via MS Teams	

Meeting Title	**Trust Board in Public**	**Date: 4th July 2024**
Report Title	2024-25 Executive Summary M1	**Agenda Item Number: 11**
Lead Director	John Blakesley, Deputy CEO	
Report Author	Information Team	

Introduction	Purpose of the report: Standing Agenda Item
Key Messages to Note	**Emergency Department:** - There were 9,107 ED attendances in May 2024, an increase of 662 attendances when compared to April 2024. - The percentage of attendances admitted, transferred, or discharged within 4 hours was 73.3%, a deterioration compared to 74.0% in April 2024. - 77.3% of ambulance handovers took less than 30 minutes in May 2024 and 95.5% took less than 60 minutes. **Outpatient Transformation:** - There were 38,256 outpatient attendances in May 2024. - 12.6% of these appointments were attended virtually and 7.7% of patients did not attend. **Elective Recovery:** - There were 2,448 elective spells in May 2024. - At the end of May 2024, 37,002 patients were on an open RTT pathway: o 1,257 patients were waiting more than 65 weeks. o 48 patients were waiting over 78 weeks. - At the end of April 2024, 12,351 patients were waiting for a diagnostic test. Of these, 55.5% were waiting less than 6 weeks. **Inpatients:** - Overnight bed occupancy in adult G&A beds was 90.3% in May 2024. - A considerable proportion of beds were unavailable due to: o 120 super stranded patients (length of stay 21 days or more). **Human Resources:** - In May 2024: o Substantive staff turnover was 13%. o Agency expenditure remained well below the threshold of 5%, at 4.0%. o Appraisals was 92% and mandatory training was 96%. **Patient Safety:** - In April 2024, the following infections were reported: o E-Coli: 1 o C.Diff: 4 o MSSA: 0 o Kilebsiella Spp bacteraemia: 2

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)*	*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*

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

Trust Performance Summary: M02 (May 2024)

1.0 Summary

This report summarises performance 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 some local transitional or phased targets have been agreed to measure progress in recovering performance. It should however also be noted that NHS Constitutional Targets remain, as highlighted in the table below:

Indicator Description	Transitional Target	Constitutional Target
ED 4 hour target (includes UCS)	74.8%	95%
RTT Incomplete Pathways <18 weeks	92%	92%
RTT Patients waiting over 65 weeks	1,354	0
Diagnostic Waits <6 weeks	95%	99%

To ensure that the continued impact of COVID-19 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 Operational Performance Targets

May 2024 performance against transitional targets and recovery trajectories:

Indicator	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
ED 4 hour target (includes UCS)	78.2%	74.8%	73.6%	73.3%	✗	▼	✗	
RTT Incomplete Pathways <18 weeks	92.0%	92.0%		39.7%	✗	▲		
RTT Patients waiting over 65 weeks (Total)	0	1,354		1,257	✓	▼		
Diagnostic Waits <6 weeks	95.0%	95.0%		55.5%	✗	▼		
62 day standard (Quarterly) ↗	70.3%	64.0%		58.7%	✗	▲		

The percentage of ED attendances that were admitted, transferred, or discharged within four hours was 73.3%, a reduction in performance compared to recent months. This was below the national performance of 74.0% but above the performance of all but four other trusts within the MKUH Peer Group (see Appendix 1).

The volume of open RTT pathways was 37,002, increasing by 64 compared to April 2024. Of this total, 1,257 patients had waited more than 65 weeks for treatment. The Trust has robust recovery plans in place to support an improvement in RTT performance and to reduce patient waiting times. The cancellation of non-urgent elective activity and treatment for patients on an incomplete RTT pathway is also being proactively managed.

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

In Q4 2023/24, the 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) was 58.7% against a national target of 85%, improving from 52.7% in the previous quarter. The percentage of patients to begin cancer treatment within 31 days of a decision to treat increased to 95.15%, below the national target of 96%. The 28 Day Faster Diagnosis performance was 72.9%, down from 73.5% in the previous quarter.

3.0 Urgent and Emergency Care

During May 2024, three of the five key indicators saw a month-on-month improvement:

Indicator	Threshold 2024 (%)	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Cancelled Ops - On Day	1%	1%	0.34%	0.25%	✓	▲	✓	
Ward Discharges by Midday	25%	25%	17.7%	18.1%	✗	▲	✗	
Patients not meeting Criteria to Reside	50			95	✗	▼		
Number of Super Stranded Patients (LOS>=21 Days)	53			120	✗	▲		
Ambulance Handovers <60 mins (%)	100%	100%	95.7%	95.5%	✗	▼	✗	

Cancelled Operations on the Day

In May 2024, seven operations were cancelled on the day for non-clinical reasons. Most of the cancellation reasons were related to insufficient time or consultant availability.

Patients not Meeting Criteria to Reside

The number of inpatients not meeting the criteria to reside at the end of May 2024 was 95 against a threshold of 50. This was a deterioration compared to 78 reported last month.

Length of Stay (Stranded and Super Stranded Patients)

The number of super stranded patients (e.g. length of stay of 21 days or more) at the end of the month was 120. This was an improvement compared to 129 reported in April 2024.

Ambulance Handovers

In May 2024, the percentage of ambulance handovers to the Emergency Department taking less than 30 minutes was 77.3%, an improvement in performance when compared with April 2024 (76.8%).

The percentage of ambulance handovers to the Emergency Department taking less than 60 minutes was 95.5%; a decrease in performance compared to 95.9% in the previous month.

4.0 Elective Pathways

Indicator	Threshold (2024-25)	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Overnight Bed Occupancy - Adult G&A	95.4%	96.4%	92.8%	90.3%	✓	▲	✓	
RTT Incomplete Pathways <18 weeks	92.0%	92.0%		88.7%	✗	▲		
RTT Total Open Pathways (including Alliss)	32,548	34,810		37,002	✗	▼		
Diagnostic Waits <6 weeks	99.0%	99.0%		55.5%	✗	▼		

Overnight Bed Occupancy

Overnight bed occupancy decreased to 90.3% in May 2024 from 95.0% in April 2024.

RTT Incomplete Pathways

The Trust's Incomplete Pathways is still to be confirmed for May.

Diagnostic Waits <6 weeks

At the end of May 2024, performance was 55.5% a deterioration compared with 56.7% in April 2024.

5.0 Patient Safety

Infection Control

In May 2024, the following infections were reported:

Infection	Number of Infections
C.Diff	4
Klebsiella Spp bacteraemia	2
E-Coli	1
MSSA	0
P. aeruginosa bacteraemia	0
MRSA bacteraemia	0

ENDS

Appendix 1: ED Performance - Peer Group Comparison

Several other NHS Acute Trusts have historically been considered as peers of MKUH. Their ED performance compared to MKUH over the past three-months can be found below:

March 2024 to May 2024 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	Mar-24	Apr-24	May-24
Homerton Healthcare NHS Foundation Trust	82.5%	83.3%	80.0%
The Hillingdon Hospitals NHS Foundation Trust	78.4%	79.1%	75.8%
Oxford University Hospitals NHS Foundation Trust	72.2%	71.4%	74.9%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	70.7%	71.4%	73.4%
Milton Keynes University Hospital NHS Foundation Trust	78.1%	74.0%	73.3%
Buckinghamshire Healthcare NHS Trust	74.6%	73.9%	72.9%
Northampton General Hospital NHS Trust	73.6%	75.0%	72.7%
Barnsley Hospital NHS Foundation Trust	73.8%	69.5%	71.0%
Mersey and West Lancashire Teaching Hospital (Formerly Southport and Ormskirk)	72.6%	69.4%	68.2%
The Princess Alexandra Hospital NHS Trust	65.5%	64.6%	64.1%
North Middlesex University Hospital NHS Trust	65.3%	65.0%	63.9%
Mid Cheshire Hospitals NHS Foundation Trust	60.6%	59.3%	58.8%

Board Performance Report 2024/25
May 2024 (M02)

OBJECTIVE 1 - PATIENT SAFETY									
Indicator	DQ Assurance	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Mortality - (HSMR) ★		91.9	91.9		93.8	✗			
Mortality - (SHMI)		100.0	100.0		105.9	✗			
Never Events		0	0	0	0	✓		✓	
Clostridium Difficile		20	<4	5	4	✗		✗	
MRSA bacteraemia (avoidable)		0	0	0	0	✓		✓	
Falls with harm (per 1,000 bed days)		0.12	0.12	0.03	0.00	✓		✓	
Incident Rate (per 1,000 bed days)		60	60	52.04	50.62	✗		✗	
Duty of Candour Breaches (Quarterly)		0	0	0	0	✓		✓	
E-Coli		27	<5	3	1	✓		✓	
MSSA		17	<3	2	0	✓		✓	
VTE Assessment		95%	95%	97.1%	97.6%	✓		✓	
Klebsiella Spp bacteraemia		14	<3	4	2	✗		✗	
P.aeruginosa bacteraemia		9	<2	0	0	✓		✓	

OBJECTIVE 2 - PATIENT EXPERIENCE									
Indicator	DQ Assurance	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
RED Complaints Received		0	0	0	0	✓		✓	
Formal Complaints responded in agreed time		90%	90%	47.4%	39.1%	✗		✗	
Cancelled Ops - On Day		1%	1%	0.34%	0.25%	✓		✓	
Over 75s Ward Moves at Night		1,500	250	276	142	✗		✗	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS									
Indicator	DQ Assurance	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Overnight Bed Occupancy - Adult G&A		95.4%	96.4%	92.6%	90.3%	✓		✓	
Ward Discharges by Midday		25%	25%	17.7%	18.1%	✗		✗	
Weekend Discharges		63%	63%	61.4%	60.5%	✗		✗	
Patients not meeting Criteria to Reside		50			95	✗			
Number of Stranded Patients (LOS>=7 Days)		184			267	✗			
Number of Super Stranded Patients (LOS>=21 Days)		50			120	✗			
Discharges from PDU (%)		12.5%	12.5%	11.2%	10.7%	✗		✗	
Ambulance Handovers <30 mins (%)		95%	95%	77.0%	77.3%	✗		✗	
Ambulance Handovers <60 mins (%)		100%	100%	95.7%	95.5%	✗		✗	

OBJECTIVE 4 - KEY TARGETS									
Indicator	DQ Assurance	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
ED 4 hour target (includes UCS)		78.2%	74.8%	73.6%	73.3%	✗		✗	
Total time in ED no more than 12 hours		95%	95%	93.7%	94.9%	✗		✗	
Triage within 15 Minutes		90%	90%	68.5%	69.1%	✗		✗	
RTT Incomplete Pathways <18 weeks		92.0%	92.0%		39.7%	✗			
RTT Total Open Pathways (inluding ASIs)		32,549	34,610		37,002	✗			
Open AFBs					5,368				
Referrals Waiting for Triage					2,669				
RTT Patients waiting over 65 weeks (Total)		0	1,354		1,257	✓			
RTT Patients waiting over 65 weeks - Non-Admitted					784				
RTT Patients waiting over 65 weeks - Admitted					473				
RTT Patients waiting over 78 weeks (Total)		0	54		48	✓			
Diagnostic Waits <6 weeks		95.0%	95.0%		55.5%	✗			
31 days Diagnosis to Treatment (Quarterly)		96.0%	96.0%		95.1%	✗			
62 day standard (Quarterly)		70.3%	64.0%		58.7%	✗			
28 Day Faster Diagnosis (Quarterly)		78.0%	74.3%		72.9%	✗			

OBJECTIVE 5 - SUSTAINABILITY									
Indicator	DQ Assurance	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Total Referrals Received		Not Available		30,813	14,769	Not Available		Not Available	
Total ASIs		0	0		2,779	✗			
Total RTT Non-Admitted Open Pathways					31,148				
Total RTT Admitted Open Pathways					5,854				
A&E Attendances		104,199	17,266	17,511	9,087	✓		✗	
Elective Spells		26,880	4,092	4,844	2,448	✓		✓	
Non-Elective Spells		26,442	4,275	5,073	2,573	✗		✗	
OP Attendances / Procs (Total)		482,353	78,441	77,374	38,256	✗		✗	
Outpatient DNA Rate		5%	5%	6.9%	7.7%	✗		✗	
Virtual Outpatient Activity		25%	25%	12.8%	12.6%	✗		✗	

OBJECTIVE 7 - FINANCIAL PERFORMANCE									
Indicator	DQ Assurance	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Income £'000		393,248	64,675	65,478	33,412	✓		✓	
Pay £'000		(246,892)	(41,285)	(42,422)	(21,433)	✗		✗	
Non-pay £'000		(115,359)	(20,865)	(21,339)	(11,014)	✗		✗	
Non-operating costs £'000		(30,997)	(4,443)	(3,979)	(1,970)	✓		✓	
I&E Total £'000		0	(1,918)	(2,262)	(1,005)	✓		✗	
Cash Balance £'000			20,226		15,735	✗			
Savings Delivered £'000		23,822	3,970	1,496	1,047	✗		✗	
Capital Expenditure £'000		(28,670)	(4,243)	(1,823)	(802)	✗		✗	
Elective Spells (% of 2019/20 performance)		130%	130%	Not Available					
OP Attendances (% of 2019/20 performance)		130%	130%	Not Available					

OBJECTIVE 8 - WORKFORCE PERFORMANCE									
Indicator	DQ Assurance	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Staff Vacancies % of establishment		7.5%	7.5%		6.4%	✓			
Agency Expenditure %		5.0%	5.0%	3.8%	4.0%	✓		✓	
Staff Sickness % - Days Lost (Rolling 12 months)		5.0%	5.0%		4.8%	✓			
Appraisals (excluding doctors)		90%	90%		92.0%	✓			
Statutory Mandatory training		90%	90%		96.0%	✓			
Substantive Staff Turnover		12.5%	12.5%		13.1%	✗			

OBJECTIVES - OTHER									
Indicator	DQ Assurance	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Total Number of NICE Breaches		8	8		NA	Not Available			
Rebooked cancelled OPs - 28 day rule		90%	90%	88.9%	91.7%	✓		✗	
Overdue Incidents >1 month		Not Available			276				
Serious Incidents		40	<7	1	0	✓		✓	

Key: Monthly/Quarterly Change

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

YTD Position

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

Data Quality Assurance Definitions

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

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

Board Performance Report: M02 (May 2024)

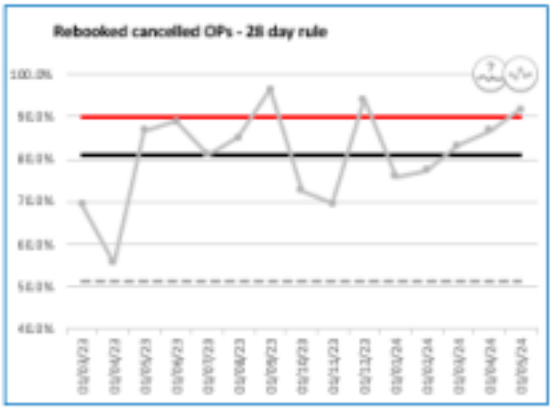
OBJECTIVE O - OTHER

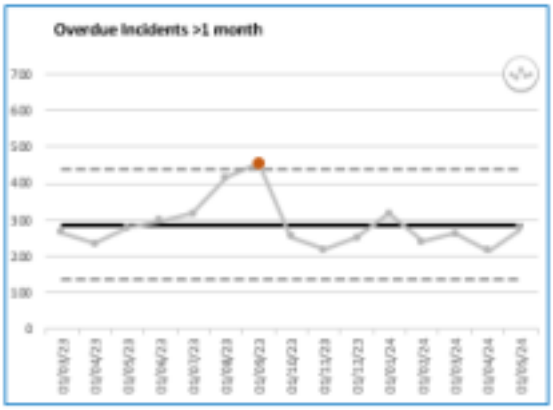
May 2024 and YTD performance against transitional targets and recovery trajectories:

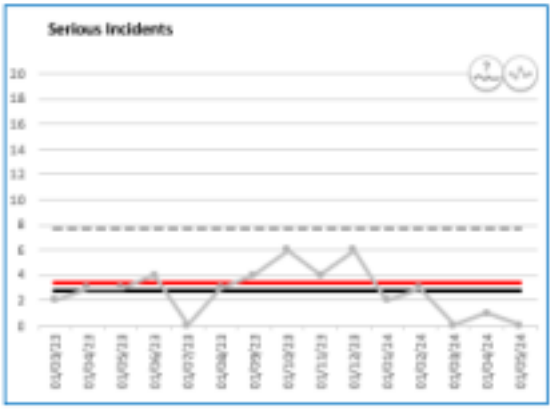
OBJECTIVES - OTHER								
Indicator	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 13 months data
Rebooked cancelled OPs - 28 day rule	90%	90%	88.9%	91.7%	✓	▲	✗	
Overdue incidents >1 month	Not Available			276		▼		
Serious incidents	48	<7	1	0	✓	▲	✓	

Key Points

- **Rebooked Cancelled Ops within 28 Days:** Of the seven operations cancelled on the day for non-clinical reasons, 91.7% were rebooked within 28 days. This has demonstrated continuous improvement since March 2024 and has moved above the 90% threshold this month.
- **Overdue Incidents > 1 month:** This remained within common cause variation.
- **Serious Incidents:** There was one serious incident in April 2024, but none were reported in May 2024. Therefore, this remained below the threshold for the fifth consecutive month.







Threshold
Mean

Board Performance Report: M02 (May 2024)

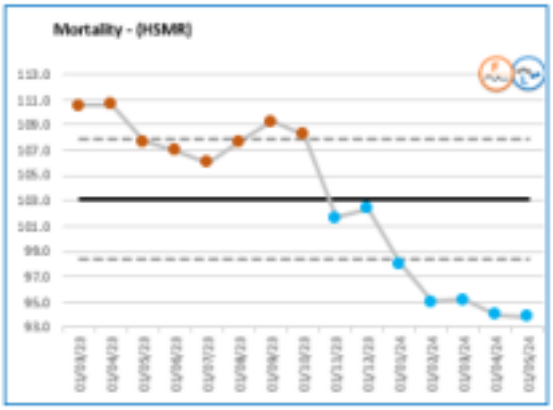
OBJECTIVE 1 – PATIENT SAFETY

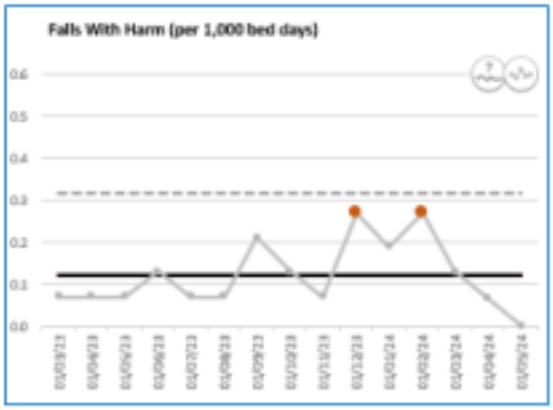
May 2024 and YTD performance against targets and thresholds:

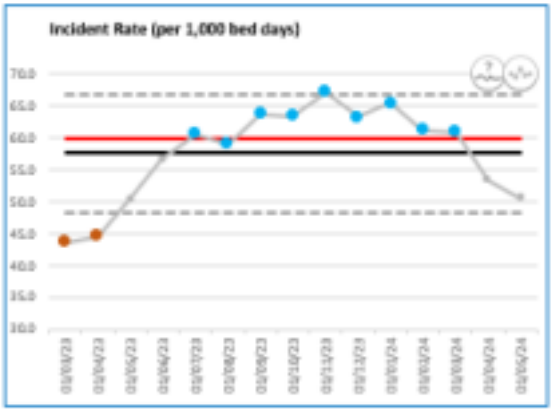
OBJECTIVE 1 - PATIENT SAFETY								
Indicator	Threshold (2024-25)	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Mortality - (HSMR) *	91.9	91.9		93.8	✗	▲		
Falls with harm (per 1,000 bed days)	0.12	0.12	0.03	0.00	✓	▲	✓	
Incident Rate (per 1,000 bed days)	60	60	52.04	59.61	✗	▼	✗	
Pressure Ulcers Classification - Total Category 2, 3, 4, DTI and Unstageable (per 1,000 bed days)	2.5	2.5	1.56	2.08	✓	▼	✓	

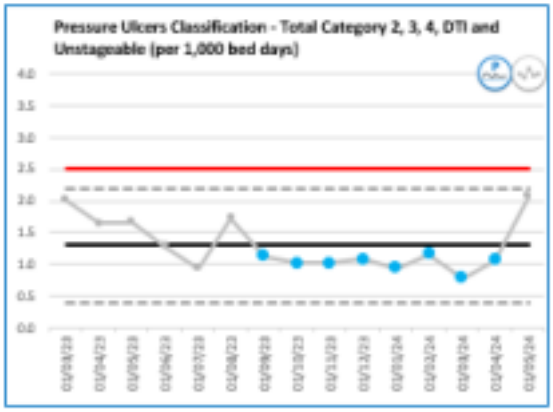
Key Points

- **HSMR:** This metric is showing special cause improving variation. The steep decline continued from 109.3 in September 2023 to 93.8 in May 2024. This metric, however, remained above the national peer figure of 91.9.
- **Falls with harm:** This remained below the threshold of 0.12, with 0.00 reported falls per 1,000 bed days in May 2024.
- **Incident Rate**: The incident reporting rate remained below the threshold for the second consecutive month.
- **Pressure Ulcers**: This metric was showing special cause improving variation previously. However, there were 33 category 2, 3, 4, DTI and unstageable pressure ulcers in May 2024, an increase from 18 in April 2024.









Threshold
Mean

Board Performance Report: M02 (May 2024)

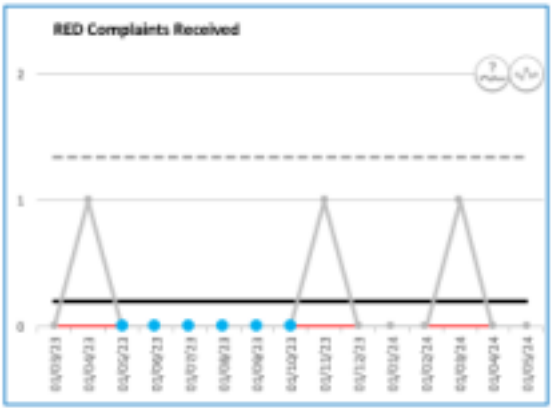
OBJECTIVE 2 – PATIENT EXPERIENCE

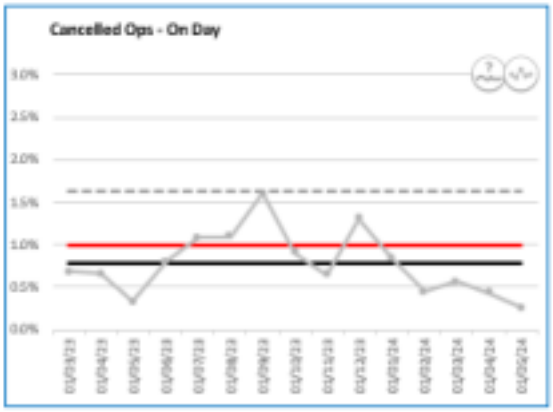
May 2024 and YTD performance against targets and thresholds

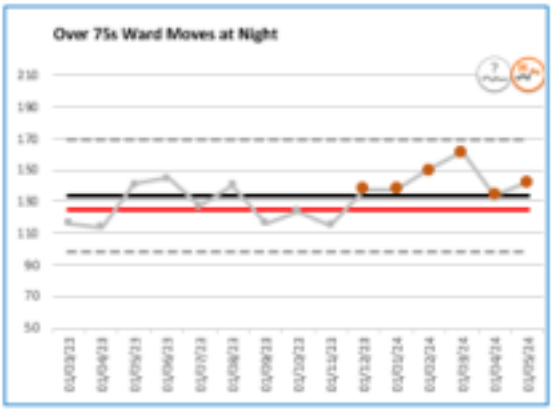
Indicator	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
RED Complaints Received	0	0	0	0	✓	=	✓	
Cancelled Ops - On Day	1%	1%	0.34%	0.35%	✓	▲	✓	
Over 75s Ward Moves at Night	1,500	250	276	142	✗	▼	✗	

Key Points

- **RED Complaints Received:** No RED complaints were reported in May 2024.
- **Operations cancelled on the Day:** Seven operations were cancelled on the day for non-clinical reasons in May 2024. The majority were due to consultant availability or insufficient time.
- **Over 75s Ward Moves at Night**: This continues to show concerting variation.







Threshold
Mean

Board Performance Report: M02 (May 2024)

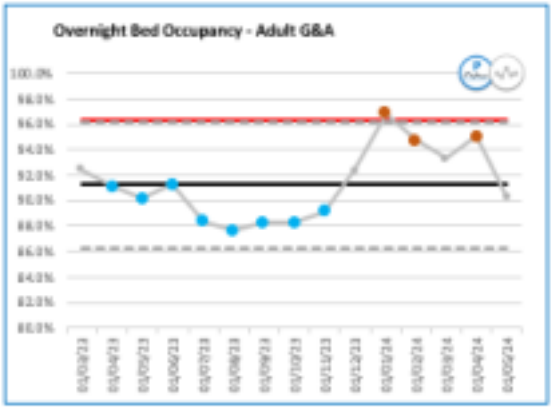
OBJECTIVE 3 – CLINICAL EFFECTIVENESS

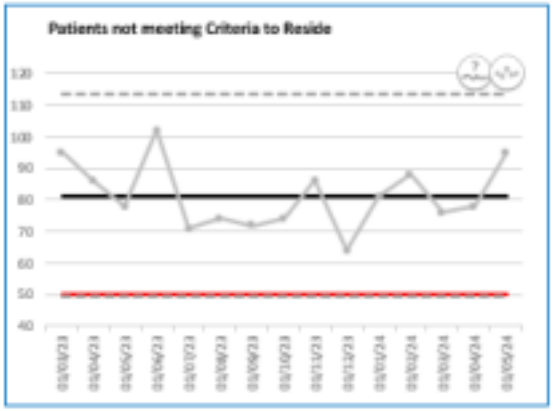
May 2024 and YTD performance against transitional targets and recovery trajectories:

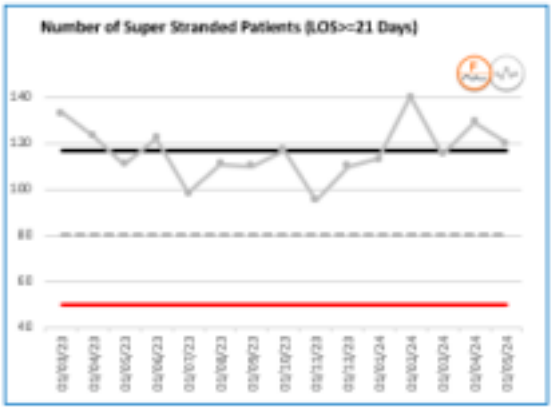
OBJECTIVE 3 - CLINICAL EFFECTIVENESS								
Indicator	Threshold 2024/25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Overnight Bed Occupancy - Adult G&A	95.4%	96.4%	92.6%	90.3%	✓	▲	✓	
Patients not meeting Criteria to Reside	50			95	✗	▼		
Number of Super Stranded Patients (LOS>=21 Days)	90			120	✗	▲		
Ambulance Handovers <30 mins (%)	95%	95%	77.3%	77.3%	✗	▲	✗	

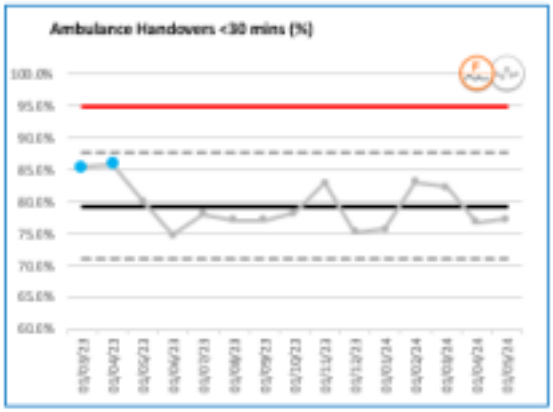
Key Points

- **Overnight Bed Occupancy:** This is demonstrating common cause variation, with the overnight bed occupancy at 90.3% in May 2024 (down from 96.9% in January 2024)
- **Patients not meeting Criteria to Reside**: This is within common cause variance but has remained above the threshold of 50, as it did for each month during 2023/24.
- A considerable volume of hospital beds were unavailable due to:
  - 120 super stranded patients (length of stay 21 days or more).
  - 267 stranded patients (length of stay 7 days or more)
- **Ambulance Handovers:** This metric remained below the desired threshold. Performance was 77.3% in May 2024, against a 95% threshold.









Threshold
Mean

Board Performance Report: M02 (May 2024)

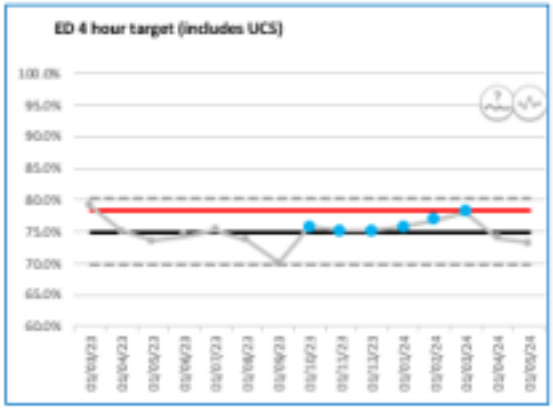
OBJECTIVE 4 - KEY TARGETS

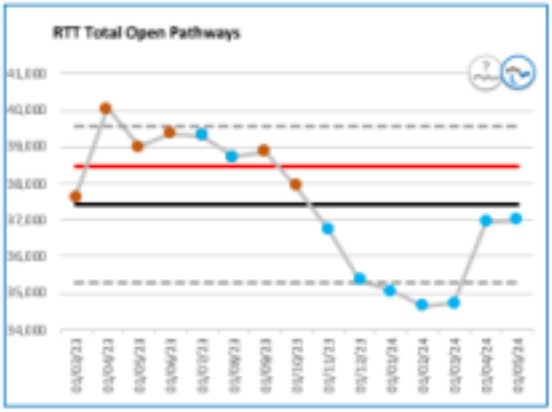
May 2024 and YTD performance against transitional targets and recovery trajectories:

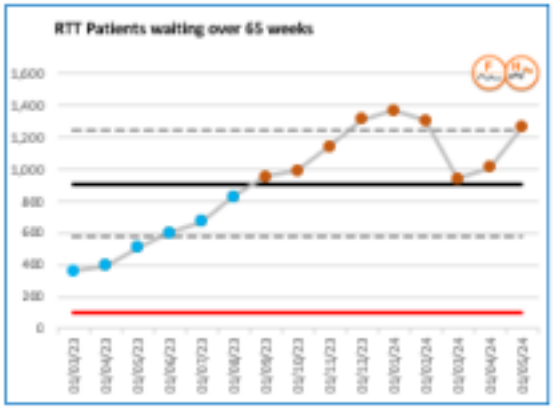
Indicator	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
ED 4 hour target (includes UCS)	78.2%	74.8%	73.6%	73.3%	✗	▼	✗	
RTT Total Open Pathways (including ASIs)	32,549	34,610		37,002	✗	▼		
RTT Patients waiting over 65 weeks (Total)	0	1,314		1,257	✓	▼		
Diagnostic Waits <6 weeks	65.0%	61.0%		56.3%	✗	▼		

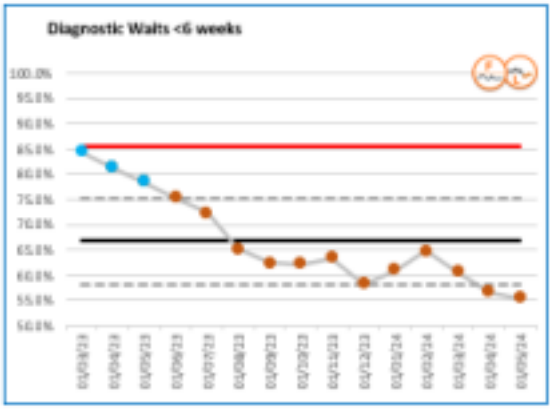
Key Points

- **ED 4-hour Performance:** Performance was below the revised 74.8% threshold at 73.3% in May 2024, down from 74% in April 2024.
- **RTT Open Pathways:** 37,002 patients were on an open RTT pathway which was above the operational plan set out for May 2024. Of these patients:
  - 1,257 patients had been waiting over 65 weeks.
  - 48 patients had been waiting over 78 weeks.
- **Diagnostics**: 11,829 patients were waiting for a diagnostic test. Of which:
  - 56.7% were waiting less than 6 weeks. This metric is demonstrating special cause concerning variation and has been consistently below the threshold.









Threshold
Mean

Board Performance Report: M02 (May 2024)

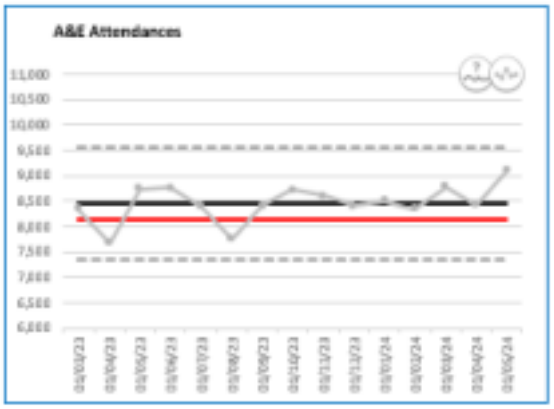
OBJECTIVE 5 – SUSTAINABILITY

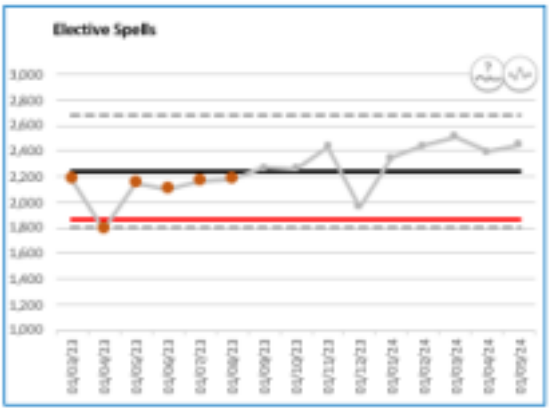
May 2024 and YTD performance against transitional targets and recovery trajectories:

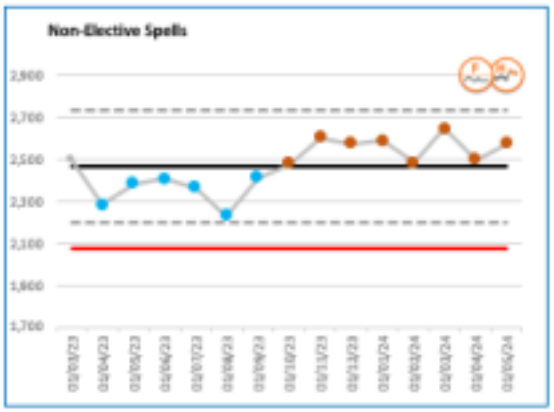
OBJECTIVE 5 - SUSTAINABILITY								
Indicator	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
A&E Attendances	104,199	17,366	17,511	9,087	✓	▼	✗	
Elective Spells	26,880	4,092	4,844	2,448	✓	▲	✓	
Non-Elective Spells	26,442	4,275	5,075	2,573	✗	▼	✗	
OP Attendances / Procs (Total)	482,353	78,441	77,574	38,256	✗	▼	✗	
Outpatient DNA Rate	5%	5%	6.9%	7.7%	✗	▼	✗	

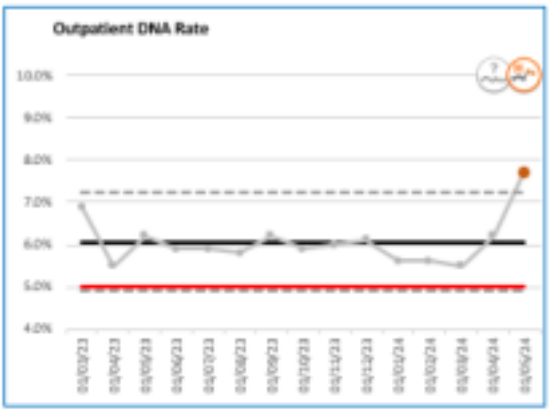
Key Points

- **A&E Attendances:** There were 9,087 A&E attendances in May 2024. This was below the provisional activity plan for the month.
- **Elective Spells:** This remained within common cause variation. However, the volume of elective spells was above the planned activity for May 2024.
- **Non-Elective Spells:** This continued to demonstrate special cause concerning variation.
- **Outpatients:** 7.7% of patients did not attend their appointment in May 2024. This has gone above the upper control limits for the first time in 15 months and is now showing special cause concerning variation.









Threshold
Mean

Board Performance Report: M02 (May 2024)

OBJECTIVE 7 - FINANCIAL PEFORMANCE

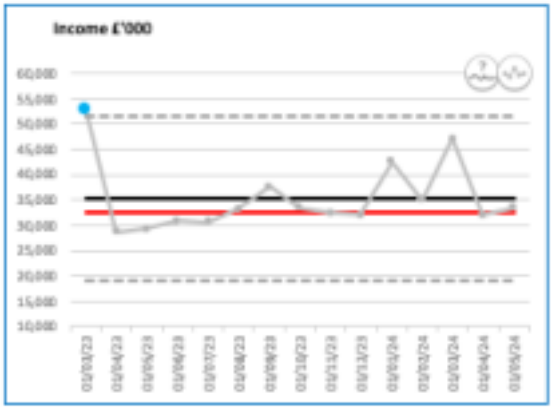
May 2024 and YTD performance against transitional targets and recovery trajectories:

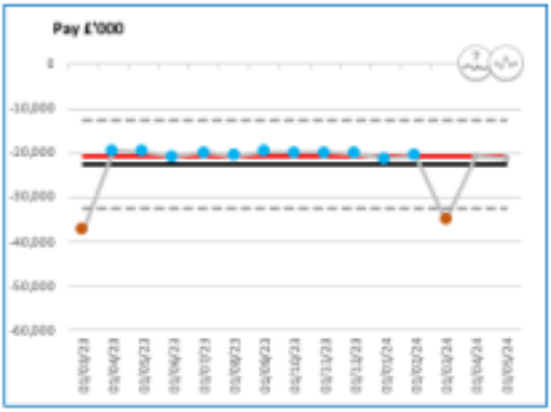
OBJECTIVE 7 - FINANCIAL PERFORMANCE								
Indicator	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Income £'000	393,248	64,675	65,478	33,412	✓	▲	✓	
Pay £'000	(266,892)	(41,285)	(42,422)	(21,433)	✗	▼	✗	
Non-pay £'000	(115,359)	(20,865)	(21,339)	(11,014)	✗	▼	✗	
Non-operating costs £'000	(30,997)	(4,443)	(3,979)	(1,970)	✓	▲	✓	

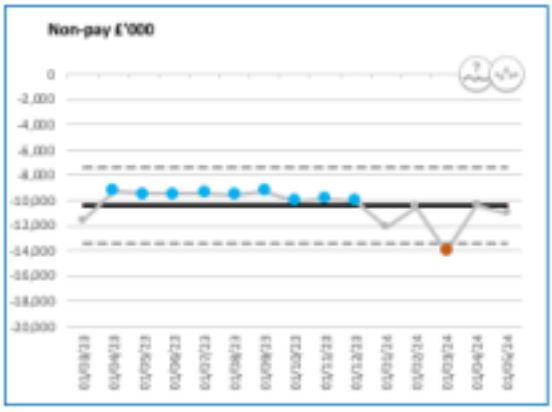
Key Points

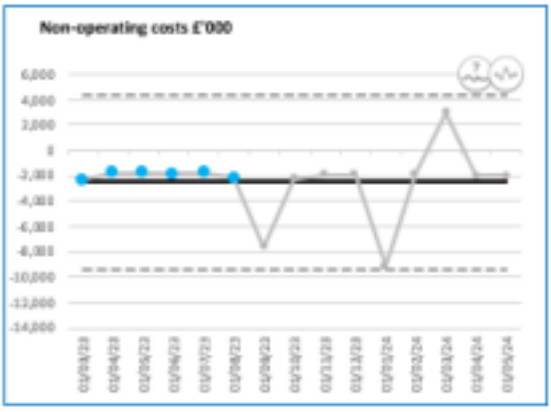
OVERALL: The Trust is £0.3m adverse to its plan in month which is largely due to operational pressures and under achievement of the challenging efficiency target at this early stage of the year.

- **Income:** Clinical revenue for Integrated Care Board (ICB), NHS England (NHSE) contracts, and variable (non-ICB income) is above plan, due to Elective Recovery Fund (ERF) and the high-cost drugs (HCD) over performance.
- **Pay:** Pay costs are higher than plan due to the cost of temporary staff in escalation wards and additional hours carried out to reduce elective backlogs. Bank and Agency expenditure has increased in May but is partly offset by substantive vacancies.
- **Non-Pay:** Non-pay is overspent on drugs which is offset by income for high-cost drugs.
- **Non-Operating Costs:** Broadly in line with plan.









Threshold
Mean

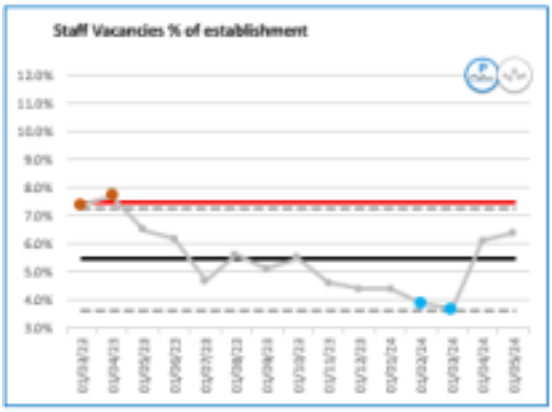
Board Performance Report: M02 (May 2024)

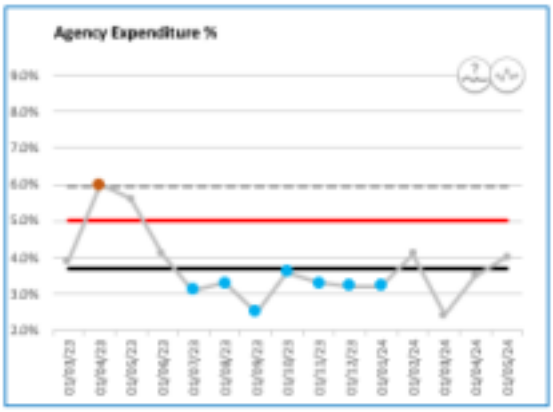
OBJECTIVE 8 - WORKFORCE PEFORMANCE

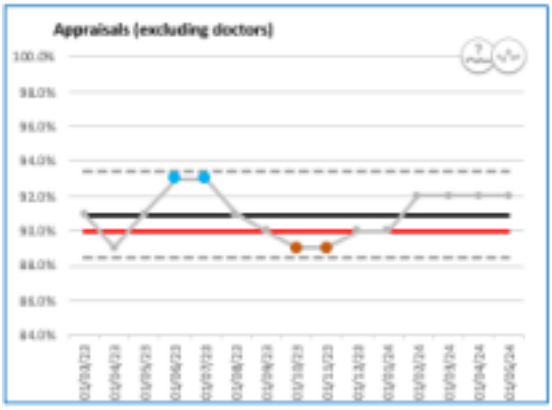
May 2024 and YTD performance against transitional targets and recovery trajectories:

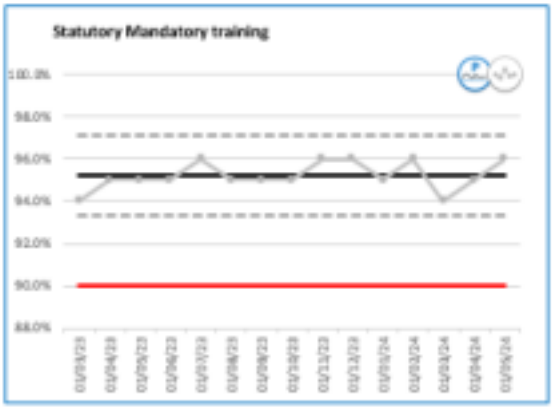
Key Points

- **Staff Vacancies:** The staff vacancy rate was reported at 6.4% in May 2024, which has risen due to an increase in budgeted establishment for the new financial year. Targeted recruitment campaigns will continue to fill the gaps.
- **Agency Expenditure:** May 2024 has remained below the 5% threshold for the past 12 months, even with a slight increase in month. Further overview of this will be carried out through the newly formed Temporary Staffing Group.
- **Appraisals:** This has remained unchanged at 92% and remains within the KPI. Improvements in Women's and Children's have resulted in the division being on target in M2
- **Statutory Mandatory Training:** This has improved slightly to 96% in May 2024 and has been consistently above the 90% target for the past 12 months.









Threshold
Mean

Meeting Title	**Public Board**	**Date: 4th July 2024**
Report Title	**Finance Paper Month 2 2024-25**	**Agenda Item Number: 12**
Lead Director	**Jonathan Dunk**	**Chief Finance Officer**
Report Authors	**Sue Fox** **Cheryl Williams**	**Head of Financial Management** **Head of Financial Control and Capital**

Introduction	This report provides an update on the financial position of the Trust at Month 2 (May 2024).		
Key Messages to Note	The Trust is reporting a deficit position of £2.3m (on a Control Total basis) to the end of the May which is adverse to plan by £0.3m. Elective Recovery Fund (ERF) performance is currently above the 106% target, with income showing £2.7m above the national target as at M02 resulting in a favourable income variance to plan of £0.9m. The Trust has a challenging financial plan this year which includes a savings target of 6% (£23.8m). £1.5m has been achieved to date against a year to date plan of £4m.		
Recommendation *Tick the relevant box(es)*	**For Information** ☐	**For Approval** ☐	**For Review** [x]

Strategic Objectives Links	7. *Spending money well on the care you receive* 10. *Innovating and investing in the future of your hospital*

Report history	None
Next steps	To note the contents of this report.
Appendices	Pages 10-12

FINANCE REPORT FOR THE MONTH TO 31st MAY 2024

TRUST BOARD

CONTENTS

TheMKWay

NHS
Milton Keynes University Hospital
NHS Foundation Trust

EXECUTIVE SUMMARY

Ref	All Figures in £'000	In Month Plan	In Month Actual	In Month Var	YTD Plan	YTD Actual	YTD Var	Full Year Plan	Full Year Forecast	Full Year Var	RAG
1	Clinical Revenue	30,016	31,071	1,055	59,979	61,102	1,123	361,218	361,218	-	
2	Other Revenue	2,226	7,729	5,503	4,840	9,764	4,924	31,662	31,662	-	
3	Pay	(20,775)	(21,433)	(658)	(41,529)	(42,422)	(893)	(247,157)	(247,157)	-	
4	Non Pay	(10,490)	(11,014)	(524)	(20,845)	(21,339)	(494)	(115,206)	(115,206)	-	
5	Financing & Non-Ops	(2,045)	(2,020)	25	(4,091)	(4,079)	12	(24,931)	(24,931)	-	
6	Surplus/(Deficit)	(1,068)	4,333	5,400	(1,646)	3,025	4,672	5,586	5,586	-	
7	Control Total Surplus/(Deficit)	(1,010)	(1,004)	5	(1,918)	(2,262)	(343)	-	-	-	
	Memos										
8	IA Cost				-	-	-	-	-	-	
9	High Cost Drugs	(2,130)	(2,552)	(422)	(4,228)	(4,923)	(695)	(25,351)	(25,351)	-	
10	Financial Efficiency	1,985	1,047	(938)	3,970	1,496	(2,474)	23,822	23,822	-	
11	Cash	15,735	15,735	-	15,735	15,735	-	12,356	12,356	-	
12	Capital Plan - CDEL (excluding Donated)	(997)	(995)	2	(1,823)	(1,821)	2	(35,287)	(35,287)	-	

Key messages

The Trust is reporting a deficit position of £2.3m (on a Control Total basis) to the end of May 2024. This is worse than plan by £0.3m).

The Trust has submitted a breakeven plan for the 24/25 financial year, and this includes an annual efficiency target of £23.8m which equates to around 6% of expenditure. At month 2 the Trust is behind it's savings plan by £2.5m which is reflected in the pressure on the pay and non-pay budget.

ERF performance is currently above the 106% target, with income showing £2.7m above the national target as at M02 and £0.9m favourable to Plan. There is a risk relating to SDEC coding which would impact the ERF position in the second half of the financial year unless we take mitigating action.

The capital expenditure programme is only marginally off plan but it is expected to be within plan by the end of the year.

(1 & 2.) Revenue – Clinical revenue for Integrated Care Board (ICB), NHS England (NHSE) contracts, and variable (non-ICB income) is above plan, due to Elective Recovery Fund (ERF) and the high-cost drugs (HCD) over performance. Other revenue is above plan due principally to donated income received.

(3. & 4.) Operating expenses – Pay costs are higher than plan due to the cost of temporary staff in escalation wards and additional hours carried out to reduce elective backlogs. Bank and Agency expenditure has increased in May but is partly offset by substantive vacancies. Non-pay is overspent on drugs which is offset by income for high cost drugs.

(7.) Control Total Deficit - The Trust is reporting a deficit position to the end of May.

(8.) Industrial Action costs – no industrial action took place in May.

(10.) Financial Efficiency – £1.5m delivered against an annual target of £23.8m.

(11.) Cash – Cash balance is £15.7m, equivalent to 16 days cash to cover operating expenses.

(12.) Capital – Capital expenditure is slightly behind plan due to the timing of capital schemes however the Trust is expected to deliver to the forecast capital plan for the end of the year. There has been additional allocated capital funding as part of the 2024/25 financial Plan resubmission in early June from the 24/25 revenue incentive scheme. This has reduced the shortfall in CDEL funding from £3.1m to £0.6m. Also, the Trust has received funding approval for the NHP enabling scheme relating to the Multi-storey car park which is £10k in 24/25 and £2.8m in 25/26.

DIVISIONAL PERFORMANCE

Row Labels	Annual Budget £	Month 2 Budget £	Month 2 Actual £	Month 2 Variance £	YTD Budget	YTD Actual	YTD Variance
Medicine							
Income	129,381	11,330	12,280	950	21,772	23,342	1,570
Pay	(71,584)	(5,840)	(6,464)	(624)	(12,031)	(12,950)	(919)
Non Pay	(14,714)	(1,332)	(1,432)	(100)	(2,440)	(2,769)	(329)
Medicine Total	**43,084**	**4,158**	**4,384**	**227**	**7,301**	**7,623**	**322**
Surgery							
Income	73,523	6,533	7,073	540	12,115	13,038	924
Pay	(50,685)	(4,318)	(4,760)	(442)	(8,636)	(9,593)	(958)
Non Pay	(12,315)	(1,084)	(1,413)	(329)	(2,168)	(2,610)	(442)
Surgery Total	**10,523**	**1,131**	**900**	**(231)**	**1,311**	**835**	**(476)**
Womens + Children							
Income	53,818	4,817	4,968	152	8,944	9,067	123
Pay	(30,869)	(2,613)	(2,812)	(198)	(5,227)	(5,487)	(259)
Non Pay	(2,699)	(225)	(268)	(43)	(450)	(446)	4
Womens + Children Total	**20,250**	**1,978**	**1,889**	**(89)**	**3,267**	**3,135**	**(132)**
Core Clinical							
Income	52,305	4,555	5,056	501	8,570	9,153	583
Pay	(42,671)	(3,596)	(3,974)	(377)	(7,190)	(7,810)	(620)
Non Pay	(44,565)	(3,740)	(4,417)	(677)	(7,441)	(8,734)	(1,292)
Core Clinical Total	**(34,932)**	**(2,781)**	**(3,335)**	**(554)**	**(6,061)**	**(7,391)**	**(1,330)**
Corporate							
Income	11,767	983	1,082	99	1,966	2,162	196
Pay	(36,100)	(3,026)	(3,232)	(206)	(6,052)	(6,389)	(337)
Non Pay	(40,009)	(3,323)	(3,480)	(157)	(6,659)	(6,772)	(113)
Corporate Total	**(64,342)**	**(5,366)**	**(5,630)**	**(263)**	**(10,746)**	**(11,000)**	**(254)**
Central Reserves	**(15,512)**	**(2,058)**	**(18)**	**2,041**	**(3,860)**	**(193)**	**3,668**
Financing	**(18,685)**	**(2,049)**	**3,363**	**5,412**	**(3,711)**	**1,300**	**5,011**
Trustwide Income Summary	**65,201**	**3,919**	**2,778**	**(1,141)**	**10,853**	**8,716**	**(2,137)**
Grand Total	**5,586**	**(1,068)**	**4,333**	**5,400**	**(1,646)**	**3,025**	**4,672**

Medicine is reporting £7.6m surplus to the end of May which is £0.3m favourable to plan. Clinical income is offsetting spend at M2. Pay and non-pay continue to be impacted by escalation areas beyond the funded establishment and A&E staffing costs.

Surgery's position is impacted by spend associated with elective recovery. As at month 2 the spend is higher than the income recorded. Centrally held reserves for some ERF schemes will be distributed in month 3.

Women's and Children is largely on plan. Medical staffing costs continue to cause a cost pressure. Weekly meetings have been organised to review bank bookings.

Core Clinical is overspent by £1.3m at month 2. The main areas of overspend are Imaging and Pathology. Escalation areas are also impacting the hotel services budget (patients catering).

Corporate pay is overspent, and this is mainly due to the CIP target. Work is continuing at pace to identify savings and reduce the current run rate.

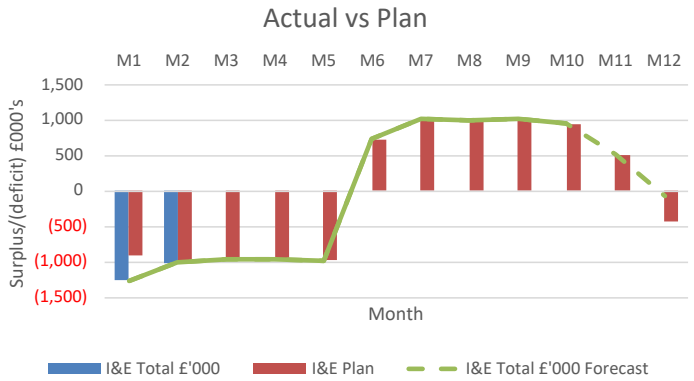
Central reserves, financing and trust wide income are shown here for completeness. Centrally held reserves are currently being reviewed and service developments prioritised ahead of investment decisions and funding transferring to divisional budgets.

FORECAST

2. Forecast

The current forecast is to meet the breakeven plan at year end 2024-25. This will be updated post quarter 1 (July 2024) with a full bottom up forecast by division.

The plan was revised in early May from an £8.1m deficit to breakeven. The phasing of the new plan delivers a deficit in the first 5 months of the year and a surplus in the remaining months to arrive at breakeven by March 2025. See the graph below for monthly phasing:



3. Risks to Plan Achievement

Industrial action cost and lost income, ongoing cost of escalation capacity, winter pressures, financial efficiency slippage, ERF baseline adjustments, the impact of Emergency Data Set reporting on ERF achievement.

4. Opportunities to improve the Position

ERF income for additional elective work (£2-4m), non-recurrent plan mitigation.

Key message

The breakeven plan includes a challenging CIP target of £23.8m which is roughly 6% of expenditure. Achievement of the plan will depend heavily on the required savings being realised and the run rate steadily improving in the second half of the financial year.

CLINICAL INCOME

5. Block contracts.

The Trust block contracts historically make up around 74% of the total clinical income, covering all activity except for planned care (covered by ERF), diagnostic imaging, HCD and devices, specialised chemotherapy activity, and the Community Diagnostic Centre (CDC).

6. Elective Recovery Fund (ERF).

Planned care income is managed through the ERF scheme. The 2024/25 target for MKUH is 106% above 2019/20 values. In 2023/24 the ERF target was reduced by 4% to 102% to compensate for the industrial action, but this has now been restored to the original target.
The 2024/25 updated baseline values were recently published, however, due to the timing of the publication, the updated baselines are not reflected in the reported position. The updated baselines include a working day (WD) adjustment to account for the number of additional days in 2024/25 comparted to 2023/24. This results in a material increase to the baseline (c£1.2m), accompanied by the Same Day Emergency Care (SDEC) pending adjustment, the Trust 2024/25 ERF income is likely to heavily affected.

The May (M02) ERF position shows an expected £2.7m over performance compared to the target. Including advice and guidance, the combined ERF performance shows £2.9m. The 2024/25 values are higher than at this point of 2023/24. Using indicative data and the nationally reported ERF rules, below shows the Trust M02 performance by care type.

	YTD Financial performance				YTD Activity performance				Current year vs Prior Year		
Care Type	YTD Target Finances (£)	YTD actuals	YTD Variance	Performance position %	YTD Target activity	YTD actuals	YTD Variance	Performance position %	Prior year YTD (£)	Cuurrent year YTD (£)	Variance (£)
01_Elective Day Case	£2,414,994	£3,600,615	£1,185,621	149.09%	2,733	4,245	1,512	155.31%	£3,004,816	£3,600,615	£595,799
02_Elective Inpatient	£2,028,734	£2,335,467	£306,733	115.12%	575	810	235	140.80%	£1,887,861	£2,335,467	£447,606
03_First Attendance with Procedure	£603,643	£227,760	-£375,883	37.73%	3,255	1,319	-1,936	40.52%	£623,759	£227,760	-£395,999
03_First Attendance without Procedures	£4,268,926	£6,223,385	£1,954,459	145.78%	20,951	27,778	6,827	132.59%	£6,229,594	£6,223,385	-£6,209
04_Follow Up Attendance with Procedure	£714,138	£563,205	-£150,933	78.86%	4,958	3,684	-1,274	74.31%	£650,676	£563,205	-£87,471
Grand Total	**£10,230,651**	**£12,950,432**	**£2,719,781**	**127%**	**32,472**	**37,836**	**5,364**	**117%**	**£12,396,706**	**£12,950,432**	**£553,726**

NHSE are yet to publish the M02 performance data, which should be available in Q2. The NHSE performance variances are expected to be higher due to NHSE reporting the freeze data months, whilst the Trust are using the indicative partially coded month to estimate the values.

The Trust is yet to receive the outstanding 2023/24 ERF performance payments; the final position should be published by the end of Q1. The 2023/24 BLMK performance payments totalled £14.9 which included an estimate for the Q4 over performance, this will be adjusted once the final position is published.

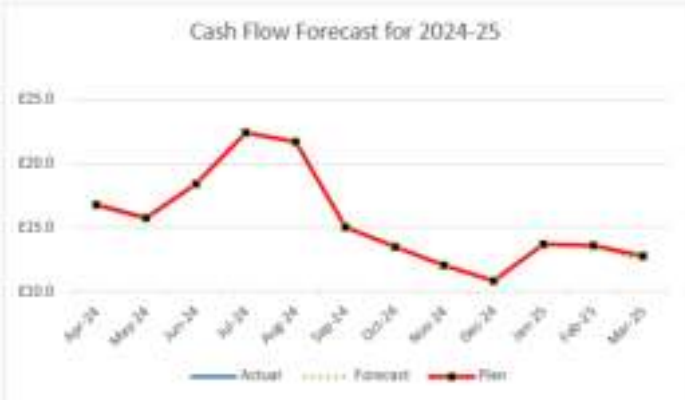
NHS Northamptonshire ICB will also pay the outstanding months once the final position is published, but NHS Buckinghamshire, Oxfordshire and Berkshire West ICB have not paid any of the 2023/24 ERF national allocation, this has been escalated to NHSE for resolution.

Key message
Overall, ERF continues to over perform in 2024/25 which is a continuation if the 2023/24 performance position. This has resulted in a favourable year to date income variance to Plan of £0.9m.
The position is expected to be impacted once the recently published national 2024/25 baselines are applied to the numbers with an anticipated negative effect.

CASH

7. Summary of Cash Flow

The cash balance at the end of May was £15.7m, the same as the revised planned figure of £15.7m and a £1.1m decrease on last month's figure of £16.8m (see opposite). The main reason for the decrease was £3.5m of capital expenditure in M2, that related to FY24 business cases, offset by a £2.4m surplus in operating working capital.



8. Cash arrangements 2024/25

The Trust will continue to receive block funding for FY25 which includes an uplift for growth plus any additional incentive funding linked to activity delivery and funding for high-cost drugs on a pass-through basis.

9. 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 due the ongoing issues with agency invoicing and NHS approvals. Both issues are being addressed and action plans are in progress to resolve them. NHS payment runs have been increased to weekly from bi-weekly to improve the target. This metric will continue to be monitored in accordance with national guidance and best practice.

Better payment practice code	Actual M2 YTD Number	Actual M2 YTD £'000	Actual M1 YTD Number	Actual M1 YTD £'000
Non NHS				
Total bills paid in the year	10,610	43,810	5,526	26,307
Total bills paid within target	10,049	41,565	5,257	25,517
Percentage of bills paid within target	**94.7%**	**94.9%**	**95.1%**	**97.0%**
NHS				
Total bills paid in the year	403	1,673	195	826
Total bills paid within target	330	1,074	159	600
Percentage of bills paid within target	**81.9%**	**64.2%**	**81.5%**	**72.7%**
Total				
Total bills paid in the year	11,013	45,483	5,721	27,133
Total bills paid within target	10,379	42,639	5,416	26,117
Percentage of bills paid within target	**94.2%**	**93.7%**	**94.7%**	**96.3%**

Key message
Cash at the end of May was in line with the (revised) plan. There was a month on month decrease of £1.1m from April, due to capital expenditure, offset by an in-month working capital surplus.

BALANCE SHEET

10. Statement of Financial Position

The statement of financial position is set out in Appendix 3. The key YTD movements include:

- Non-Current Assets have increased from March 24 by £2.0m; this is driven by a £2.5m increase in the Right of Use assets, offset by a £0.5m decrease in Intangible assets.
- Current assets have decreased by £0.6m; this is due to the increase in other receivables of £12.0m, offset by a decrease in NHS receivables of £1.1m and a decrease in cash of £11.5m.
- Current liabilities have decreased by £5.9m; this is due to the £1.1m decrease in borrowings (IFRS16 accounting re ROU assets), £1.3m decrease in deferred income and the £3.5m decrease in payables.
- Non-Current Liabilities have decreased from March 24 by £3.0m; this is due to the Right of Use assets, related to IFRS 16.

11. Aged debt

- The debtors position as of May 24 is £6.4m, which is an increase of £3.8m from the prior month. Of this total £0.7m is over 121 days old.

12. Creditors

- The creditors position as of May 24 is £8.7m, which is a decrease of £3.0m from the prior month. £1.7m is over 30 days of ageing with £1.1m approved for payment.

Key message
Main movements in year on the statement of financial position are the reduction in cash of £11.5m, other receivables increase of £12.0m, the current liabilities decrease of £5.9m and the £3.0m increase in non-current liabilities.

RECOMMENDATIONS TO board

13. Trust Board is asked to note the financial position of the Trust as of 31st May 2024 and the proposed actions and risks therein.

APPENDICIES

Appendix 1

Statement of Comprehensive Income
For the period ending 31st May 2024

	FY25	M2 CUMULATIVE			M2			PRIOR MONTH	
	Annual Budget £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	M1 Actual £'000	Change £'000
INCOME									
Outpatient First	31,754	5,423	7,218	1,796	3,469	4,120	651	3,098 ▲	1,022
Outpatient Procedures	5,076	846	398	(448)	429	435	6	(427) ▲	862
Chemotherapy delivery	2,433	406	347	(59)	227	184	(43)	163 ▲	21
Day Case Admissions	21,191	3,532	4,314	782	2,000	2,137	137	2,177 ▼	(40)
Elective Admissions	16,667	2,778	2,914	136	1,620	1,283	(337)	1,631 ▼	(348)
High Cost Drugs & Devices	25,411	4,239	4,240	1	2,427	1,685	(742)	2,555 ▼	(870)
Total Variable Income	**104,520**	**17,423**	**19,442**	**2,019**	**10,392**	**9,845**	**(547)**	**9,597 ▲**	**248**
Outpatient Follow up	24,433	4,072	3,965	(107)	1,847	2,442	595	1,523 ▲	919
Emergency Admissions	93,557	15,626	15,627	1	7,451	8,035	584	7,392 ▲	643
A&E	20,489	3,424	3,416	8	1,777	1,690	(87)	1,721 ▼	(31)
Other Admissions	16,950	2,825	402	(2,423)	1,650	225	(1,425)	177 ▲	48
Maternity Other (including Deliveries_	0	0	2,423	2,423	0	1,421	1,421	1,002 ▲	419
Maternity pathway (ante/post natal)	9,036	1,504	1,500	(4)	767	758	(9)	746 ▲	12
Critical Care (adult)	4,164	694	693	(1)	360	325	(35)	383 ▼	(73)
Neonatal	3,726	621	621	(0)	401	530	129	51 ▲	479
Imaging	7,360	1,227	1,227	(0)	658	580	(78)	647 ▼	(67)
Direct Access Pathology	6,123	1,021	1,021	(0)	549	527	(22)	494 ▲	33
Best Practice Tariffs	627	105	104	(0)	49	49	1	55 ▼	(6)
Other block income	8,511	1,418	1,419	(0)	728	2,229	1,501	(820) ▲	3,059
Total Block / Fixed Income	**193,968**	**32,328**	**32,232**	**(96)**	**16,218**	**18,811**	**2,573**	**13,411 ▲**	**5,400**
Non-recurrent & additional income	0	(570)	(1,339)	(769)	(2,420)	(2,981)	(561)	0 ▼	(2,981)
National Block	62,715	10,798	10,798	0	6,209	5,399	(810)	7,021 ▼	(1,622)
Clinical Income	**361,218**	**59,979**	**61,102**	**1,123**	**30,036**	**31,075**	**1,051**	**30,033 ▲**	**1,045**
Non-Patient Income	25,480	4,452	4,376	(76)	2,226	2,361	135	2,058 ▲	303
Donations	6,293	388	5,388	5,000	0	5,388	5,388	0 ▲	5,388
Non-Patient Income	**31,774**	**4,840**	**9,764**	**4,924**	**2,226**	**7,739**	**5,501**	**2,058 ▲**	**5,681**
TOTAL INCOME	**392,992**	**64,819**	**70,866**	**6,048**	**32,262**	**38,800**	**6,558**	**32,066 ▲**	**6,734**
EXPENDITURE									
Pay - Substantive	(220,804)	(38,348)	(36,267)	2,081	(19,184)	(18,285)	918	(17,999) ▼	(285)
Pay - Bank	(10,361)	(1,739)	(3,312)	(1,594)	(859)	(1,667)	(808)	(1,645) ▼	(22)
Pay - Locum	(2,200)	(367)	(1,090)	(724)	(183)	(572)	(389)	(518) ▼	(54)
Pay - Agency	(5,665)	(952)	(1,581)	(628)	(476)	(866)	(379)	(735) ▼	(131)
Pay - Other	(942)	(157)	(171)	(14)	(78)	(79)	(1)	(92) ▲	13
Pay CIP	36	6	0	(6)	3	0	(3)	0 ▲	0
Vacancy Factor	50	8	0	(8)	4	0	(4)	0 ▲	0
Pay	**(241,266)**	**(41,520)**	**(42,412)**	**(891)**	**(20,775)**	**(21,433)**	**(658)**	**(20,989) ▼**	**(444)**
Non Pay	(89,818)	(14,617)	(14,817)	200	(8,309)	(8,462)	(153)	(7,955) ▼	(507)
Non Tariff Drugs (high cost/individual drugs)	(25,411)	(4,226)	(4,920)	(694)	(2,119)	(2,533)	(414)	(2,370) ▼	(163)
Non Pay	**(115,409)**	**(20,845)**	**(21,339)**	**(494)**	**(10,490)**	**(11,014)**	**(524)**	**(10,325) ▼**	**(689)**
TOTAL EXPENDITURE	**(361,475)**	**(62,374)**	**(63,752)**	**(1,388)**	**(31,265)**	**(32,447)**	**(1,183)**	**(31,314) ▼**	**(1,133)**
EARNINGS BEFORE INTEREST, TAXATION, DEPRECIATION AND AMORTISATION (EBITDA)	**30,517**	**2,445**	**7,105**	**4,660**	**977**	**6,353**	**5,376**	**752 ▲**	**5,601**
Interest Receivable	480	80	161	81	40	123	83	38 ▲	85
Interest Payable	(1,266)	(211)	(97)	114	(106)	(40)	66	(57) ▲	17
Depreciation, Impairments & Profit/Loss on Asset Disposal	(16,679)	(2,780)	(2,832)	(52)	(1,383)	(1,433)	(50)	(1,398) ▼	(35)
Donated Asset Depreciation	(707)	(120)	(102)	18	(58)	(51)	7	(50) ▼	(1)
Profit/Loss on Asset Disposal & Impairments	0	0	0	0	0	0	0	0 ▲	0
DEL Impairments	0	0	(116)	(116)	0	(55)	(55)	(61) ▲	6
AME Impairments	0	0	0	0	0	0	0	0 ▲	0
Unwinding of Discounts	0	0	0	0	0	0	0	0 ▲	0
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**13,044**	**(535)**	**4,101**	**4,672**	**(520)**	**4,878**	**5,407**	**(776) ▲**	**5,654**
Dividends Payable	(6,457)	(1,079)	(1,079)	0	(539)	(545)	(7)	(531) ▼	(14)
OPERATING SURPLUS/(DEFICIT) AFTER DIVIDENDS	**5,186**	**(1,344)**	**3,021**	**4,672**	**(1,068)**	**4,333**	**5,400**	**(1,307) ▲**	**5,640**

TheMKWay

Milton Keyn
University Hospit
NHS Foundation Tr

Appendix 2

Statement of Cash Flow
As of 31st May 2024

	Mth12 2023-24 £000	Mth 2 £000	Mth 1 £000	In Month Movement £000
Cash flows from operating activities				
Operating (deficit)/surplus from continuing operations	13,970	4,153	(695)	(4,848)
Operating (deficit)/surplus from continuing operations	**13,970**	**4,153**	**(695)**	**(4,848)**
Non-cash income and expense:				
Depreciation and amortisation	17,229	2,951	1,447	(1,504)
Impairments	0	0	0	0
(Increase)/Decrease in Trade and Other Receivables	(3,720)	(9,695)	144	9,839
(Increase)/Decrease in Other Assets	0	0	0	0
(Increase)/Decrease in Inventories	(127)	(4)	(4)	0
Increase/(Decrease) in Trade and Other Payables	544	(3,388)	1,161	4,549
Increase/(Decrease) in Other Liabilities	(6,967)	(1,162)	(186)	976
Increase/(Decrease) in Provisions	8,698	(9)	(6)	3
NHS Charitable Funds	(8,415)	(5,388)	0	5,388
Other movements in operating cash flows	891	(1)	(1)	0
NET CASH (USED IN) GENERATED FROM OPERATIONS	**22,103**	**(12,543)**	**1,860**	**14,403**
Cash flows from investing activities				
Interest received	1,399	161	37	(124)
Addition of ROU assets	0	0	0	0
Purchase of intangible assets	(425)	54	(34)	(88)
Purchase of Property, Plant and Equipment	(34,087)	(3,349)	(14,950)	(11,601)
Process from sale of Property, Plant and Equipment	252	0	0	0
Net cash (used in) investing activities	**(32,861)**	**(3,134)**	**(14,947)**	**(11,813)**
Cash flows from financing activities				
Public dividend capital received	11,039	0	0	0
Capital element of finance lease rental payments	(5,078)	(971)	2,772	3,743
Unwinding of discount	0	(116)	(61)	55
Interest element of finance lease	(680)	(97)	(57)	40
PDC Dividend paid	(5,725)	0	0	0
Receipt of cash donations to purchase capital assets	8,415	5,388	0	(5,388)
Net cash generated from/(used in) financing activities	**7,971**	**4,204**	**2,654**	**(1,550)**
(Decrease)/increase in cash and cash equivalents	**(2,787)**	**(11,473)**	**(10,433)**	**1,040**
Opening Cash and Cash equivalents	**27,208**	**27,208**	**27,208**	
Closing Cash and Cash equivalents	**27,208**	**15,735**	**16,775**	**1,040**

Appendix 3

Statement of Financial Position as of 31st May 2024

	Mar-24 Unaudited	May-24 YTD Actual	YTD Mvmt	% Variance
Assets Non-Current				
Tangible Assets	241.4	241.3	(0.1)	(0.0%)
Intangible Assets	16.6	16.1	(0.5)	(3.0%)
ROU Assets	18.6	21.1	2.5	13.4%
Other Assets	3.2	3.3	0.1	3.1%
Total Non Current Assets	**279.8**	**281.8**	**2.0**	**0.7%**
Assets Current				
Inventory	5.3	5.3	0.0	0.0%
NHS Receivables	12.0	10.9	(1.1)	(9.2%)
Other Receivables	7.5	19.5	12.0	160.0%
Cash	27.2	15.7	(11.5)	(42.3%)
Total Current Assets	**52.0**	**51.4**	**(0.6)**	**(1.2%)**
Liabilities Current				
Interest -bearing borrowings	(1.5)	(0.4)	1.1	(73.3%)
Deferred Income	(11.6)	(10.3)	1.3	(11.2%)
Provisions	(11.7)	(11.7)	0.0	0.0%
Trade & other Creditors (incl NHS)	(60.8)	(57.3)	3.5	(5.8%)
Total Current Liabilities	**(85.6)**	**(79.7)**	**5.9**	**(6.9%)**
Net current assets	**(33.6)**	**(28.3)**	**5.3**	**(15.8%)**
Liabilities Non-Current				
Long-term Interest bearing borrowings	(18.2)	(21.2)	(3.0)	16.5%
Deferred Income	(0.5)	(0.5)	0.0	0.0%
Provisions for liabilities and charges	(1.6)	(1.6)	0.0	0.0%
Total non-current liabilities	**(20.3)**	**(23.3)**	**(3.0)**	**14.8%**
Total Assets Employed	**225.9**	**230.2**	**4.3**	**1.9%**
Taxpayers Equity				
Public Dividend Capital (PDC)	294.2	294.2	0.0	0.0%
Revaluation Reserve	64.6	64.6	0.0	0.0%
Financial assets at FV through OCI reserve	(2.6)	(2.6)	0.0	0.0%
I&E Reserve	(130.3)	(126.0)	4.3	(3.3%)
Total Taxpayers Equity	**225.9**	**230.2**	**4.3**	**1.9%**

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%
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

Meeting Title	Board Report	**Date:** July 2024
Report Title	Workforce Paper – M2	**Agenda Item Number:** 13
Lead Director	Danielle Petch, Chief People Officer	
Report Author	Louise Clayton, Deputy Chief People Officer	

Introduction	This report provides an update to Board on workforce activity and compliance for M2 2024-25		
Key Messages to Note	There have been improvements in several of the KPI's in M2.		
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)***	**To employ and retain the best people to work for you**

Report History	This is the first version of this report
Next Steps	JCNC
Appendices/Attachments	

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators as at 31 May 2024 (Month 2), covering the preceding 13 months.

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

Indicator	Measure	Target	05/2023	06/2023	07/2023	08/2023	09/2023	10/2023	11/2023	12/2023	01/2024	02/2024	03/2024	04/2024	05/2024
Staff in post *(as at report date)*	Actual WTE		3697.4	3710.4	3776.8	3744.1	3758.3	3775.2	3820.9	3826.0	3834.9	3850.3	3869.1	3861.1	**3880.6**
	Headcount		4206	4222	4293	4261	4278	4296	4351	4352	4368	4381	4402	4392	**4415**
Establishment *(as per ESR)*	WTE		3956.4	3956.0	3963.2	3965.5	3962.0	3996.0	4005.3	4001.9	4012.1	4008.1	4018.1	4109.9	**4144.0**
	%, Vacancy Rate - Trust Total	**7.5%**	6.5%	6.2%	4.7%	5.6%	5.1%	5.5%	4.6%	4.4%	4.4%	3.9%	3.7%	6.1%	**6.4%**
	%, Vacancy Rate - Add Prof Scientific and Technical		24.4%	24.4%	25.6%	25.1%	20.6%	16.1%	15.7%	19.5%	18.6%	17.7%	16.1%	19.9%	**21.4%**
	%, Vacancy Rate - Additional Clinical Services *(Includes **HCA**s)*		6.4%	5.3%	0.3%	3.1%	3.4%	8.2%	9.5%	11.1%	16.0%	15.3%	15.3%	16.3%	**15.5%**
	%, Vacancy Rate - Administrative and Clerical		3.0%	3.0%	2.8%	3.1%	3.7%	3.6%	3.1%	2.1%	1.5%	1.6%	1.4%	2.9%	**2.9%**
	%, Vacancy Rate - Allied Health Professionals		16.5%	17.4%	17.1%	15.3%	16.9%	15.0%	16.0%	16.0%	15.3%	13.1%	12.1%	11.6%	**17.0%**
	%, Vacancy Rate - Estates and Ancillary		8.4%	7.2%	6.2%	7.0%	7.8%	8.0%	4.6%	4.9%	3.6%	3.8%	4.3%	9.2%	**8.7%**
	%, Vacancy Rate - Healthcare Scientists		6.3%	9.3%	6.2%	6.1%	6.0%	4.2%	0.0%	-1.7%	-0.5%	0.2%	-0.9%	4.1%	**5.2%**
	%, Vacancy Rate - Medical and Dental		0.0%	0.0%	0.0%	1.4%	0.4%	0.0%	0.0%	-2.3%	-1.8%	-1.0%	-1.3%	1.4%	**2.1%**
	%, Vacancy Rate - Nursing and Midwifery Registered		7.7%	7.1%	7.6%	6.2%	4.3%	4.2%	2.5%	1.3%	-0.8%	-2.0%	-2.2%	0.9%	**0.8%**
Staff Costs (12 months) *(as per finance data)*	%, Temp Staff Cost (%, £)		15.3%	15.1%	14.8%	14.5%	14.0%	13.7%	13.4%	12.7%	12.4%	12.2%	12.2%	11.9%	**11.7%**
	%, Temp Staff Usage (%, WTE)		14.3%	14.2%	14.0%	13.8%	13.5%	13.3%	13.1%	12.8%	12.6%	12.4%	12.2%	12.2%	**12.0%**
Absence (12 months)	%, 12 month Absence Rate	**5.0%**	4.7%	4.6%	4.5%	4.5%	4.5%	4.5%	4.6%	4.6%	4.7%	4.7%	4.7%	**4.8%**	*4.8%*
	- %, 12 month Absence Rate - Long Term		*2.4%*	*2.4%*	*2.3%*	*2.4%*	*2.3%*	*2.4%*	*2.5%*	*2.5%*	*2.6%*	*2.5%*	*2.6%*	**2.6%**	*2.6%*
	- %, 12 month Absence Rate - Short Term		*2.3%*	*2.2%*	*2.2%*	*2.2%*	*2.2%*	*2.1%*	*2.1%*	*2.1%*	*2.2%*	*2.2%*	*2.1%*	**2.2%**	*2.2%*
	%,In month Absence Rate - Total		3.9%	3.9%	4.2%	4.0%	4.1%	5.1%	5.0%	5.6%	5.6%	5.0%	4.5%	**4.8%**	*4.5%*
	- %, In month Absence Rate - Long Term		*2.3%*	*2.5%*	*2.4%*	*2.3%*	*2.3%*	*3.0%*	*3.0%*	*3.1%*	*3.0%*	*2.8%*	*2.7%*	**2.4%**	*2.4%*
	- %, In month Absence Rate - Short Term		*1.6%*	*1.4%*	*1.8%*	*1.7%*	*1.8%*	*2.1%*	*2.0%*	*2.5%*	*2.6%*	*2.2%*	*1.8%*	**2.4%**	*2.0%*
Starters, Leavers and T/O rate (12 months)	WTE, Starters (In-month)		62.6	44.0	73.3	35.6	56.0	27.0	58.9	24.8	46.0	38.0	41.4	31.8	**46.1**
	Headcount, Starters (In-month)		71	52	83	42	62	30	68	28	51	42	48	36	**54**
	WTE, Leavers (In-month)		25.4	33.8	41.8	37.2	45.4	18.3	27.3	29.6	38.7	28.0	28.6	40.2	**30.2**
	Headcount, Leavers (In-month)		30	40	47	42	58	24	30	38	44	34	36	49	**34**
	%, Leaver Turnover Rate (12 months)	**12.5%**	14.9%	14.9%	14.4%	14.1%	14.1%	13.1%	13.0%	12.9%	12.8%	13.0%	12.6%	13.2%	**13.1%**
Statutory/Mandatory Training	%, Compliance	**90.0%**	95%	95%	96%	95%	95%	95%	96%	96%	95%	94%	94%	95%	**96%**
	Moving and Handling - Level 1 - 3 Years													94.0%	**94.0%**
	Moving and Handling - Level 2 - 3 Years													94.0%	**94.0%**
Appraisals	%, Compliance	**90%**	91%	93%	93%	91%	90%	89%	89%	90%	90%	91%	92%	92%	**92%**
Time to Hire (days)	General Recruitment	**35**	51	49	50	43	50	49	46	50	48	44	43	49	**54**
	Medical Recruitment (excl Deanery)	**35**	70	75	49	51	53	98	93	45	62	69	52	79	**76**
Employee relations	Number of open disciplinary cases		19	13	13	16	19	20	21	21	22	21	19	16	**20**

2.1. **Temporary staffing usage** has dropped slightly to 12% with a 2.3% improvement in cost from the beginning of the financial year 2023/24. Bank usage is currently under review to ensure that all Nursing and Healthcare Support Worker requests are scrutinised by senior nursing prior to being paid on Health Roster.

2.2. The Trust's **headcount has increased** and there are now 4415 employees in post. The **vacancy rate** has increased in M2 due to the increase in budgeted establishment for the new financial year (6.4%).

2.3. **Staff absence is at 4.5%** in month and is at 4.8% for the 12 month period, which is on trend for the time of year and is predicted to improve further into Q2. Managers continue to support staff back to work in line with our sickness absence and attendance policy.

2.4. **Staff turnover** has improved slightly to 13.1%. Retention projects in areas of high turnover continue and the HRBPs are carrying out bespoke pieces of work where turnover is high. Healthcare Support Workers remain an area of focus for improved retention.

2.5. **Time to hire** has increased to 54 days. The manageable delays in processes are being reviewed to close the timeline where possible. The Specialist Recruitment Managers are working with Divisions to support with recruitment to help close the gaps where clinical commitments delay the administration of recruitment.

2.6. The number of **open disciplinary cases** is 20. A detailed Employee Relations case report is produced monthly to JCNC and the Annual Employee Relations Report will be presented to Workforce Development and Assurance Committee in M4.

2.7. **Statutory and mandatory training** compliance is at 96% and **appraisal** compliance is at 92%.

2.8. There is currently less than 1 wte nursing vacancy in the Trust. There are some areas such as Theatres that appear to be over-recruited due to their budgeted establishment being set against Operating Department Practitioners rather than Nursing roles.

2.9. There are **87 HCSW vacancies** (B2 and B3 and including Maternity Support Workers) across the Trust.

3. Continuous Improvement, Transformation and Innovation

3.1. The **Sexual Safety Steering Group** has met to review the work against the six workstreams that have been set up with leads. Members are asked to encourage their teams to attend and contribute where they have an interest in this area and the group is asking for an increase in male representation in the group.

3.2. The first **Temporary Staffing Taskforce Meeting** was held in M3 to review temporary staffing usage and spend with increased scrutiny across the Divisions. Areas of focus were bank and overtime and the group will be sharing data on hotspot areas to support with improved efficiencies

4. Culture and Staff Engagement

4.1. The Staff Survey **'You Said – We Did'** campaign has been launched with a suite of posters that managers can print and display in their area. Evidence shows that linking results from the survey to outcomes improves future survey engagement. The recruitment team also have a suite of staff survey accolades for managers to select for their adverts on Trac and NHS Jobs adverts to showcase the Trust's staff survey success and support recruitment.

4.2. The Trust's **Gender Pay Gap** report shows improvements in our median pay gap and is being presented to Workforce Development and Assurance Committee in M4. A full Equality, Diversity and Inclusion report will be prepared to review performance against national benchmarks and to evidence progress over the last 12 months; this will include the pay gap, WRES and WDES performance data.

4.3. The Trust honoured **Windrush Day** in M3 with speakers sharing their lived experiences and the legacy that their relatives who came to the UK from Jamaica post-WWII have left behind. This was arranged by the BAME Network and attended by Executive colleagues. The recording is available on the intranet and staff are encouraged to view this.

4.4. The Women's Network, UNISON and OD team are launching a **period product initiative** to create a more supportive and inclusive workplace for everyone. The initial products and baskets will be supplied thanks to a generous donation from UNISON and support from the Trust. The project operates on a "take one, donate one" basis, so your contribution can make a real difference.

5. Current Affairs & Hot Topics

5.1. BLMK continues to move forwards with their **People Digital Agenda** with three key projects: the Digital Staff Passport, the NHS Staff App, the Digital Readiness Campaign. The national team are asking for staff to join the User Reference Group to help shape the future of the NHS Staff App to help evaluate prototypes, provide feedback and identify areas for improvement.

6. Recommendations

6.1. Members are asked to note the report.

Meeting Title	Board Report	**Date:** July 2024
Report Title	Freedom to Speak Up Annual Report 2023-24	**Agenda Item Number:** 14
Lead Director	Danielle Petch, Chief People Officer	
Report Author	Philip Ball, Lead Freedom to Speak Up Guardian	

Introduction	This report provides an update on FTSU activity for the period 1 April 2023-31st March 2024		
Key Messages to Note	Referrals to the FTSU Service have increased. The themes are generally around intolerance of poor behaviours. Training and recruitment to champion roles has increased our numbers. The business case was approved for increased hours for the Lead Guardian. The Lead Guardian retired and a new Guardian joined the Trust in June.		
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)*	To employ and retain the best people to work for you

Report History	This report has also been submitted to the Workforce Development and Assurance Committee in May.
Next Steps	N/A
Appendices/Attachments	Appendix 1: Data tables and charts

Freedom to Speak Up
Annual Report
1 April 2023 – 31st March 2024

Philip Ball
Lead Freedom to Speak Up Guardian
March 2024

Contents

1. Executive Summary

As per the guidelines from the National Guardian Office (NGO), Freedom to Speak Up (FTSU) Guardians are to report at least twice a year to the Trust Board.

In the period from 1st April 2023 to 31st March 2024 there have been 94 new concerns raised to the FTSU Team. In many cases where the witness has asked for support and intervention from the Guardian, the case has been dealt with through FTSU intervention with line managers or support from the Human Resources teams. Each witness has their own case number and there may be several witness allegations or concerns raised that relate to one individual or occurrence.

The team have started to collect more data from those speaking up, however due to concerns of anonymity, witnesses are often unwilling to have their details documented. In some cases, this could indicate the witness' perception of believing a risk of detriment for speaking up. Using anonymity, or partial disclosure, has made collation of witness name, respondent name, and any witness' protected characteristics particularly challenging. Without this data being consistently given for each case, it is difficult to identify trends and themes. Where the witness is unwilling to name the person they are raising a concern about, their case outcome cannot be tracked through informal and formal HR processes. The use of an App remains an aspiration to assist efficient data collection that will support information about the efficacy of the service, however issues with the digital provider have resulted in this objective not being achieved. A digital solution in data collation would still be an important efficiency.

The establishment of a dedicated office for FTSU in early 2024 has led to having an extension number for messages as well as a dedicated secure space in which to meet those who wish to speak up. The office is located near Eaglestone Restaurant making it a convenient place for staff to pop in.

The newly appointed Lead Freedom to Speak Up Guardian commenced employment at the beginning of June 2024.

2. Introduction

This report outlines the FTSU activity for the Trust between 1st April 2023 to 31st March 2024. The data is sourced from the confidential log kept by the Guardians which acts as the Trust's FTSU record system. The log stores information about each case and groups cases by type. The case types as defined by the National Guardian Office (NGO) are:

- Patient safety/quality
- Bullying and harassment
- Other inappropriate attitudes or behaviour
- Worker safety or wellbeing
- Disadvantageous and/or demeaning treatment (detriment)

This report analyses the FTSU activity Trust wide and across each of the Trust's five Divisions.

The report also details the makeup of the FTSU Team, and highlights work ongoing and planned alongside any national or regional initiatives.

3. FTSU Team

The Team is made up of the following:

Guardian f/t or p/t	Hours per week as Guardian	Role	Professional background
1 x p/t until 31 March 2024 1 x f/t from June 2024 onwards	15 hours 37.5 hours	Lead FTSU Guardian	Nursing Management and Equality Diversity & Inclusion
2 x p/t protected time	0.5 day per week = 1 complete day	FTSU Guardian	Nursing
1 x p/t protected time	0.5 day per week	FTSU Guardian	Physiotherapist
1 x p/t protected time	0.5 day per week	FTSU Guardian	SOPD Theatres
1 x f/t (from June 2024)	37.5 hours per week	Lead FTSU Guardian	

The Guardians who are working as such under protected time can come under pressure from line managers to drop Guardian activities at times of service pressure. The Lead Guardian has supported the Guardians impacted by this and liaised with line mangers to support their release. The Guardians are supported by 11

Champions, including 9 trained and recruited in 2023, who act as first points of contact and signposts to Guardians where required. During the year three Champions decided to stand down for personal or professional reasons.

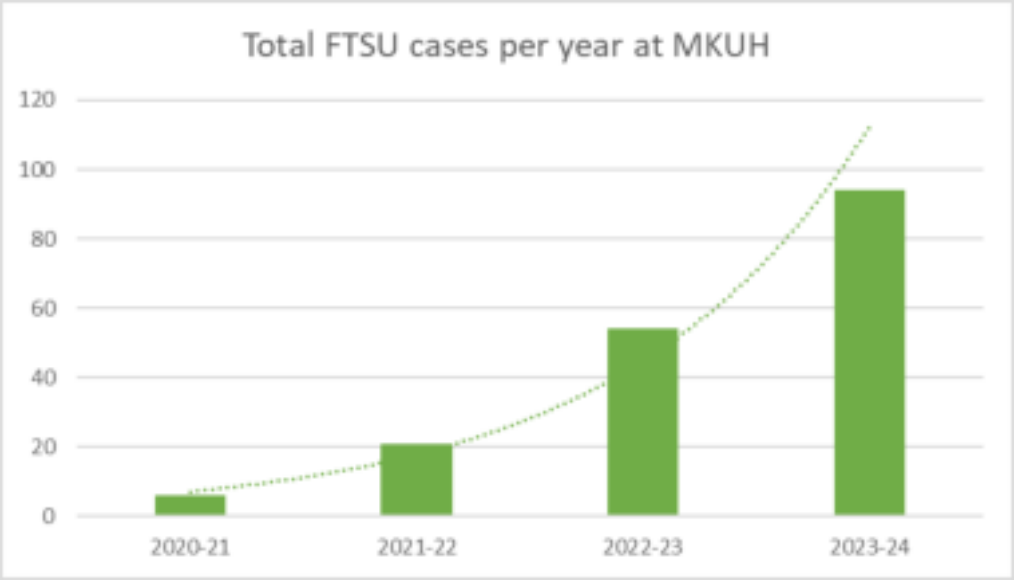
The entire team cover a range of roles including clinical, (nursing, therapies and ODP), administrative and support services. They include one MKUH Staff Network Chair.

During the year the Guardians have meetings every month to keep in touch with developments and receive support and training. This includes the opportunity for updates on policies via a HR Business Partner.

There are quarterly business meetings for all Champions, Guardians, and associated stakeholders e.g., the Trust Chair, Chief People Officer, Patient Safety Team, EDI Lead. In addition, the Guardians are encouraged to attend the quarterly virtual and/or in person East of England Regional meetings, and the monthly Community of Practice. The NGO provide regular lunch and learn webinars and Guardians undertake the mandated refresher training.

4. Analysis of FTSU Activity

The cases reported for the period has shown a significant increase with 94 new cases compared to 54 new cases recorded in 2022-23.



The charts (see Appendix 1) show the areas, case types[1], and staffing categories[2] of cases raised so far. Surgery has the most at 36, followed by Core Clinical with 26. Neither CSU nor Department level data is currently recorded. There were 25 cases related to inappropriate attitudes and behaviours and 26 worker safety and wellbeing cases, and 22 cases of bullying and harassment. Nurses and Midwives were the

[1] Categories set by the NGO.
[2] Categories set by the NGO.

highest reporting group with 25 cases, followed by Allied Health Professionals with 16 cases.

From 1st April 2023 the Guardians started collating protected characteristic data from those speaking up to be able to provide better data for ethnicity, age range, disability status, and gender. As the reporting of this data continues, it will help us identify groups who are more likely to speak up and help identify trends by Division and Case Type. The team have recently started collecting data on which department the person speaking up works in. Less than half of witnesses have shared their protected characteristic data.

4.1. Findings by Case Type

Case categories are agreed with the person speaking up, and where these are multi-faceted, the Guardian will allocate a primary category, and a second and third if required. The data is based on the primary category that was agreed with the witness.

Worker safety and wellbeing = 26 cases. The most common theme is on wellbeing which can range from reports of violence and aggression, to feeling stressed, and unable to carry on working with a particular colleague, often resulting in long term sickness.

Inappropriate behaviours or attitudes = 25 cases. These cases consist of a broad category of examples, where colleagues have talked over others or staff have felt ignored due to their job role. There have been cases where line managers have referred staff to the Guardians rather than seek to sort the concerns themselves.

Bullying or harassment = 22 cases. These cases range from reports of feeling pressured to cover bank shifts, to being exposed to upsetting comments from colleagues or senior managers.

Disadvantageous and/or demeaning treatment (Detriment) = 9 cases. These cases consist of where a witness has raised an issue to their manager and then this act has had a detrimental impact on their working relationships.

Patient safety/quality = 12 cases. These cases have been related to indirect concerns of possible patient safety, for example where staffing levels are raised as a concern with the suggestion that this is impacting on patient safety. The Guardians work closely with the Patient Safety Team to enable sharing of concerns and data to ensure patient safety has not been compromised. This category has been used for cases where there is a potential negative impact on patient care. No cases have been raised with the Guardians in the period where there has been patient harm. Guardians know they have a responsibility to report any immediate risk to patient safety to the appropriate senior clinicians and safeguarding as required.

4.1.1 Equality and Diversity Data

Gathering data on protected characteristics has been a new objective for the Guardians. Less than half of witnesses declare their protected characteristics, the data collated since April 2023 is in Appendix 1. The data shows that 31% of those recorded as speaking up are from a BAME background. You are more likely to speak up to the FTSU Guardians if you identify as male.

All cases are logged. The recorded options for follow up actions taken by Guardians once we have asked "What would you like to happen next?" are:

- If the case is anonymous, record what narrative has been given so it can be considered against other cases that may be related.
- Agree the witness will take next action e.g., speak to another directly.
- Advise taking case to HR, to be reviewed for action against a formal policy such as Disciplinary or Grievance.
- Advise meeting with a line manager to pass details on which may lead to an investigation.
- Agree plan for ongoing contact and support where cases may be ongoing.
- Seek feedback on the work done by Guardians from those who have spoken up.

4.2. Themes

The Lead FTSU Guardian meets regularly with members of the Workforce Team to identify trends and themes. Various data sources are used to undertake this work alongside the FTSU data including Staff Survey results, Employee Relations activity, exit interviews, and feedback from staff engagement events.

This review has identified the following themes and trends:

- Speaking up cases continue to increase. Incivility and inconsistent treatment and behaviours from managers are common themes.
- Managers' listening up skills are variable. The increase in cases has shown that some employees feel that managers are not taking action to challenge inappropriate behaviours.
- Some managers refer to FTSU rather than deal with the situation themselves, potentially due to a confidence and knowledge in how to address the issues.
- Following up by managers is not always carried out promptly or to the employee's satisfaction.
- The HRBPs have a programme of retention work and have invited the Lead Guardian to contribute to the delivery of this through the Steering Group.
- Where a worker has told us they are concerned about their own wellbeing, be it mental or physical because of the situation they are facing, they are encouraged to use Trust resources such as Vivup and the Staff Health and Wellbeing team for further support.

Work continues to triangulate outcomes from concerns raised with HR data so that progress reports and activity can be shared with the Trust to reassure that action is taken. It is noted that the Trust is embarking on further work around the culture of the workplace that will help understand where the Trust can improve on processes and

programmes of activity to improve culture and inclusion in line with Trust values and behaviours.

Whilst the trend of increasing numbers of speaking up cases continues, the need to address behaviours that are not in line with Trust values requires some resource and focus. The Lead Guardian speaks at the MKUH Managers Way programme and continues to engage regularly in Trust induction mornings.

5. FTSU Team Activity Update

The FTSU Team have trained and recruited more Champions during the year. The recruitment process is carried out using an NGO template to develop a robust and fair approach, with a focus on building the number of Champions. Developing Champions into Guardians after a set period and where there is enthusiasm to take on the role needs careful consideration to avoid dilution, confusion, and inconsistency in the FTSU service. Guidance from the NGO should be followed.

Guardians hold regular confidential catch-up sessions with each other to ensure our own wellbeing and to give support. The Champions are supported in groups by each Guardian, again to offer support and encouragement. October is the NGO Speaking Up month with the theme for 2024 to be announced by the NGO. Working with Communications to plan FTSU activity for the coming year will ensure that there is publicity in place to support good attendance at the events.

Recruitment to the FTSU Lead Guardian role was carried out in Q4 with a national advert and promotion through linked in and the Guardian network. Recruitment was carried out with engagement from the networks, FTSU Guardians, and Human Resources with stakeholder events and peer assessments. The selected candidate started in post full-time in June 2024.

6. National/Regional Update

The NGO provides regular updates and is working to emphasise the importance of speaking up in the light of the cases that still occur. The NGO encourages cultural change work to take place, particularly to make sure selection, recruitment, and retention are focused on appointing people with the required values. The Trust is currently developing Values Based Recruitment processes.

The East of England regional network is active and as well as quarterly network meetings, hold monthly community of practice meetings. In between times the network communicates ideas and questions to help individual Guardians when a question arises. All our Guardians try to access these meetings, though time-constraints often make this difficult.

7. Audit & Governance

An opportunity to use a questionnaire for MKUH employees and workers to complete regarding FTSU is planned for 2024. Oversight of the FTSU service is done through regular updates and reviews with the Deputy Chief People Officer. Feedback is

sought from those who speak up through a feedback form for the service and of those returned the feedback is 100% positive. Audits related to FTSU are required to aid service planning going forward.

7.1. CQC Readiness Update

The Lead Guardian has engaged with the Trust CQC Preparedness Board meetings. The Speaking Up policy has been reviewed and updated based on the NHSE template policy dated 2022. Whilst senior leaders and the lead Guardian would be interviewed by the CQC, they will also interview staff at all other levels about access to, and value of FTSU at the Trust. It will be expected by the CQC that managers will be able to describe the 'Speak Up, Listen Up and Follow Up' processes that are highlighted in the training modules. The Trust is currently at 98% compliance for Freedom to Speak Up Training. Managers and senior managers are both at 88%.

7.2. Local FTSU Self-Assessment Update

The Executive Lead for FTSU (Chief People Officer) reviews the local Trust FTSU activity against the national reflection and planning toolkit. Following this an action plan is devised to amend processes and procedures as required. Progress against the action plan this period is -

- The Speaking Up policy was reviewed to ensure compliance against the national policy and revised incorporating the NHSE model.
- Increased numbers of Champions

Progress planned next period is -

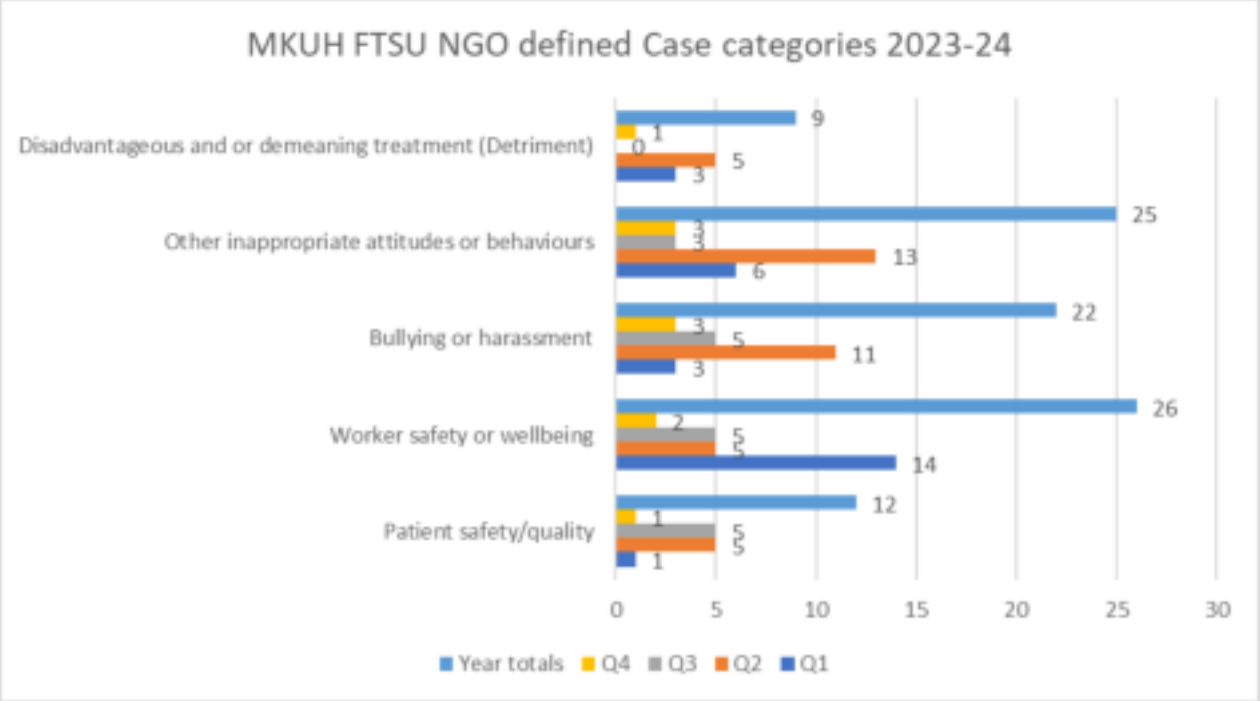
- New Lead Guardian and more Champions to be recruited.
- Training for the Guardians and Champions on HR processes
- Introduction of Courageous Conversations training for leaders and managers on the soft skills needed for listening to concerns.
- Focussed FTSU support and visibility.
- Working with the Assistant Director of OD and Education for increased input and support into implementing cultural change around behaviours.

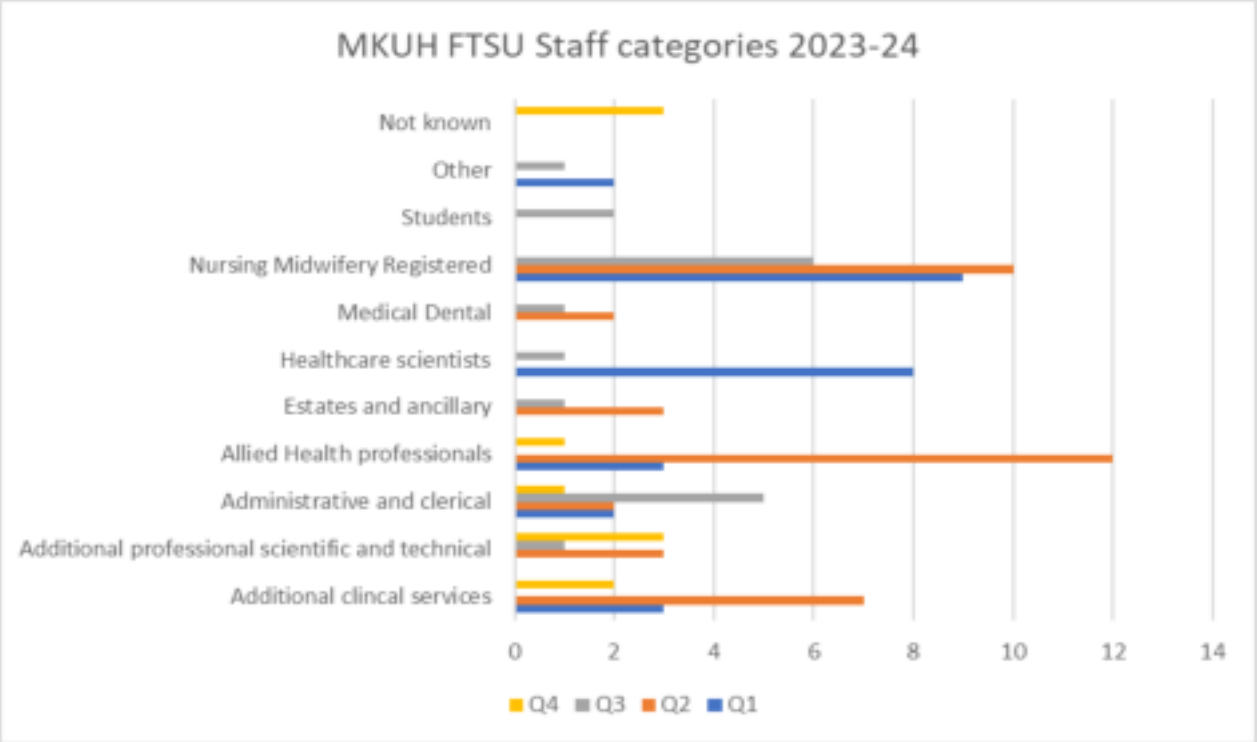
Completed actions include regular meetings with the Deputy Chief People Officer, sharing data with HR Business Partners and a FTSU presence in management training and staff induction sessions.

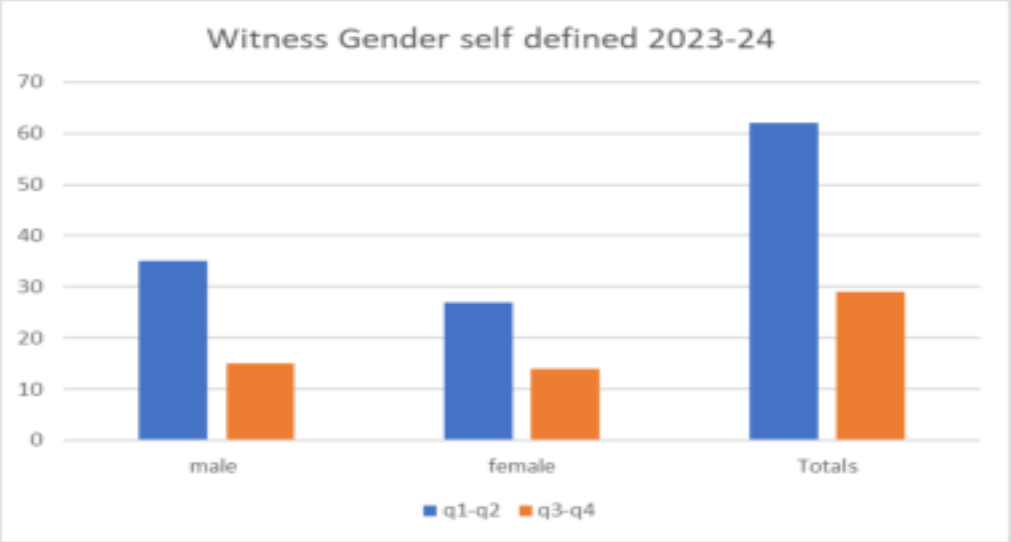
8. Recommendations

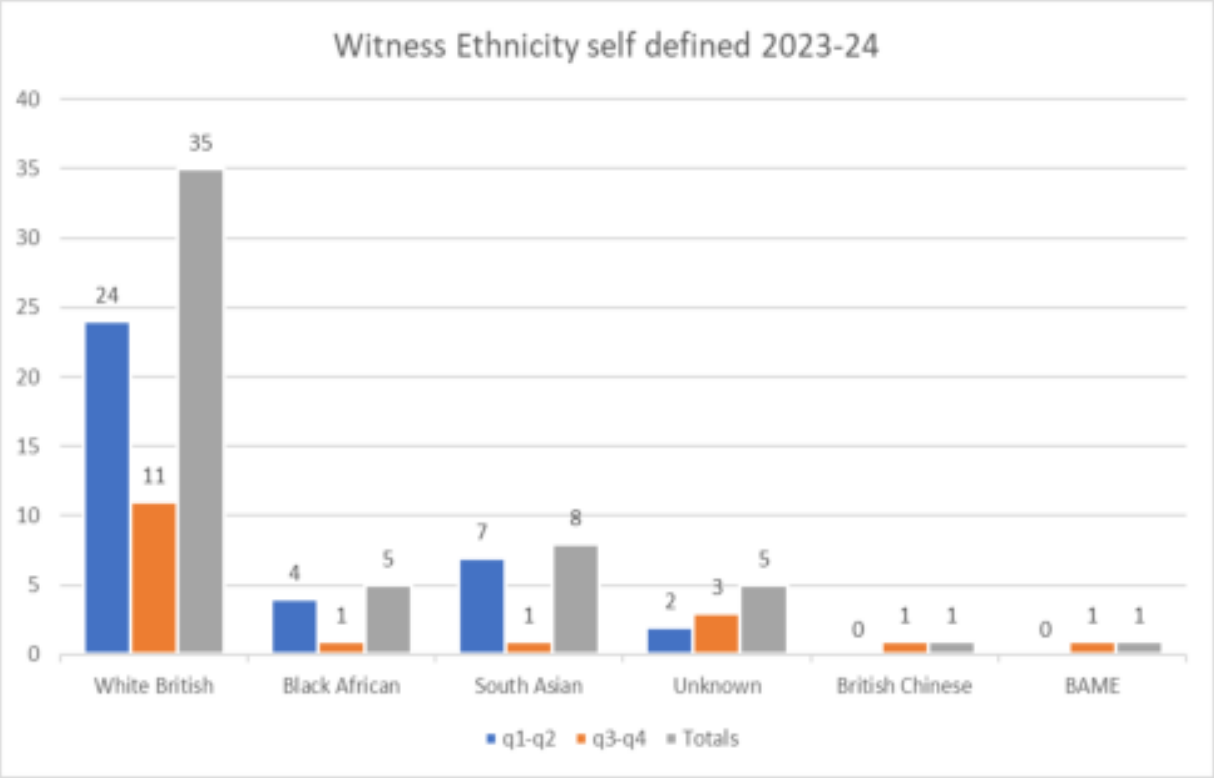
Board members are asked to note the contents of this report and the actions listed.

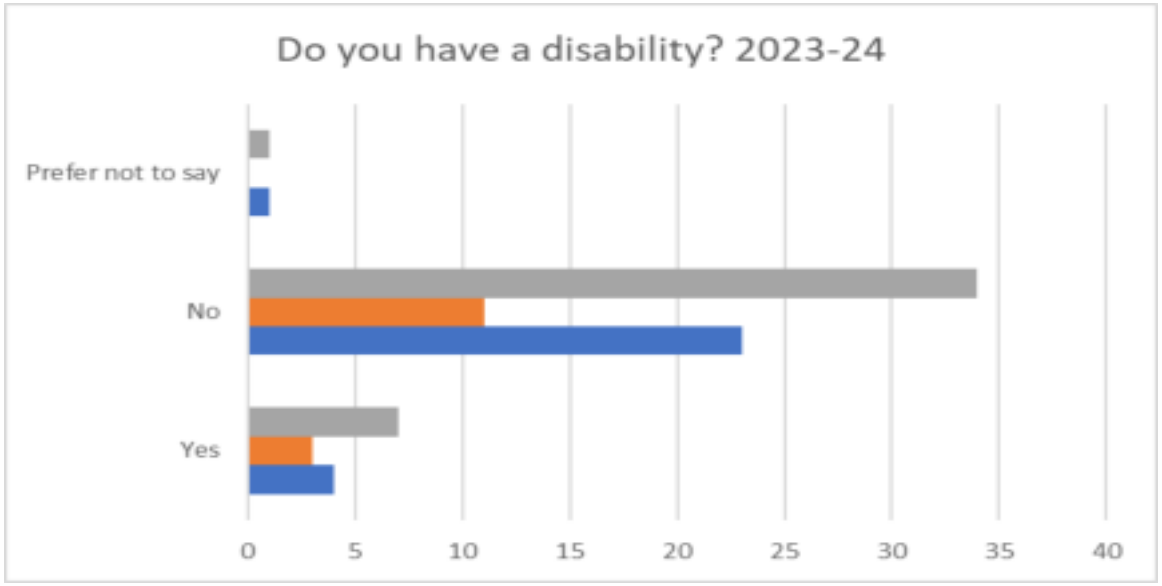
Appendix 1
Data Charts

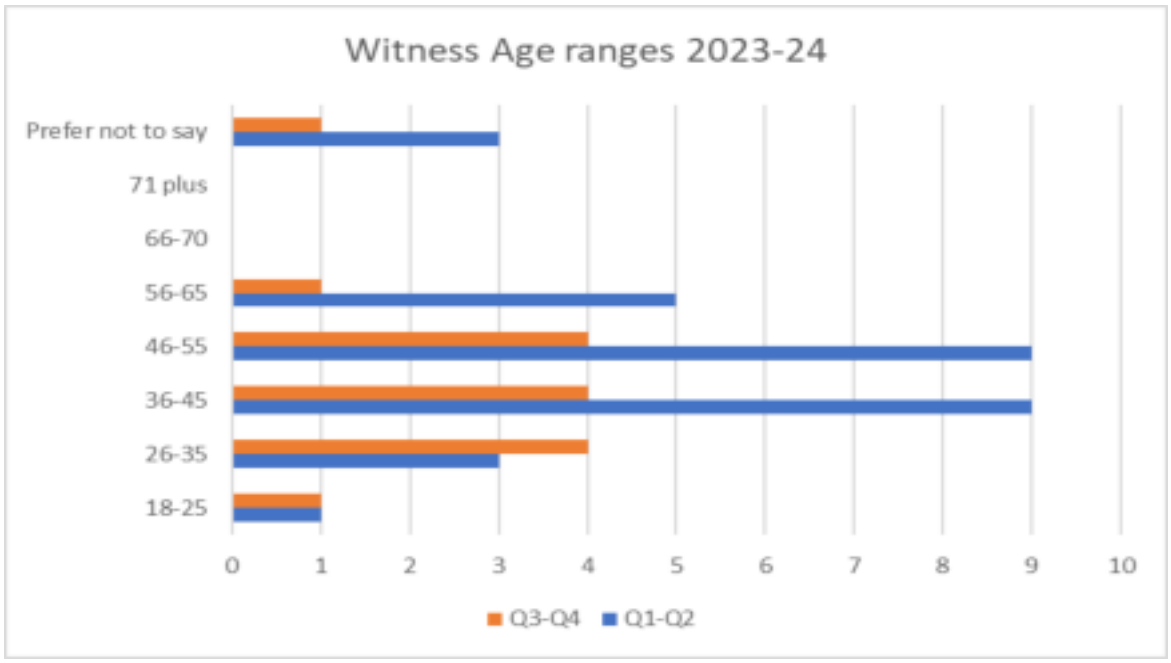





Witness Gender self defined 2023-24
70
60
50
40
30
20
10
0
male
female
Totals
q1-q2
q3-q4


Witness Ethnicity self defined 2023-24
40
35
30
25
20
15
10
5
0
24
11
35
4
1
5
7
1
8
2
3
5
0
1
1
0
1
1
White British
Black African
South Asian
Unknown
British Chinese
BAME
q1-q2
q3-q4
Totals


Do you have a disability? 2023-24
Prefer not to say
No
Yes
0
5
10
15
20
25
30
35
40


Witness Age ranges 2023-24
Prefer not to say
71 plus
66-70
56-65
46-55
36-45
26-35
18-25
0
1
2
3
4
5
6
7
8
9
10
Q3-Q4
Q1-Q2

Meeting Title	**Trust Board**	**Date: 4th July 2024**
Report Title	**Risk Register Report**	**Agenda Item Number: 15**
Lead Director	***Kate Jarman, Director of Corporate Affairs***	
Report Author	***Paul Ewers, Senior Risk Manager***	

Introduction	The report provides an analysis of all risks on the Risk Register, as of 5th June 2024.		
Key Messages to Note	Please take note of the trends and information provided in the report. **Risk Appetite:** This is defined as the amount of risk the Trust is willing to take in pursuit of its objectives. The risk appetite will depend on the category (type) of risk.		
Recommendation ***(Tick the relevant box(es))***	**For Information** ☐	**For Approval** ☐	**For Review** √

Category	Appetite	Definition
Financial	Open	Willing to consider potential delivery options and choose while also providing and acceptable level of reward and value for money
Compliance/ Regulatory	Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Strategic	Seek	Eager to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk
Operational	Minimal/ As low as reasonably practicable	Preference for ultrasafe delivery options that have a low degree of inherent risk and only for limited reward potential
Reputational	Open	Willing to consider potential delivery options and choose while also providing and acceptable level of reward and value for money
Hazard	Avoid	Preference to avoid delivery options that represent a risk to the safety of patients, staff, and member of the public

Note: The Risk Appetite statements are currently under 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	
Appendices/Attachments	Appendix 1: Corporate Risk Register

Milton Keynes University Hospital NHS Foundation Trust

Trust Board

Risk Management Report

July 2024

Paul Ewers

Data for report as of 5th June 2024

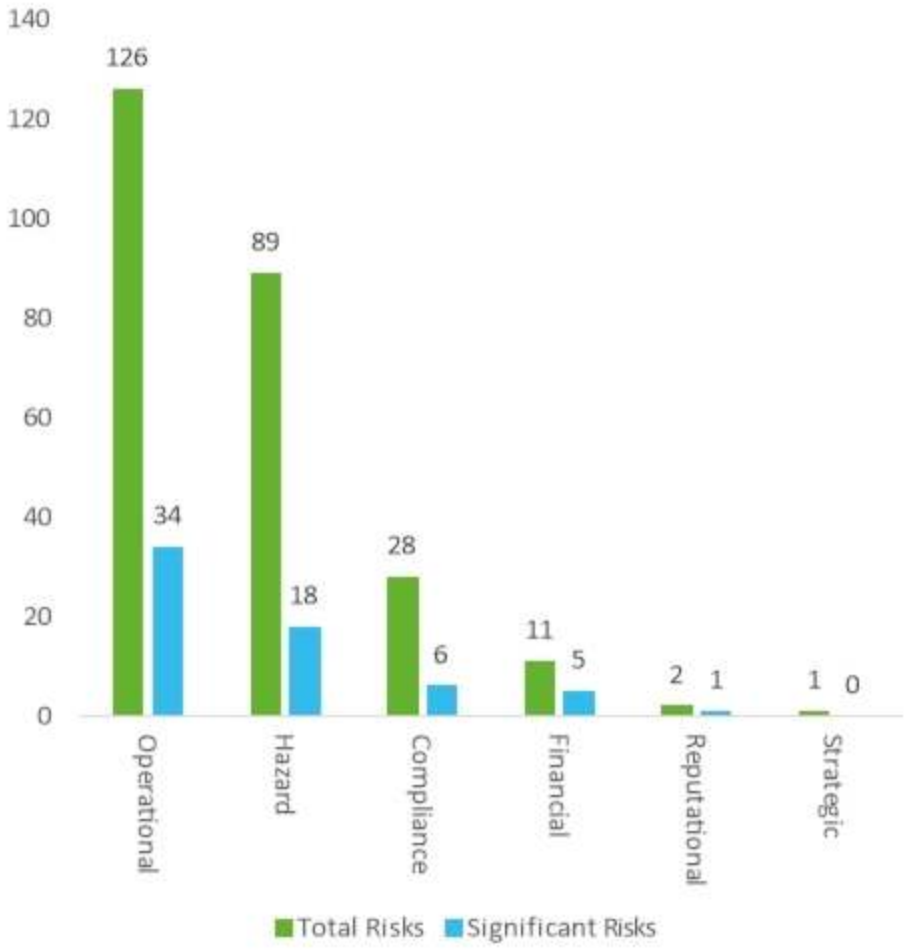
TheMKWay

Risk Profile

This chart shows the breakdown of categories of risk.

It identifies that most risks are Operational and Hazard risks. Representing 84% of the 257 risks across the Trust.

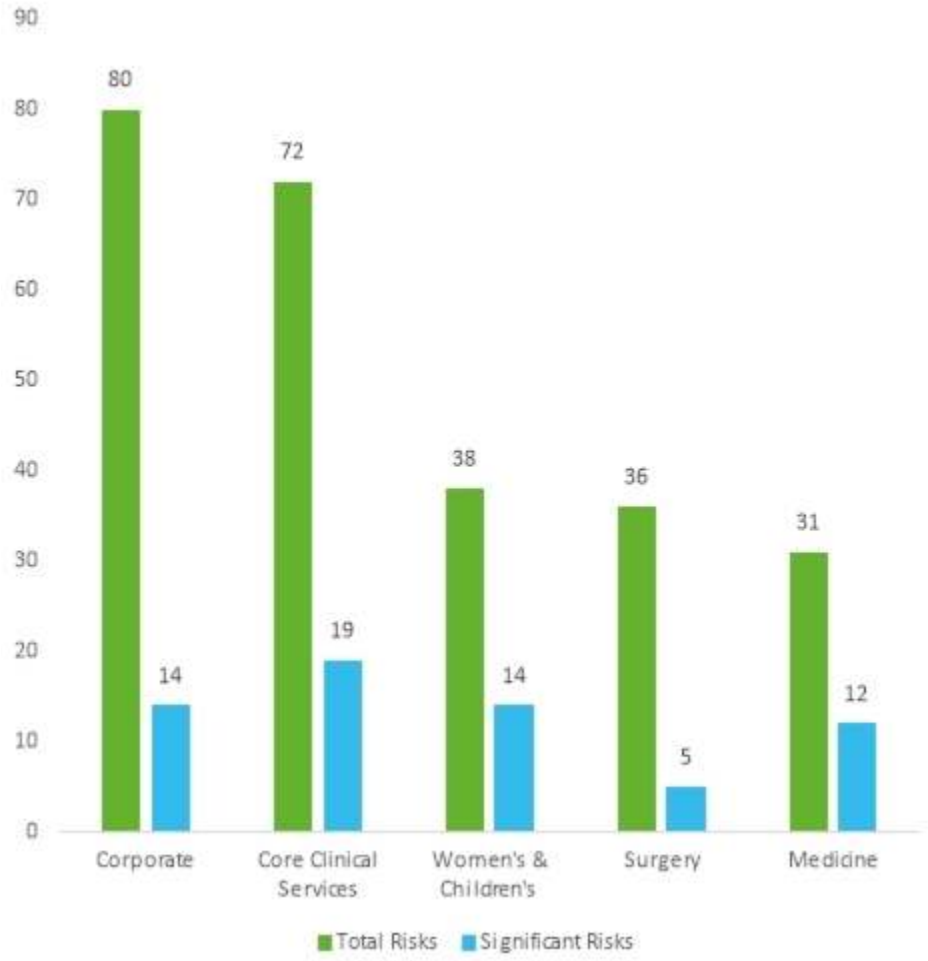
Similarly, these categories make up However, Divisions represent 52 (80%) of the Significant risks.



Risk Profile

The Divisional chart shows that most risks identified relate to corporate departments (for example, Estates, Workforce etc). These departments represent 31% of the 257 risks on the Risk Register.

However, Divisions represent 50 (78%) of the Significant risks.



Risk Heatmap

Milton Keynes University Hospital NHS Foundation Trust

The above chart shows all 257 risks and how they are distributed in relation to their **Current Risk Score**.

This demonstrates that 64 (25%) risks are currently graded as significant (red) risks, 129 (50%) are currently graded as moderate (amber) risk and 64 (25%) risks are currently graded as low/very low (yellow/green) risk.

Current Risk Score

Likelihood \ Consequence	1	2	3	4	5
5	0	1	15	11	0
4	0	0	36	27	5
3	1	16	41	19	6
2	1	11	20	12	8
1	2	1	1	8	3

Potential Significant Risks

There are 11 risks where the Consequence is 4 (major) or 5 (catastrophic).

Whilst the overall Current Risk Scoring is low, they have the potential to be <u>significant events</u> if they were to occur.

Current Risk Score		Consequence				
		1	2	3	4	5
Likelihood	5	0	1	15	11	0
	4	0	0	36	27	5
	3	1	16	41	19	6
	2	1	11	20	12	8
	1	2	1	1	8	3

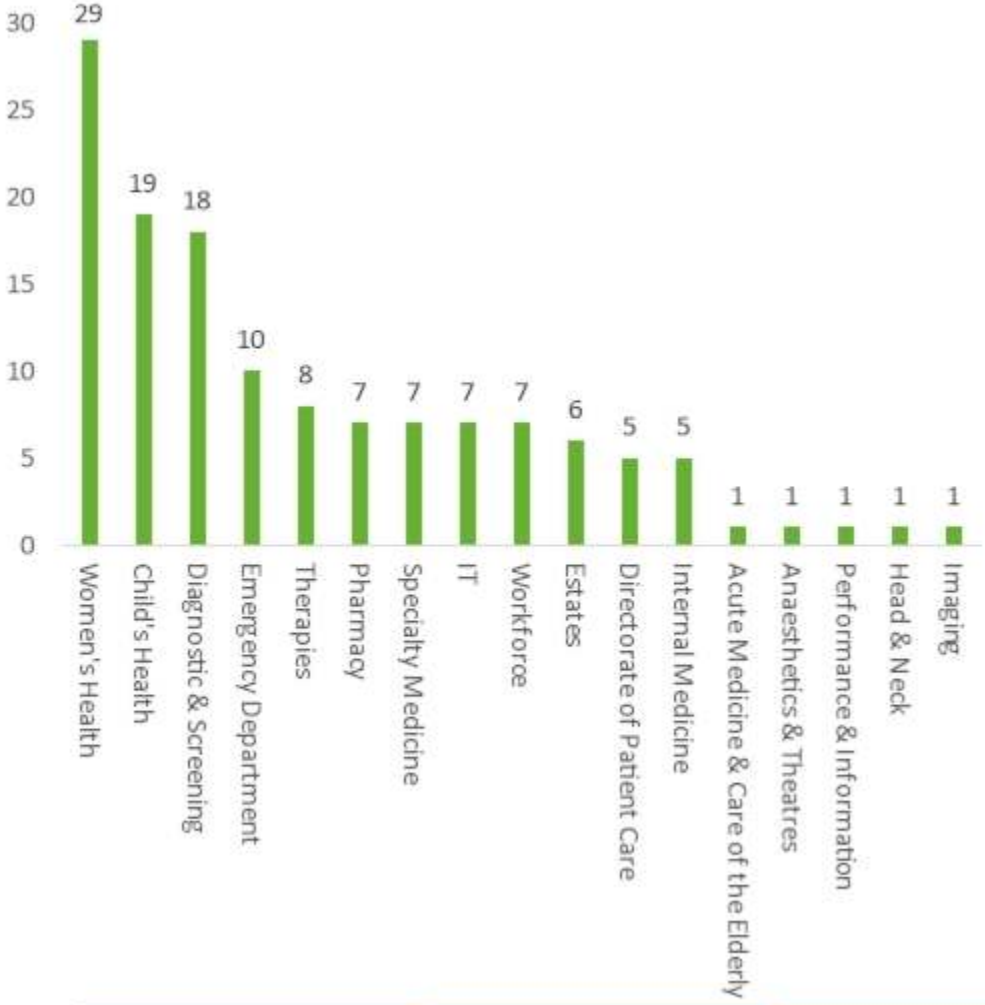
Recommendation 1:

Divisions are to review risks where the consequence is 4 or 5 and the likelihood is 1 to ensure the controls are in place and effective - to provide assurance to the Board.

Agree Lead and Deadline

Milton Keynes University Hospital NHS Foundation Trust

Overdue Controls



There are 133 controls that have past their due date.

Increase of 23

Controls need to be kept up to date to support decision-making and to ensuring robust monitoring of how effectively the risk is controlled.

Recommendation 2:

Review risk controls and ensure due dates are updated to reflect current information

Agree Lead and Deadline

TheMKWay

No Controls to Mitigate Risk

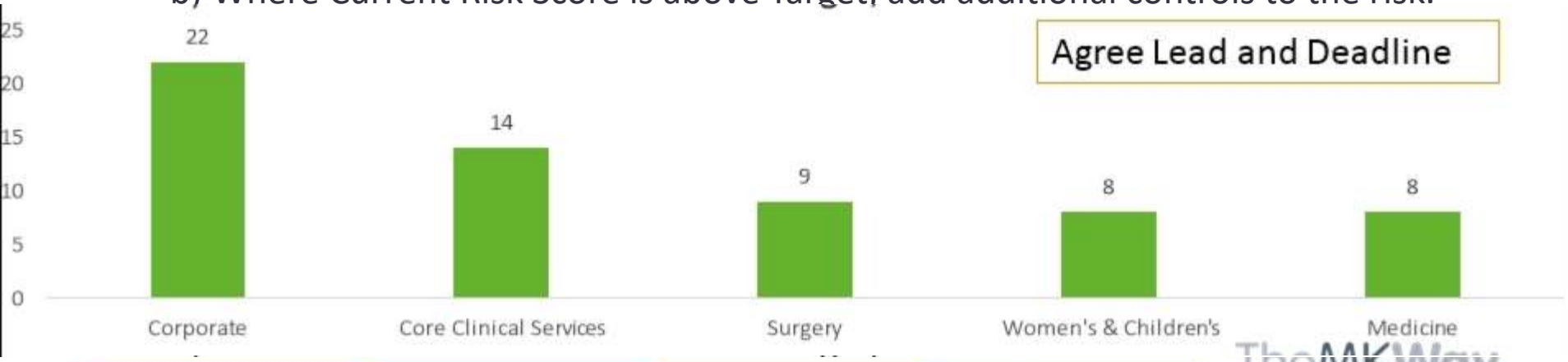
There are 61 risks where there are no outstanding controls, and the risk is not being tolerated. I.e. the Risk Treatment column is 'Treat'.

Recommendation 3:

a) Review risks where risk is being 'Treat':

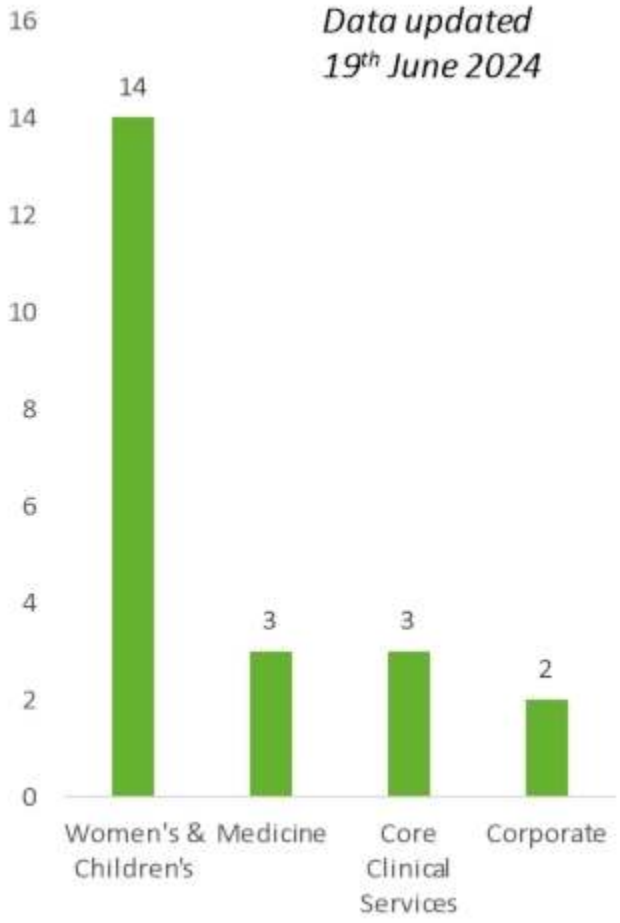
a) Where Current and Target Risk Score is the same, change Treatment Type to 'Tolerate'.

b) Where Current Risk Score is above Target, add additional controls to the risk.



Overdue Risks

At the time of reporting, there are **22** risks that are overdue review across the Trust.
13 risks are more than 1 month overdue, of which 2 are more than 3 months overdue.



Recommendation 4:

Ensure overdue risks are reviewed and updated to reflect up to date information.

Recommendation 5: Agree Lead and Deadline

Ensure ongoing monitoring and review of risk in line with Risk Management Framework

Agree Lead and Deadline

Milton Keynes University Hospital NHS Foundation Trust

Risks for Escalation to Corporate Risk Register

RSK-545 – IF the Trust is unable to access information from the legacy Risk Management System (RLDatix).

Inability to access legacy data such as incidents, complaints, claims, safety alerts has potential for Trust wide impact on the ability to benchmark and monitor trends pre-November 2021. It also has potential to prevent the Trust responding to Freedom of Information requests and requests for data from solicitors. **Risk escalated due to Trust wide impact.**

RSK–549 - IF Trust does not adapt to climate change impacts.

Risk has the potential to impact maintaining a safe patient service. Also potential for climate change to cause surge in activity due to adverse effects. **Risk escalated due to Trust wide impact.**

Recommendation 6:

That the two risks above are approved onto the Corporate Risk Register.

Milton Keynes University Hospital NHS Foundation Trust

Risk Management Training

Exploring proposal for Risk Management Training to be made mandatory for Senior Managers (Grade 7 and above) on a rolling 3 yearly programme.

Supported by Internal Audit.
Supported by feedback from staff attending previous training sessions.

Staff training in month:	7
Total Staff trained (>01/04/2023):	210

Reference	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-016	IF there is a lack of flow in the organisation THEN there may be an unsafe environment for patients	LEADING TO a potentially impact on bed space capacity, ambulance queues, missed Emergency Access Targets and overcrowding into ED/radiology corridors creating Health & Safety hazard and continued pressure, leading to poor patient care/treatment, nursing patients outside of cubicles in corridors and the middle of majors,and delays in discharge/transfer and the potential for an increase of incidents being reported regarding assessment/care/treatment, and or significant number of patients with a high acuity/ dependency being cared for in areas that are not suitable for safe care	Organisation		Kirsty McKenzie	04-Jun-2024	08-Jul-2024	Planned	25	20	12	Recruitment drive for more nurses/HCA's ongoing. Active management of Nursing/Consultant and Registrar gaps in rota daily to ensure filled. (12-Jun-2024)	EPIC consultant in place to aid flow within department and speed up decision making(22-Sep-2021), RAT-ing process and specialty referrals having a RAG system developed to prioritise sickest patients to be assessed.(22-Sep-2021), Walking majors and resus reconfigured. Expanded Cubicle space in Majors - extra 10 spaces, increased capacity using Acorn Suite.(22-Sep-2021), Internal escalation policy in place. CSU lead developing trust escalation criteria to alert trust leads to problems sooner - diverting patients to; Ambulatory care(22-Sep-2021), Since Covid pandemic, phasing plan in place with red and green zones within ED.(22-Sep-2021), Escalation plan for ED to mitigate patient pressures(22-Sep-2021)	Low	Treat	No change	07-Mar-2016
RSK-035	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		Helen Smith	07-Jun-2024	12-Jul-2024	Planned	20	20	6	Actively recruiting staff (01-Dec-2023), Add R&R	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	continued efforts to recruit. 2 posts offered but still lasrge gaps	07-Aug-2019
RSK-110	IF MKUH does not have a dedicated maternity triage area separated from ADAU, with dedicated staffing. THEN calls are answered by a variety of staff and in times of high activity, calls are missed, the staff that are answering the calls are being taken away from other competing priorities AND Delays to triage and ongoing care to service users And Delays to ADAU service users.	LEADING TO service users not being able to access advice resulting in delayed presentation; potential financial risk to the trust should adverse outcomes occur as a result; service users not being triaged and assessed for urgency of clinical need resulting in delayed assessment and possible adverse outcome; Day assessment users being seen alongside triage users results in delays of care with increased risk of poor outcomes and missed care. Poor experience leading to and increase complaints	Region	Women's Health	Natalie Lucas	18-Jun-2024	18-Jul-2024	Pending	16	20	6	Compliance to new pathway audit (15-Apr-2024), Assess feasibility of moving ADAU into a separate area from triage with costing (18-Jun-2024), Review staffing establishment for triage and ADAU to create separate establishment. (18-Jun-2024), Identify and create area for telephone triage which is away from the acute triage area (18-Jun-2024), Review obstetric contact for triage and ADAU to ensure timely escalation and review of patients (18-Jun-2024), Review feasibility of recording calls within triage for quality and training purposes Update: To implement call recording (15-Apr-2024)	1. Currently unable to staff a dedicated phoneline(26-Oct-2021), 2. RAG rating in place to mitigate current lack of formal maternity triage system(26-Oct-2021), BSOTS was partially put in place and is being audited weekly.(26-Oct-2021), Triage band 7 post to be advertised(12-Apr-2022), Submit business plans for change to the area to support the implementation of triage(27-Apr-2022), Implement MEOWs into maternity(27-Apr-2022), Review the staffing model(27-Apr-2022), Risk assessment to be performed in relation to Triage to understand if the implementation has been successful or if further changes are required(13-Nov-2023), Risk assessment to be performed in relation to Triage to understand if the implementation has been successful or if further changes are required(13-Nov-2023), Review staffing establishment for triage and ADAU to create separate establishment.(15-Dec-2023), Review opening hours for ADAU to assess feasibility for increased opening hours(15-Dec-2023), GAP triage guideline with recent RCOG triage best practice(15-Dec-2023), Review sluice area to have adequate space for testing such as PiGF and FFN(15-Dec-2023), Review sluice area to have adequate space for testing such as PiGF and FFN(15-Dec-2023), Review and plan for 90% of all inpatient staff to be BSOTS trained.(15-Dec-2023),	Low	Treat	No change to risk	06-Sep-2021
RSK-131	IF the cross-sectional imaging demand continues to increase for CT, MRI and ultrasound. THEN image acquisition and report generation turnaround times will significantly be delayed. This is due primarily from a lack of staffing capacity rather than equipment capacity.	LEADING TO delayed diagnosis and treatment with ultimately poorer patient health outcomes. As well as reputational damage due to long patient imaging waits and financial penalties being incurred from the department of health due to a lack of adherence to internal KPI'S and more importantly DMO1 national imaging datasets. Imaging team members also being affected and decreasing recruitment and retention ability due to pressurised working conditions. Pertaining to cancer pathways, potential increase in the required treatment, potential poorer prognosis for patient, poor patient experience, increase in complaints and litigation cases.	Region	Diagnostic & Screening	Paula Robinson	10-Jun-2024	31-Jul-2024	Planned	20	20	9	Business Case to be developed for Radiographers (10-Jun-2024), Review of Radiologists - demand and capacity (10-Jun-2024), Recruitment of staff (10-Jun-2024)	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), New CT Machine to be implemented(19-Apr-2022)	Low	Treat	Risk remains high. Service is reliant on agency to support service. Increased demands on service and workload pressures. Unable to meet demand with current capacity mostly due to staffing deficit.	01-Jun-2021

RSK-134	If there is insufficient funding, then the Trust may be unable to meet financial plans and targets or deliver its strategic aims,	Leading to service failure and regulatory intervention THEN the Trust will be unable to meet its financial performance obligations or achieve financial sustainability	Organisation	Karan Hotchkin	10-Jun-2024	10-Jul-2024	Planned	20	20	8	Work with ICS partners and NHSE to mitigate financial risk.	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), The current funding has now been clarified .The trust will work with BLMK system partners during the year to review overall BLMK performance(21-Mar-2022), Internal budgetary review/financial performance oversight processes to manage/mitigate cost pressures. Financial efficiency programme identifies headroom for improvement in cost base. Close monitoring/challenge of inflationary price rises(16-Nov-2022), Financial efficiency programme identifies headroom for improvement in cost base.(04-Sep-2023), Close Monitoring/challenge of inflationary price rises(04-Sep-2023), Medium Term financial modelling commenced with ICS partners.(04-Sep-2023), Escalation of key issues to NHSE regional team for support(04-Sep-2023), Close monitoring of Elective Recovery Fund (ERF) activity and income(09-Jan-2024)	High	Treat	Risk transferred from Datix	01-Apr-2022
RSK-202	IF Financial Efficiency schemes are not fully developed THEN There is a risk that the Trust will not delver the required level of savings	LEADING TO potential cash shortfall and non-delivery of its key targets	Organisation	Karan Hotchkin	10-Jun-2024	10-Jul-2024	Planned	20	20	8		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), Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partner. There are no cross-cutting transformation schemes yet identified and savings of around £9.2m as the end of Oct 223 have been identified against the £17m target. Whilst this shortfall can be mitigated this year, the risk is around the underlying financial position.(16-Nov-2022)	Medium	Treat	Risk transferred from Datix	01-Apr-2022
RSK-305	If there is insufficient strategic capital funding available in relation to NHP 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	Karan Hotchkin	10-Jun-2024	10-Jul-2024	Planned	16	20	10		The trust has a process to target investment of available capital finance to manage risk and safety across the hospital(06-Dec-2021), Trust is discussing this with the regional Capital Team and with the ICB capital allocations for 23/24.(16-Nov-2022), The Trust has established management processes to prioritise investment of available capital resources to manage emerging risk and safety across the hospital.(04-Sep-2023), The Trust is responsive in pursuing additional NHSE capital programme funding as/when additional funding is available.(04-Sep-2023), The Trust is agile in responding to alter notified capital slippage from across the ICS and wider region to take advantage of additional capital budget(04-Sep-2023)	Medium	Treat	On-going conversations with regional and national capital team	01-Apr-2022
RSK-374	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	Sally Burnie	04-Apr-2024	31-Jul-2024	Planned	12	20	8	weekly restore and recovery clinical meetings and weekly operational meetings (13-Jun-2023)		Medium	Treat	Risk continues as high due to current cancer performance and harm review processes in place, ADOs and Execs aware and performance reports produced for TEC	05-Aug-2022

RSK-409	IF the demand within the ED department outweighs the departments capacity THEN there could be increased waiting times for patients to be seen; there could be increased triage times, privacy and dignity of patients may be compromised; there could be increased violence and aggression towards health care providers; long length of stay for specialty patients in ED; delayed ambulance handover	LEADING TO medical condition being exacerbated with delayed treatment/hospitalisation/death; privacy and dignity compromised, poor patient experience leading to complaints/claims; vulnerable adults on trolleys in corridor in majors; Lack of space to hoist patients' safety, lack of dignity and respect in hoisting patients in middle of department ;Increase risk of stress and morale burnout of staff due to an inability to give basic nursing care to patients; Trapped in the event of incident/insufficient space to evacuate promptly leading to potential physical injury; Nurses do not have the necessary specific skills or competence to monitor speciality patients in ED such as oncology, Cardiac, gynaecological, endocrinology and acute care of the elderly patients requiring increased enhanced observation; the Trust may receive increased complaints, claims/litigation, enforcement leading to financial penalties/enforcement notices – breaches of Health & Safety at Work etc Act 1974, Manual Handling Operations Regulations 1992, Management of Health & Safety at Work Regulations 1999, Workplace Health Safety & Welfare Regulations 1999; Trust may be in breach of RCEM guidance; negative affect on recruitment and retention - low levels of staffing	Region	Emergency Department	Kirsty McKenzie	04-Jun-2024	08-Jul-2024	Planned	15	20	12	Reviewing specialist pathways to support flow within ED department (30-Jun-2023)	Rapid assessment and treatment (RAT) in place to support early identification and treatment of acute illness / trauma(13-Dec-2022), RAT area is monitored by a nurse in charge and emergency physician in charge (EPIC) to safety triage patients and initiate any specific tests/ scans or referrals to specialists(13-Dec-2022), Hospital ambulance liaison officer (HALO) in place to support Ambulance off loads.(13-Dec-2022), Daily escalation of pressures in department at site meetings(13-Dec-2022), ED dashboard updated to evidence escalation at site meetings(13-Dec-2022), Escalation to divisional directors for speciality support as requested(13-Dec-2022), Identified nurse to support with complaints in department(13-Dec-2022), Streaming nurse supports with quick rapid assessment and streaming to alternative service accordingly(13-Dec-2022), Standard Operating procedure to support streaming service and expectations of streaming nurse(13-Dec-2022), Streaming nurse to support with quick triage and observations of patients accordingly to ensure high risk patients are diverted accordingly to Majors or prioritised(13-Dec-2022), AECU encouraged to pull patients from ED as appropriate during escalation meetings(13-Dec-2022), Vulnerable patients moved onto a hospital bed under 4hrs and earlier at RAT if there is an increased risk of harm post x-ray(13-Dec-2022), Violence and aggression on the organisational risk register. Staff	Low	Treat	Risk approved at ED CIG and by triumvirate	20-Sep-2022
RSK-411	IF child protection medical assessments continue to be undertaken with current workforce arrangements within the Paediatric Assessment unit (PAU) as part of the current consultant and junior doctor and nursing workload . THEN there will be issues regarding the current workflow and clinical risk within a busy acute/emergency area.	LEADING TO delays and avoidable risk in being able to complete the medical assessments as per RCPCH guidelines and completion of medicolegal child protection reports for multiagency partners and court with the subsequent impact of children suffering further abuse/neglect or death.	Region	Child's Health	Keya Ali	10-Apr-2024	30-Apr-2024	Overdue	20	20	10	Clinicians currently try and complete this work within regular workload or work additional hours without remuneration. (10-Apr-2024), Junior doctor rota to include allocated slots in the week for child protection medical assessments and report writing (16-Aug-2023), Time for child protection medical assessments to be factored into consultant's job plans with additional consultant on the rota for child protection medical assessments and supervision as per RCPCH standards. (16-Aug-2023), Protected SPA time for Medical Report writing and formal peer review processes. Time for paediatric consultants to meet with junior team and deliver education on interpretation of injuries, multiagency working and child protection processes. (16-Aug-2023), In other areas the service is provided by community paediatricians. Trust to offer service for children under the age of two years only. Further discussions with BLMK ICB to progress this issue (16-Aug-2023), To include child protection activity within the winter escalation policy with a clear process as to how this activity will be managed safely given bed pressures (PAU closed to admissions and children to be seen in PED). (16-Aug-2023), To move location to an outpatient or day care setting ensuring appropriate IT support/ equipment and support staff/ chaperone available. (16-Aug-2023), Allocated area, child friendly environment to facilitate	Wherever possible the examinations are undertaken during the quieter times to enable an appropriate chaperone is present.(20-Dec-2022), Wherever possible cubicles are used for examinations(20-Dec-2022), The safeguarding nurses try and make themselves available. This has an impact on safeguarding team's capacity.(20-Dec-2022), HIE access on eCare SystmOne on certain computers only.(20-Dec-2022), Social worker requested to attend medical assessment(20-Dec-2022)	Low	Treat	Risk reviewed, no change.	28-Sep-2022
RSK-417	IF the Gastroenterology Department has an overwhelming number of new and follow up patients on their waiting list, and there is a significant demand on follow up capacity THEN there may be insufficient capacity to meet the demand on the service and recover the backlog of patients	LEADING TO Patients not being seen in a timely manner, Urgent referrals not being seen as quickly as they should, poor patient experience, competing priorities between new and follow up demand.	Region	Specialty Medicine	Lizzie Vella	22-Apr-2024	30-Jun-2024	Planned	20	20	10	PTL validation of all patients over 18 weeks (02-Oct-2023), Admin validation of Non-RTT (02-Oct-2023), Recruitment of nursing staff to enable more OPA capacity and implementation of IBD PIFU (20-May-2024)	Patients Expedited through WLI sessions(13-Jan-2023), Triaging of referrals where possible(13-Jan-2023), Slot utilisation report has been created and used by Patient Access and Medicine Division to ensure all slots are fully utilised and not wasted.(13-Jan-2023), Patient Pathway Coordinators ensure results are reviewed and follow up appointments booked when needed- linked to PTL validation.(13-Jan-2023), Clinical Validation of the non-RTT starting with the most overdue patients. This relies on free sessions and is slow progress at 25 patients per session.(13-Jan-2023), PIFU is implemented in Gastro, only small numbers of around 10-15 per month. Clinical triage is increasing numbers being put on PIFU.(13-Jan-2023), Patient Pathway Coordinators are now starting to review some clinics ahead of time to identify any duplicate appointments.(13-Jan-2023), One off report was run identifying over 200 duplicates, all duplicates were removed by Medicine Division.(13-Jan-2023), Recruitment into 12-month consultant and 12 month middle grade post(13-Jan-2023), Recruitment of 1WTE middle grade.(13-Jan-2023), Service review to allow clinical triage of new and follow ups(13-Jan-2023), Training CBO to check for duplicate appointments before booking, when creating a referral in RPAS to book outside of eReferral, to make sure eReferral is closed and discharged.(13-Jan-2023), Monthly duplicate report to be done by patient access and duplicates removed and closed(13-Jan-2023)	Low	Treat	Risk reviewed at Specialty Medicine CIG - No changed to risk.	21-Oct-2022

RSK-427	IF there is an increase in demand for inpatient and ED CT scans THEN some scans will be routinely waiting a number of days to be performed.	LEADING TO potential delays to patient treatment; delays to discharge.	Region	Diagnostic & Screening	Mike Pashler	28-Apr-2024	31-Jul-2024	Planned	16	20	6	Purchase and installation of 4th CT scanner (28-Apr-2024), Recruitment of Radiographers (15-Sep-2023)	Recruitment of Imaging Assistants(08-Feb-2023), Patients are prioritised based on clinical urgency to minimise risks as best as possible(09-Feb-2023), Adopting a fluid approach to managing the workload. Adapting to changes in priority at short notice.(09-Feb-2023)	Low	Treat	JD review and planned recruitment. Risk remains high due to staffing pressure and wait times.	20-Oct-2022
RSK-439	IF the Maternity Early Obstetric Warning Score (MEOWS) is not routinely used to assess observations of pregnant and postnatal service users outside of maternity THEN there is a risk that that identification of clinical deterioration could be delayed	LEADING TO a delayed response of escalation to maternity and rapid response and poor outcomes.	Region	Women's Health	Roxanne Vidal	18-Jun-2024	18-Jul-2024	Planned	8	20	4	Project to support the implementation of MEOWs within the Trust		Low	Treat	escalation to KLIB	07-Mar-2023
RSK-456	IF there is an increasing demand on the Blood Sciences service and staffing levels are no longer sufficient to provide a robust 24/7 service THEN staff will be unable to continue to meet service demands	LEADING TO: 1.The inability to cover 24/7 service and several gaps in the rota, which has already been evidenced 4 times in the last 3 months and this will result in no Out of hours cover which will mean the Trust will need to consider closing AE/Maternity and Theatres 2.Chief BMS having to cover shifts and calling people on sickness leave to help cover shifts due to lack of staff 3.An increasing delay in the turnaround time of results – KPI's for Biochemistry are significantly failing to meet the demands of the urgent service 4.Risk of losing limited expertise knowledge from department due to sickness 5.The inability to provide resilience cover for shifts due to having insufficient numbers enough to cover the shifts. 6.Increase in overdue governance and quality tasks 7.More samples are marked 'urgent' as clinicians hear of possible delays which exacerbates the problem. 8.A backlog of samples at the end of the day which is carried over to the following day or beyond which impacts integrity of samples from GP's 9.Senior scientific staff spend more time doing routine bench work to address the increase	Region	Diagnostic & Screening	Rebecca Potter	10-Jun-2024	19-Jun-2024	Pending	20	20	8	Recruitment of staff (10-Jun-2024), Training & Competency progression new staff (10-Jun-2024), Sickness Monitoring (10-Jun-2024), Monitor staff available for out of hours rota (10-Jun-2024)	Use of Agency, Locum and Bank Staff(17-May-2023), Currently utilising the 8a Chief BMS to cover shifts where possible.(17-May-2023), Prioritisation of urgent work(17-May-2023), Existing staff offered overtime(17-May-2023), Increase WTE staff resource in Chemistry within budget(23-Jun-2023), Recruit Haematology bank Bnd 4 resource(23-Jun-2023), Recruit Chemistry bank Bnd 6 resource(23-Jun-2023), Recruit Haematology agency Bnd 6 resource(23-Jun-2023), Recruit Chemistry Agency Bnd 6 resource(23-Jun-2023)	Low	Treat	Staffing levels remain critical. OOH covered by Ops Manager at least once a week since last update.	02-Mar-2023
RSK-457	If there are insufficient staffing levels (radiographers) THEN there will be reduced capacity in the department resulting in closure of the 3rd CT Scanner	LEADING TO delays to patient diagnosis and treatment, potential missed diagnosis; increased stress / increased sickness and potentially inability to retain staff	Organisation		Mike Pashler	28-Apr-2024	31-Jul-2024	Planned	20	20	6	Recruitment of staff (28-Apr-2024)	Prioritising 2WW patients at the expense of urgent, routine and planned/cancer follow-up patients(27-Jun-2023), Signposting patients to PALS Team, where appropriate(27-Jun-2023)	Low	Treat	JD reviewed and planned recruitment.	22-Jun-2023
RSK-529	IF Registered Nurse to patient ratios are not in line with national recommendations within acute paediatric services THEN there is an increased likelihood of delayed assessment, care and treatment to babies, children, young people and their families	LEADING TO an increased risk of physical and psychological harm coming to patients and their families and a detrimental impact on the well-being of staff members leading to a negative impact on recruitment and retention.	Region	Child's Health	Charlotte Nunn	18-Jun-2024	31-Jul-2024	Planned	20	20	5	Daily staffing management must include reporting in line with national standards for nurse-to-patient ratios. (13-May-2024), Recruitment of staff as per amendments to the establishment for the acute paediatric areas, following establishment review and benchmarking, To increase the number of practice supervisors and assessors to a minimum of 70% of the Registered Nursing workforce.	Escalation to Chief Nurse and agreement for additional RN to be added to every night shift on Ward 5 pending further establishment review and benchmarking against national standards.(10-Apr-2024), SafeCare is being implemented as part of trust wide Safer Staffing oversight.(10-Apr-2024), Paediatric Senior Nursing representation at daily staffing huddles.(10-Apr-2024), Red flags can be raised which include reasons for "short fall in RN time" or "skill deficit".(10-Apr-2024), Utilisation of Senior Nursing Team members or Nurses working on non-clinical duties to support clinical areas as required to maintain patient safety.(10-Apr-2024), PAU staffing has been separated from Ward 4 inpatient bed capacity to support with timely assessment(10-Apr-2024), Recruitment of Nursing Associates to support the Registered Nursing workforce.(10-Apr-2024), SNCT being undertaken twice a year to provide oversight and regular review of nursing establishment for acute paediatric workforce(10-Apr-2024), Nurse in Charge on day shifts aims to be supernumery to be able to provide oversight of acute ward setting.(10-Apr-2024), Specialist Nursing Teams (inc. Respiratory, Allergy, Diabetes and Oncology) are available to support with providing nursing advice and support for patients within their remit within the acute ward setting during working hours.(10-Apr-2024), Level 1 pathway available to support with children who are at risk of deterioration and require enhanced assessment and intervention(10-Apr-2024)	None	Treat	Risk reviewed at divisional quad meeting. Risk remains the same. Plan for escalation of risk to ensure trust oversight. business case to be commenced following establishment review and benchmarking against national standards.	28-Mar-2024
RSK-541	IF the interventional radiology department are unable to keep up with the demand of lower limb angioplasty procedures THEN patients there will be delayed diagnosis and treatment for patients that are referred for lower limb angioplasty procedures due to blockages within their arteries within the lower limbs	LEADING TO ulcers, necrosis, tissue/digit/limb loss	Region	Diagnostic & Screening	Richard Oldfield	12-Jun-2024	30-Jun-2024	Planned	16	20	16	Create a possible plan to long-term increase the number of slots for lower limb angioplasty procedures, Long-term increased number of slots for procedure	Prioritising procedures based on clinical risk/need(15-May-2024), Temporary increase of the number of slots set aside for lower limb angioplasty procedures(15-May-2024), Identify an increased number of slots available for the coming 6 weeks(15-May-2024)	Low	Treat	The locum radiologist will not return until 1st July. This leaves one radiologist who will only be able to perform 2 angioplasty procedures per week.	23-Mar-2024

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;	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		Tina Worth	08-Apr-2024	30-Jun-2024	Planned	20	16	12		Incident Reporting Policy(06-Sep-2021), Incident Reporting Mandatory/Induction Training(06-Sep-2021), Incident Reporting Training Guide and adhoc training as required. 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), Staff competence and confidence with Radar reporting, with improved reporting rate, reduction in inaccurate reports on system and/or failure of incidents being reported(01-Apr-2022)	Low	Treat	Risk reviewed - reporting rate on Radar has been increasing however as flagged at SIRG 7& Patient Safety Board the category of reported incidents is not felt to capture all untoward events or near misses + these have been received via alternative routes (CQC, complaints)	06-Sep-2021
RSK-036	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		Helen Smith	07-Jun-2024	12-Jul-2024	Planned	16	16	6	Recruitment of staff (05-Mar-2024)	Use of remote bank staff to update policies(28-Sep-2021), Business Case for additional Pharmacy staff(19-Apr-2022)	Low	Treat	staffing gaps remain	01-Oct-2021
RSK-053	IF the old building management system (BMS) does not effectively regulate the temperature within orthopaedic theatres 11 & 12. THEN when the the outside temperature is warm, and the temperature in theatres increases to above 25-26 degrees theatre staff are unable to regulate this from the theatre suite, and estates are also unable to reduce the temperature. **The recommended temperature perform orthopaedic surgery is 19 -20 degrees.	LEADING TO Patients – increases the possibility of infections, performing joint replacements at higher temperatures goes against manufacturers recommendations when using bone cement as the cement sets too quickly. Cancellations in surgery, Staffing - This also has a detrimental impact of staff that could be wearing x-ray gowns and are scrubbed, wearing gowns, gloves & face masks, making the staff and clinicians feel unwell and unable to work.	Region	Anaesthetics & Theatres	Arabelle Casey	31-Jan-2024	30-Jun-2024	Planned	9	16	4	Implementation of surgical block as part of new hospital build (11-Apr-2024)	Estates department are currently investigating. We are unable to put controls into place at this time.(01-Oct-2021), Improved alignment with Estates to investigate issues and make plans to resolve(03-Jun-2023), Plan in place to resolve issues with AHU for 27th- 29th December(07-Dec-2023)	Low	Treat	NO further update	18-Jun-2021
RSK-080	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	Jane Waddington	03-Jun-2024	24-Jun-2024	Pending	12	16	8		- 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), Implementation of Pathway Unit(27-Apr-2022)	Low	Treat	Risks graded 8 or above must be reviewed at least monthly. Therefore Risk Review Due changed to 21st July 2023	14-Jul-2011
RSK-088	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	Child's Health	Lazarus Anguvaa	10-Apr-2024	30-Apr-2024	Overdue	25	16	9	New Women's & Children's hospital build, Discussions with network to ensure appropriate admission/transfers into unit wherever possible Increase in accommodation added to capital plan (09-Mar-2023), Overcrowding at bedside - ensure prompt removal of equipment when not required. Wall mounted equipment to allow access at cotside Ultimately will not be resolved until new build has been completed and NNU moves across (09-Mar-2023)	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), x1 cubicle has been removed to provide workspace for staff(09-Mar-2023)	Low	Treat	Risk reviewed remains the same	19-Dec-2022

RSK-095	IF the Trust does not have access to suitably staffed and equipped Paediatric High Dependency beds that meet the recommendations of the RCPCH 2014 standards THEN the Trust runs the risk of failing to meet the needs of babies, children, young people and Families	LEADING TO Level 2 and Level 3 patients (and those at our tertiary centres who cannot repatriate children with High dependency needs) being potentially unable to access a Paediatric Intensive Care /High Dependency bed	Region	Child's Health	Charlotte Nunn	18-Jun-2024	30-Sep-2024	Planned	12	16	8		1. Children receive Paediatric High dependency care Levels 1 and 2 within our children's ward, however the staffing levels do not match the recommendations for this level of care, resulting in the need to use Agency to backfill when available(22-Oct-2021), 2. Th team have educated to degree level approximately 30 nurses to care for children with high dependency needs- the team endeavour to ensure 1 of these Nurses is always on duty(22-Oct-2021), 3. The team are currently benchmarking ourselves against the RCPCH PPICC standards to ensure the team can deliver care at a good standard- this is identifying gaps in equipment needs and staffing levels.(22-Oct-2021)	Low	Treat	Reviewed at divisional quad meeting on 18.06.24 - risk and review date updated. Paper presented to ED and discussed at divisional board related to gap in HDU nursing staffing and outlining recommendations. Exec team agreed to liaise with Spec Comm regarding HDU paediatric provision.	22-Oct-2021
RSK-107	IF uterine artery doppler are not performed for pregnant women who meet the criteria according to SBLv3 THEN there will be non-compliance with the recommendations by the Saving babies Lives bundle V3	LEADING TO pregnant women with HIGH RISK factors for fetal growth restriction who are at increased risk of perinatal mortality if there is failure to recognize increased risk of & fetal growth restriction and failure to serially scan them from 28 weeks; There will be missed opportunities to discuss high risk cases for early input with fetal medicine team	Region	Women's Health	Faryal Nizami	11-Apr-2024	31-May-2024	Overdue	16	16	6	Complete 3 months of audits for assurance that implementation has been successful (12-Mar-2024)	We are offering serial scans from 28 weeks to all high risk women which has put significant pressures on demand and capacity of the ultrasound department.(26-Oct-2021), Sonographers to be trained in UAD scanning(27-Apr-2022), Review with Obs and USS when in the service the dopplers will be implemented(12-Oct-2022), Obs USS SOP to be updated to align with fetal growth assessment guideline(07-Mar-2023)	Low	Treat	No change to risk	24-May-2021
RSK-126	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		Lazarus Anguvaa	10-Apr-2024	30-Apr-2024	Overdue	25	16	9		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), Refurnishing of Milk Kitchen and Sluice(04-Nov-2021)	Low	Treat	Reviewed and will be reassessed	19-Dec-2022
RSK-135	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	Rebecca Potter	18-Jun-2024	19-Jul-2024	Planned	16	16	4	Project Manager role identified to lead project for MKUH (18-Jun-2024), UAT to be completed (18-Jun-2024), Analyser Connections (18-Jun-2024)	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), High Level Design Completed(01-Dec-2021), Low Level Design to be completed(03-Feb-2022)	Low	Treat	Budget approved until Dec 24, backfill approved until Dec 24, ongoing progress with analyser connections. Go live date is now a window, Dec 24.	01-Sep-2019
RSK-142	IF there is insufficient capacity and ongoing unsustainable demand for dietetic input for Paediatric patients (both inpatient and outpatient) . IF Home Enterally Fed Paediatrics patients continue to be seen our outpatient structure which is not adequate to meet their demands and needs. 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		Elizabeth Pryke	03-Jun-2024	01-Jul-2024	Planned	15	16	6	In contact with commissioners to discuss service provision Collecting additional data (feedback from stakeholders, benchmarking etc) to support business case (13-May-2024), Business Case for paediatric Home enteral feeding service (13-May-2024)	Existing staff are working some additional hours but this remains insufficient to meet the needs of the service(04-Nov-2021)	Low	Treat	Insufficient time to take forward - re. commissioning of community paediatric service	01-Nov-2021
RSK-157	IF There is insufficient Speech and Language Therapy capacity to meet referrals demands resulting from poor workforce supply/ capacity and inefficient use of clinical time due to IT access.	LEADING TO patients not receiving input in line with Sentinel Stroke Audit National Programme (SSNAP) (communication and timely input to support patient discharges Delayed discharges, poor patient experience and increased length of stay.	Region	Therapies	Jamie Stamp	17-Jun-2024	09-Jul-2024	Planned	16	16	4	To scope requirement for SLT provision at MKUH (03-Jun-2024)	Daily updates are provided by the SLT to confirm outstanding referrals and priority patients for that day.(12-Nov-2021), To review opportunities to skill mix current workforce in light of recruitment challenges. For example, meetings to take place with community services to consider increasing therapy assistant time to improve input on the Stroke Unit.(11-Apr-2022), Team Leader is now in post - to ensure that regular meetings are taking place to look at recruitment and training. Band 3 Therapy Assistant (FTC) interviews are scheduled. SSNAP actions plan has been updated to reflect this.(24-Jun-2022), To create Quality Scheduled to capture data relating to Speech and language Therapy activity for discussing at quarterly meetings with the provider. Head of Therapy has met with the Operational lead for medicine to start initial discussion about what data they want captured from a stroke point of view.(24-Jun-2022), To meet with medicine division to understand areas of improvement needed to achieve the SSNAP data for Speech and language Therapy(14-Dec-2022), Arrange meeting with CNWL to discuss current staffing levels and mitigation(14-Dec-2022)	Medium	Treat	Score remains unchanged, despite improvements being noted in the SSNAP score in the last quarter (from E to C) this score has dropped again back to E in the last quarter due to annual leave, absence and high numbers of stroke patients - reported by Speech and Language Therapy. An options appraisal has been submitted to Chief Nurse and Executive Directors for consideration (See Attached).	12-Nov-2021

RSK-377	IF Microbiology does not have a Quality Management System and is unable to provide quality assurance THEN the department may not able to achieve accreditation for the range of tests performed in the department	LEADING TO potential for patients to receive incorrect results or delays in receiving results, diagnosis and treatment, impact on Trust's reputation, financial penalties, loss of Service User Contracts, loss of ICB commissioning, loss of staff, difficulties recruiting staff, inability to manage incidents, audit, Trust policies and equipment records in a timely manner	Region	Diagnostic & Screening	Rebecca Potter	20-May-2024	19-Jun-2024	Pending	16	16	8	Improve training and competency programme (20-May-2024), ISO 15189:2022 Gap analysis complete for Pathology. Path-wide action plan devised. (20-May-2024)	Quality Manager and Quality Associate Practitioner in post(30-Aug-2022), Monthly KPI's to monitor progression(30-Aug-2022), Additional support utilising bank staff as required(30-Aug-2022), Quality Management System in place that is robust in 5 other disciplines within Pathology(30-Aug-2022), Additional training for staff in utilising the QMS and understanding(30-Aug-2022), Monthly departmental and clinical meetings to review, communicate and action decisions(30-Aug-2022), EQA and IQC participation(30-Aug-2022), Audit Programme(30-Aug-2022), Training and Competency programme(30-Aug-2022), Mock UKAS inspection(30-Aug-2022), 1-1's with Senior staff to establish training gaps(30-Aug-2022), Increase formal training within departments for all staff to use Q-Pulse as required(30-Aug-2022), Improved clarity of roles and responsibilities(30-Aug-2022), Implement stock management system(30-Aug-2022), Review rota Management(30-Aug-2022), 2x Band 7 acting as Chief from OUH to support for 3 months,.(16-Jan-2023), Lean process review of all bench areas - led by OUH staff(16-Jan-2023)	Low	Treat	UKAS 2022 Gap analysis underway. Gaps in QMS identified.	01-Jul-2022
RSK-399	IF the staffing establishment within the Pharmacy Aseptic Team is not resilient and there is insufficient senior aseptic staff to complete the higher technical tasks THEN there is potential for the department to be regularly working over capacity	LEADING TO a breach in regulatory guidance, an ability to maintain the QMS work required.	Region	Pharmacy	Stephen Thomas	02-May-2024	01-Aug-2024	Planned	16	16	12	work with finance to understand funding streams to enable business case development. (02-May-2024), Request QA roles utilising savings made by pharmacy procurement. (02-May-2024)	Outsource some patient specific chemotherapy(09-Nov-2022), Discussed at monthly QMS meeting, more critical QMS tasks being prioritised for available time at present(09-Nov-2022), Review of staffing to establish what additional staffing is needed and who to improve retention and development of staff we currently have(09-Nov-2022), Review of senior staffing, including succession planning. Develop posts/time for staff to focus purely on quality tasks, not just operational.(09-Nov-2022)	Medium	Treat	Movement of budget to support but still requires resolution	01-Nov-2022
RSK-414	IF The Dermatology Department does not have appropriately trained nursing staff to be able to provide a Phototherapy Service THEN the service will not be able to provide a phototherapy, which is an integral part of the Dermatology Service	LEADING to patients that are unable to access Phototherapiy being placed potentially on medication unnecessarily to try to manage their conditions in the interim	Region	Specialty Medicine	Elizabeth Winter	04-Jun-2024	31-Jul-2024	Pending	16	16	12	Recruitment of adequately trained phototherapy nurse. (09-Apr-2024)	List is closed to new referrals(13-Jan-2023), Patients have been reviewed and where appropriate placed on medication(13-Jan-2023)	Low	Treat	Referred to Liz for recruit and retention update	02-Nov-2022
RSK-424	IF the new information standard regarding SDEC is released without significant operational and technical changes to the way the relevant information is collected THEN MKUH may not be able to submit the dataset in the required format with the required content LEADING TO a potential financial and reputational impact to MKUH	Potential financial, reputational, contractual, or operational impacts.	Organisation		Craig York	05-Jun-2024	04-Sep-2024	Planned	12	16	4	Review of data needs, implications on workflow in eCARE, needs to be undertaken before any known work can be scoped. New data standard has been released, work required on SDEC data collection before consideration for meeting national standards.		Medium	Treat	Work has started on understanding workflows in SDEC to support the design of a new solution to be able to capture data for the submission.	25-Jan-2023
RSK-438	IF children and young people <17-years waiting for a mental health bed or a mental health assessment, have an increased length of stay in the Emergency Department THEN the patients may have an increased waiting time; exposure to acute traumatic incidents potentially triggering challenging behaviours; increased pressure on staff	LEADING TO increased risk of self-harm and suicide; increase in complaints; poor patient experience; increased risk of violence/abusive towards staff; staff absence/low morale/stress;	Region	Emergency Department	Kirsty McKenzie	04-Jun-2024	08-Jul-2024	Planned	15	16	16	Reviewing specialist pathways to support flow within ED department (10-Apr-2024)	Daily escalation of pressures in department at site meetings,(07-Mar-2023), Staff support escalated daily to the Matron of the day at safety huddle(07-Mar-2023), Escalation meetings daily with relevant stakeholders to discuss care and support(07-Mar-2023), CAHMS provide RMN support, if unable escalated at site meeting(07-Mar-2023), Escalation to divisional directors for speciality support as appropriate(07-Mar-2023), ESR training in place to support development of staff(07-Mar-2023), Identified nurse to support with complaints in department(07-Mar-2023), If appropriate and on appropriate risk assessments carried out, patients can use ward 4 or 5 for a shower(07-Mar-2023), Meals provided by cook chill(07-Mar-2023), Families if appropriate encouraged to stay to support patient(07-Mar-2023), In the adult ED Panic button in place in Minors(07-Mar-2023), Body cam worn by staff in high-risk localities such as streaming and triage in the adult ED(07-Mar-2023), Emergency button by each bed(07-Mar-2023), Security in the hospital24/7(07-Mar-2023), Breakaway training available for all staff and highly advised in ED(07-Mar-2023), Zero tolerance policy to Violence and Aggression in department – escalate to NIC, site team, as appropriate. Encouraged to fill out a	Low	Treat	Risk description simplified following review at Risk & Compliance Board (05/04/23)	08-Nov-2022
RSK-473	IF the Trust does not have a working CTG flatbed scanner THEN CTGs may not being available on EDM negatively impacting on patient care, the ability to review / audit / investigate / birth reflections	LEADING TO poor patient care / experience; delay in learning & improving from incidents, complaints, claims etc; inability to provide evidence for inquests/claims	Region	Patient Access	Stevie Jones	10-Jun-2024	10-Jul-2024	Planned	20	16	8	Backlog has reduced from 12 months to 9 months. (03-Jun-2024)	Request CTGs from medical records(10-Aug-2023), Obtain a flatbed scanner with a view to increasing to two scanners.(10-Aug-2023), Recruitment of sufficient staff for 2 CTG scanners to be running daily(10-Aug-2023), We have seen a reduction of backlog of CTG(05-Apr-2024)	Low	Treat	Risk reviewed by Tasmane Thorp - Fixed-Term contract in place to run daily scanner and second member of team. Backlog being cleared slower than anticipated. Likelihood reduced to 4, however risk remains.	20-Feb-2023

RSK-481	IF there is no designated vascular access team/service or additional staff are not trained to place PICC and midlines and who are not skilled in repairing tunnelled catheters THEN patients will not get PICC/midlines, or will wait unacceptable lengths of time for appropriate vascular access to be inserted, or will require multiple peripheral cannulas, or will be admitted to have the line removed and reinserted or transferred to have the line repaired.	LEADING TO patients not receiving essential medications/nutrition; Patients having to endure multiple peripheral cannula placements; Patients not having their nutritional requirements met, leading to malnutrition and weight loss as an inpatient; Only one type of parenteral nutrition being available for peripheral access which does not meet most patients protein or electrolyte requirements; An increased risk of pressure sores and delayed wound healing due to poor nutrition: Increasing the risk of patients suffering thrombophlebitis from peripheral lines used for infusions with high osmolarity (PN); Increased risk of arm DVTs from multiple cannulations; Extended length of stay due to delayed treatment and the above; Undue pain and suffering for the patient; Poor patient experience; The potential for clinical negligence/litigation/complaints; Patients needing to go to theatre for central line insertions, which is more distressing for the patient and less cost effective; The potential for litigation and patient complaints.	Region	Specialty Medicine	Jane Radice	13-Jun-2024	13-Jul-2024	Planned	20	16	4	Ability for Vascular Access Service to place inpatient PICC lines and inpatient midlines, Implementation of a repair service for patients presenting to ED with fractured tunnelled lines, Vascular Access Service to provide support/intervention for inpatients with line occlusions. i.e to give alteplase, Training for all staff managing patients with all types of central lines, Vascular Access Service to monitor/audit inpatient central lines	Peripheral cannulas are placed. But this limits the parenteral nutrition that can be given. There is only one type of peripheral Parenteral nutrition available and for most patients this does not meet protein and electrolyte requirements.(07-Sep-2023), Peripheral cannula are changed every 48hrs due to the high osmolarity of PN(07-Sep-2023), ICU staff are frequently required to assist with cannulation of these patients(07-Sep-2023), When no peripheral access can be obtained, patients have been booked into theatre for a central line. This is a short-term central line that requires removal after 14 days. A PICC line can remain in place for 1 year(07-Sep-2023)	Low	Treat	Request to merge RSK-481, RSK-482 and RSK-483 into one risk.	08-Aug-2023
RSK-486	IF Ward 9 and 10 do not have the recommended bed numbers/side rooms, space between bed spaces, clean utility, ensuite facilities, milk kitchen, medication preparation areas, storage and bathroom facilities THEN there will be insufficient capacity for demand, difficulty moving the beds in and out of the bed space, minimal space for baby(s), belongings and visitors, staff having to move around items and cots to perform duties such as routine or emergency care or infection control duties, equipment being stored in the corridor or inappropriate areas, medications and milk being prepared in inadequate areas, delays to services users being able to access bathrooms	LEADING TO patient safety concerns, capacity issues, labour ward rooms being utilised for readmissions with suspected/confirmed, delay's to medications and feed, manual handling concerns and injury and low staff and patient experience.	Region	Women's Health	Mary Plummer	18-Jun-2024	31-Aug-2024	Planned	8	16	1	Review alternative options for EPAU to revert back to ward 9 area, New build unit with adequate spacing and design	Encourage service users to: keep minimal belongings users to keep curtains open ask visitors not to sit on service user beds or neighbouring bed(13-Sep-2023), Encourage staff to: remove equipment not being used from around the bedside use blue tooth scanners for medication WOWs use of Care aware connect for medication and some eCare functions Use laptops on wheels provided to make it easier to manoeuvre in bays attend Conflict Resolution training and Moving and Handling training as per Trust mandatory and statutory training requirements have confidential conversations held in available side rooms/private space move bed away from wall during emergency to allow easier access to oxygen and suction use staff room used for shift handovers have ergonomic assessment by MKUH Specialist Manual Handling & Ergonomic Advisor escalate to estates any work required to repair damage required staff attend ANTT daily equipment cleaning logs for staff if phototherapy required provide side room if available return borrowed equipment to correct area risk assess patients requiring the rooms to ensure	Low	Treat	Now monitoring impact on elective work capacity	13-Sep-2023
RSK-490	IF there is the absence of a competent person to deliver Manual handling and Ergonomic DSE compliance THEN the Trust will be unable to provide training, advice and guidance to staff in relation to manual handling and ergonomics	LEADING TO staff, patients and visitors are at increased of injury, ill health including musculoskeletal injury, sprains, strains, stress – increased sickness absence, low staff morale; Pressure sore development where appropriate equipment is not available and patient is left on floor for a period of time e.g. beds, equipment to manage the fallen patient; Patient experience compromised along with privacy and dignity; Trust at risk of increased staff absence, patient complaints, adverse publicity in local press, claims/litigation and financial costs of settlements; Trust at risk of enforcement action from the Health & Safety Executive Inspectorate for not providing a safe place of work and complying with legislation – verbal advice, improvement/prohibition notices, criminal prosecution, fee for intervention from investigation enquiries	Region	Workforce	Joanna Klimera	01-May-2024	30-Sep-2024	Planned	16	16	4	Recruit to substantive post (10-Jun-2024)	Recruit temporary cover through agency(28-Sep-2023), Use of external provider to supply training(28-Sep-2023), Advertise role with R&R Premia and removal costs(03-Jan-2024), Review role and training provision(03-Jan-2024)	Low	Treat		17-Sep-2023
RSK-500	IF the capacity to increase Consultant-led Sleep New appointments is not increased THEN patients will face significant delays in appointment waiting times	LEADING TO DM01 breaches and potentially patient safety	Region	Internal Medicine	Alexandra Peers	03-Jun-2024	05-Aug-2024	Planned	16	16	4		Operations Team are providing adhoc additional capacity(15-Nov-2023), All referrals are triaged by Chief Respiratory Physiologist(15-Nov-2023), Respiratory Physiology Pathway Administrator reviewing weekly(15-Nov-2023), Operations Respiratory Physiology Pathway Administrator reviewing weekly(15-Nov-2023), Urgent patients prioritised(15-Nov-2023), Change in pathway to allow Chief Respiratory Physiologist to triage patients for Nox(15-Nov-2023), Demand and Capacity Review(15-Nov-2023), Extremely urgent cases are referred to the weekly Sleep MDT(15-Nov-2023)	Low	Treat	QIP to reduce Sleep Service has been submitted to Execs	18-Oct-2023

RSK-522	IF the pathway for cardiology patients requiring dental review prior to transfer to OUH for cardiology surgery is not clearly defined THEN there will be a significant increase in length of stay for cardiology inpatients, causing a delay for patients to have their urgent valve surgery	LEADING TO very poor patient experience, with possible deterioration of the patient condition and prognosis	Region	Internal Medicine	Estelle Cawley	06-Mar-2024	05-Apr-2024	Overdue	16	16	4	Service Spec of the patient pathway developed and implemented	Patients are being manually 'pushed' through the process on a case-by-case basis(06-Mar-2024)	Low	Treat	Risk given Triumvirate approval via email on 8th February 2024	26-Sep-2023
RSK-523	IF there is not a reduction of VTE prophylaxis errors THEN there could be a risk of increased hospital acquired thromboembolism cases	LEADING TO extended and/or life long treatment, morbidity, or mortality. AND Increase risk complaints, legal and safety investigations, and reputational and financial risk.	Region	Women's Health	Elaine Gilbert	18-Jun-2024	18-Jul-2024	Planned	16	16	4	VTE pop up alerts to align with maternity assessment times (Within 6hrs of birth and (equals and greater than) than 3 days in patient. (21-Mar-2024), Admission VTE audit (21-Mar-2024), 28 week VTE audit (15-Apr-2024), Booking VTE audit (15-Apr-2024), PN/TTO VTE audit (21-Mar-2024), Admission VTE audits (21-Mar-2024)	Update eCare AN VTE Powerform to align with RCOG national guidance(12-Mar-2024), Update eCare PN VTE Powerform to align with RCOG national guidance(12-Mar-2024)	High	Treat	risk remains the same - ongoing MDT work with patient safety team	12-Mar-2024
RSK-526	IF the Trust does not have a sufficient capital expenditure limit (CDEL) Then the Trust will not be able to complete the level of planned capital investment	Leading to insufficient capital expenditure putting a risk on the trusts backlog maintenance and planned clinical replacement programme	Organisation		Karan Hotchkin	10-Jun-2024	10-Jul-2024	Planned	16	16	6		Trusts 24/25 planning process will prioritise capital based on clinical need and key maintenance risks(20-Mar-2024), The trust will pro-actively manage in-year underspend across other capital schemes(20-Mar-2024), Discussions are on-going with the National NHSE Capital team about the CDEL allocation(20-Mar-2024)	Medium	Treat		20-Mar-2024
RSK-532	IF the paediatric service is unable to provide the required specialised child and adolescence mental health care for patients with eating disorders and disordered eating without the support of a fully staffed eating disordered service THEN patient care would be compromised, and patients would be at severe risk of deterioration, mentally, physically, socially, and educationally	LEADING TO lack of access to appropriate support and services, prolongation of admission, and admission to T4 services.	Region	Child's Health	Brett Kintu	16-Apr-2024	16-May-2024	Overdue	20	16	4	Daily meetings to allow for escalation of concerns, Establishing weekly MDT meetings with all stakeholders including Integrated health board and Milton Keynes Lifespan Specialist Eating Disorder Service (MKLEDS), Incident Reports (Radars) to be submitted as needed to highlight the provision of supportive care on the wards	Acute admission to acute ward to ensure that child, young person is in a place of safety in hospital requiring 1:1 observation.(16-Apr-2024), Insufficient service provision has been escalated to integrated care board, requiring a formation of a multi-professional steering Group(16-Apr-2024), Paediatric Complex Pathway nurse in post to affect communication between multi-disciplinary and multi professional teams, both in the trust and externally with the integrated care board level.(16-Apr-2024), Discharge planning discussed at MDT and MKLED forum(16-Apr-2024)	None	Treat	Risk approved at Child's Health CIG 03/04/2024	01-Mar-2024
RSK-544	IF the Trust is unable to provide the financial support for the prescription of Aerobika devices and commensurate staffing THEN the respiratory service will be unable to fulfil the requirements of the new BLMK prescribing guidelines	RESULTING IN potential harm to patients may not be able to manage their condition effectively, with the likelihood of increased hospital admissions and exposure of the Trust to possible litigation	Region	Therapies	Celia Hyem-Smith	24-May-2024	24-Jun-2024	Pending	16	16	4	Community/AIRS service to under the re-issue of Aerobika at 12 months	Making patients aware the device should be changed at 12 months(24-May-2024), Patients given daily/weekly cleaning advice with leaflet(24-May-2024), Patient advised to see GP to get referred to us to replace/review device. D/C letter to GP(24-May-2024)	None	Treat	Risk approved at Therapies CIG	04-May-2024
RSK-550	IF the Trust does not have an MRI compatible Patient Monitor THEN we will be unable to provide continuous monitoring of respiration, unable to effectively monitor the patient during medical emergencies that occur in MRI, unable to deliver MRI services to deteriorating patients, unable to undertake paediatric MRI scans for patients under 5yrs requiring sedation	LEADING TO patients potential delays in identifying adverse events during procedure; potential delays in treating deteriorating patients; potential harm and impact on patient outcomes and treatments; impact on staff being unable to adequately monitor patients under their care	Region	Diagnostic & Screening	Thozama Cele	04-Jun-2024	04-Jul-2024	Planned	16	16	4	Purchase of three MRI Compatible monitors to be located in each MRI scanner and one in the paediatric ward.		None	Treat	Approved at CIG 21/05/24	04-Jun-2024
RSK-019	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	Sushant Tiwari	30-Apr-2024	30-May-2024	Overdue	12	15	8	Police panic button in reception and majors (13-Mar-2024), Review of Reception (13-Mar-2024), Single seats to be removed from use in the department as they pose a projectile risk (10-Jun-2024), Fixed row seating in adult and Paeds need review for securing to the floor/ wall., Full review of seating plan iED with a view to future replacement., Consideration of panic alarms for ED staff (22-Mar-2024), Dedicated triage space to include entrance and exit between rooms. 14/03/24 requested and accepted	CCTV cameras in place (dead spot remains in "Streaming")(22-Sep-2021), Conflict Resolution training(22-Sep-2021), unacceptable behaviour posters + national abuse posters(22-Sep-2021), Security forum for Trust(22-Sep-2021), Incidents reviewed on Datix incident reporting system(22-Sep-2021), Waste bins to be secured to prevent the risk of being used as a projectile.(21-Mar-2024), Review Fire extinguisher attachments to reduce the risk of them being used as a projectile in ED(21-Mar-2024), Profile the use of the 4x body camera's for ED staff on shift(21-Mar-2024)	Low	Treat	Risk reviewed - no change to risk	09-Mar-2009
RSK-101	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	Elaine Gilbert	11-Apr-2024	30-Sep-2024	Planned	15	15	6	Hospital new build to include Maternity theatres (12-Mar-2024)	Escalation policy available for staff to use in situations where a 2nd theatre is needed by can not be opened(27-Apr-2022), Elective Caesarean work is completed the Theatre 1 during a booked morning session, Theatre 3 is set for obstetric emergencies.(01-Sep-2022), SOP developed to support in the incidence where two theatres are required(13-Apr-2023)	Low	Treat	Risk remains the same	06-Sep-2021

RSK-111	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	Elaine Gilbert	18-Jun-2024	31-Oct-2024	Planned	16	15	6	Implement Ockenden 2 (Recalculated headroom/gap) (18-Jun-2024)	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), Review establishment birth rate+ report(27-Apr-2022), Business case for future funding of birth rate+ to be developed.(13-Dec-2022), Business case to be taken to board for agreement.(13-Dec-2022), Workforce retention and recruitment plan(13-Jan-2023), Midwifery workforce plan(13-Jan-2023), MSW project(13-Jan-2023), Interview and offer shortened MW course places(13-Jan-2023)	Low	Treat	awaiting next BR plus for review	13-Dec-2022
RSK-158	IF the escalation beds are open across the medical and surgical divisions. Then the additional patients that will need to be seen will put additional demand on the Inpatient Therapy & Dietetic Services that are already stretched due to long term vacancies.	LEADING TO: Patients deconditioning, nutritional needs of patients may not be met and increased Length Of Stay (LOS), high volume of patients will not be seen daily, priority will be given to new assessments, discharges and acute chests. Majority of patients may only be seen once a week for rehabilitation which is insufficient to maintain a patient's level of function. Staff morale will reduce as they will not be providing the appropriate level of assessment and treatment to their patients.	Organisation		Laura Sturgeon	17-Jun-2024	29-Jul-2024	Planned	16	15	6	inpatient improvement project- aiming to review patient pathways to optimise staffing (03-Jun-2024)	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), Closure or Reduction in Escalation Beds(19-Apr-2022), To ensure that inpatients teams are aware of open escalation areas and patient are prioritised in line with agreed criteria(12-Apr-2023), agency physiotherapist and occupational therapist to cover additional workload.(09-May-2023)	Medium	Treat	escalation and reverse boarding beds remain in use. Locum agreements in place, have been filled for approx. 50% of hours available. risk remains unchanged	27-Nov-2018
RSK-166	IF there is an increasing workload and a lack of Consultant Pathologists THEN there is a risk that the Cellular Pathology department will be unable to meet the clinical needs of the service	LEADING TO potential inability to meet cancer reporting targets; potential to miss an unexpected malignancy; reporting backlog may also increase	Region	Diagnostic & Screening	Angus Molyneux	18-Jun-2024	19-Jul-2024	Planned	15	15	3	Recruitment (18-Jun-2024), Out source of Reporting work to Source Bioscience (18-Jun-2024), Review of demand and reporting capacity to identify the gap between the two, when a t establishment. (18-Jun-2024), Reporting WLI sessions are available (18-Jun-2024)	Outsourcing non-urgent work(12-Nov-2021), Additional hours worked - in house Pathologists(12-Nov-2021), Locum Pathologist in place working limited hours(12-Nov-2021), Prioritising 2 week wait reports(12-Nov-2021), Prioritising urgent reports(12-Nov-2021), Prioritising work based on clinical information(12-Nov-2021), Appoint to substantive Consultant post and LAS post(12-Nov-2021), Purchase additional Microscope for 8th Consultant(11-May-2022), 8th Consultant start date and induction to be completed.(11-May-2022)	Low	Treat	Cell Path reporting capacity continues to be outstripped by demand. Reporting team continues to function with depleted numbers and relies on locum and bank staff.	01-Jun-2022
RSK-170	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	Rebecca Potter	24-May-2024	19-Jun-2024	Pending	12	15	3	Change control process for safe introduction of replacement autoclaves. (20-May-2024), Replacement of Autoclaves (22-May-2024)	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), Business Case Development for replacement/repair of autoclaves(11-May-2022), 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 autoclaved once weekly. In case of failure of autoclaves, offsite contingency is in place with Tradebe.(12-Sep-2022), Waste is held in CL3 until ready to be autoclaved.(12-Sep-2022), Waste is transported in lockable metal tins with close fitting lids and a seal to prevent liquid spillage. Lids are not removed until	Low	Treat	Autoclaves in use. Close risk following updated RA and completed CC, awaiting microbiology.	10-Jul-2022

RSK-176	IF the Cellular Pathology workload continues to increase without sufficient staffing resources this will THEN there is a risk that the department results turnaround time will continue to increase and staffing burnout will occur	LEADING TO further increased turnaround times for processing and reporting specimens for routine and urgent work where a backlog risk has already been identified. This will have a detrimental effect on the patient experience as the potential for missed or delayed diagnosis increases along with stress and wellbeing concerns of the staff.	Region	Diagnostic & Screening	Amanda Brice	20-May-2024	19-Jun-2024	Pending	9	15	12	Review of staffing levels and initiation of consultation to extend working hours to include weekends (20-May-2024)	Cellular Pathology staff currently work during weekdays and routine cover for weekends is not in place. Weekend cover can be provided by existing staff on a limited and voluntary basis and this impacts on the number of staff available during core hours. The existing work backlog may increase and further work will need to be sent away incurring additional costs(12-Nov-2021), New contract provider for additional dermatology clinics - no change yet to weekend working requirement.(12-Nov-2021)	Low	Treat	Staffing levels remain challenging. Recruitment gaps persist.	01-May-2021
RSK-250	IF staff across MKUH continue to use eCARE in the same way, that the volumes of requests made to the IT Department remain at their current rate, and the volume of change and project work continues at the current volume THEN the IT Department will become less responsive and a range of functions within eCARE will continue to be left without action	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		Craig York	05-Jun-2024	04-Sep-2024	Planned	15	15	3	Identification of staff time and resources (11-Apr-2023), Business case being written by the end of spring 2023 to identify the amount of staff time required. Update Aug 2023 - being reconsidered during early stages of DQ review., Review volumes against historical figures to reflect reality of challenge. Include in business case. Consider additional posts for all.	Prioritisation of workload is in place to cover the most impacting of issues or projects, however this only reduces the potential impact slightly(26-Nov-2021)	Low	Treat	Issues related to low levels of engagement in eCARE training and in eCARE projects continue to be raised, training needs identified on a regular basis, with the issue having been discussed at HIPB 04/06/2024 for consideration. No action agreed.	25-Jan-2023
RSK-271	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	Ayca Ahmed	20-May-2024	20-Jun-2024	Pending	15	15	3	The MEL dept relocation is on the draft capital plan under estates (20-May-2024)	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.	23-Aug-2020
RSK-275	IF The Trust does not recruit suitably qualified estates personnel THEN there will be a shortfall of qualified skilled estates staff to perform Statutory Maintenance, Emergency On-Call & Day to Day reactive Breakdown requests and Appointed Persons	LEADING TO the Trust being at risk and service delivery systems will increasingly fail directly affecting clinical service and patient care	Organisation		Mike Stark	31-May-2024	30-Jun-2024	Planned	15	15	5		Agency staff option to back fill to current vacancies, whilst recruitment process continues if required(30-Nov-2021), Current vacancies in Estates Services - 1 x Estates Officer Mechanical & 1 x Capital Projects(30-Nov-2021), Change paper put through to TEG for additional resources, better R&R payments and to bring 7 day working over longer hours by introducing a shift pattern which should protect the service availability, enhance remuneration closer to market rate and make on-call sessions less onerous. Approved subject to funding like date March 2022(30-Nov-2021), Validation pending on some changes to funding going through(30-Nov-2021)	Low	Treat	Electrician & Electrical Supervisor staff turnover and recruitment issues, Estates Officer post turnover with no contingency and heavy workload, difficulty in staffing on-call, additional buildings without increased headcount, additional compliance work, additional strategic capital support, Trust services growth without support staff investment.	23-Apr-2024
RSK-343	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	Elizabeth Pryke	03-Jun-2024	01-Jul-2024	Planned	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), Locum Dietitian working remotely To go back out to advert for B6 Dietitian(05-Feb-2023), Recruit Band 6 Dietitian(09-May-2023)	Low	Treat	High numbers of escalation beds / increased referral rates	02-May-2022
RSK-388	IF Audiology Services do not get a second testing room equipped for the testing of younger and complex children. This area must be accessible for wide wheelchairs 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	Ruth Horner	20-May-2024	15-Jul-2024	Planned	15	15	8	Second testing room equipped for the testing of younger and complex children (11-Jun-2024)	Current room being used to full capacity.(17-Oct-2022), Contact Estates and external company to explore options for conversion of workshop on Level 4 to testing facility(17-Oct-2022)	Low	Treat	On capital plan and unlikely to be support in 2024/25	22-Sep-2022
RSK-459	IF there is insufficient capacity to maintain a core team of trained radiographers THEN there will be a decreasing number of trained CT staff within the department.	LEADING TO a potential inability to provide a 24-7 emergency CT service	Organisation		Mike Pashler	10-Jun-2024	10-Jul-2024	Planned	15	15	4	Recruit substantive staff to increase capacity for training (28-Apr-2024)	Offering fast-track training to allow staff to volunteer for extra duties to facilitate training(28-Jun-2023), Employ agency staff to cover substantive staff(28-Jun-2023)	Low	Treat	JD review and planned recruitment. Staffing pressures ongoing due to sickness and annual leave.	27-Jun-2023
RSK-513	IF there is not adequate theatre capacity for gynae cases, THEN there will be continued delays in explorative and diagnostic treatment	LEADING TO a risk of mortality and morbidity, AND Increase in complaints, media interest and reputational/financial impact	Region	Women's Health	Jennifer Barker	18-Jun-2024	30-Sep-2024	Planned	15	15	6		Additional weekend lists to support capacity(12-Mar-2024), Add hic additional lists when staff available(12-Mar-2024), Referral of certain urogynae surgery cases to be completed offsite(12-Mar-2024)	High	Treat	Doing ASA3 - extra list every Saturday all day. additional scrutiny on all theatre session. Review end of September in line with national target	20-Feb-2024
RSK-520	IF the the Eye Clinic does not have enough space to transport a hospital bed/stretcher, no department hoist, congested waiting room and other rooms at full capacity THEN the department is not accessible to patients that require a bed.	LEADING TO potentially delayed diagnosis/treatment and potential for the patient to sustain permanent vision loss.	Region	Head & Neck	Denise Holland	11-Jun-2024	11-Jul-2024	Planned	25	15	5		Pathway for patient to wait in a bed on the Patient Discharge Lounge and consultation with Doctor occurs there.(05-Mar-2024)	None	Treat	Risk approved at Ophthalmology CIG meeting on 26/02/2024.	02-Feb-2024

RSK-527	If there is inaccurate and late recording of clinical activity on the trusts E-Care system Then there is a risk that the Trust's clinical activity will be understated	LEADING to a loss of income through the ERF	Organisation	Daphne Thomas	10-May-2024	10-Jun-2024	Overdue	15	15	8		Training and a SOP for the clinical staff entering patient data on E-Care(20-Mar-2024), Checking and feedback of activity volumes to relevant teams to address issues(20-Mar-2024)	Medium	Treat		20-Mar-2024
RSK-549	IF Trust does not adapt to climate change impacts THEN the hospital will be impacted not only in its operations to maintain safe patient service, but will face surge in activity due to its adverse effects	LEADING TO unintended harm to patients, loss of services, loss of estates capabilities, cancellation of electives, increased staff risk or sickness.	Organisation	Adam Biggs	12-Jun-2024	12-Jul-2024	Planned	20	15	5		Local Resilience Forum(04-Jun-2024), Local Health Resilience Partnership(04-Jun-2024), MKUH Adverse Weather and Health Policy(04-Jun-2024)	Low	Treat	Risk reviewed at TEC. Approved onto the Corporate Risk Register.	03-Jun-2024

Reference	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-016	IF there is a lack of flow in the organisation THEN there may be an unsafe environment for patients	LEADING TO a potentially impact on bed space capacity, ambulance queues, missed Emergency Access Targets and overcrowding into ED/radiology corridors creating Health & Safety hazard and continued pressure, leading to poor patient care/treatment, nursing patients outside of cubicles in corridors and the middle of majors,and delays in discharge/transfer and the potential for an increase of incidents being reported regarding assessment/care/treatment, and or significant number of patients with a high acuity/ dependency being cared for in areas that are not suitable for safe care	Organisation		Kirsty McKenzie	04-Jun-2024	08-Jul-2024	Planned	25	20	12	Recruitment drive for more nurses/HCA's ongoing. Active management of Nursing/Consultant and Registrar gaps in rota daily to ensure filled. (13-Mar-2024)	EPIC consultant in place to aid flow within department and speed up decision making(22-Sep-2021), RAT-ing process and specialty referrals having a RAG system developed to prioritise sickest patients to be assessed.(22-Sep-2021), Walking majors and resus reconfigured. Expanded Cubicle space in Majors - extra 10 spaces, increased capacity using Acorn Suite.(22-Sep-2021), Internal escalation policy in place. CSU lead developing trust escalation criteria to alert trust leads to problems sooner - diverting patients to; Ambulatory care(22-Sep-2021), Since Covid pandemic, phasing plan in place with red and green zones within ED.(22-Sep-2021), Escalation plan for ED to mitigate patient pressures(22-Sep-2021)	Low	Treat	No change	07-Mar-2016
RSK-035	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		Helen Smith	05-Mar-2024	05-Apr-2024	Overdue	20	20	6	Actively recruiting staff (01-Dec-2023), Add R&R	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	worsening situation with	07-Aug-2019
RSK-134	If there is insufficient funding, then the Trust may be unable to meet financial plans and targets or deliver its strategic aims,	Leading to service failure and regulatory intervention THEN the Trust will be unable to meet its financial performance obligations or achieve financial sustainability	Organisation		Karan Hotchkin	10-May-2024	10-Jun-2024	Planned	20	20	8	Work with ICS partners and NHSE to mitigate financial risk.	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), The current funding has now been clarified .The trust will work with BLMK system partners during the year to review overall BLMK performance(21-Mar-2022), Internal budgetary review/financial performance oversight processes to manage/mitigate cost pressures. Financial efficiency programme identifies headroom for improvement in cost base. Close monitoring/challenge of inflationary price rises(16-Nov-2022), Financial efficiency programme identifies headroom for improvement in cost base.(04-Sep-2023), Close Monitoring/challenge of inflationary price rises(04-Sep-2023), Medium Term financial modelling commenced with ICS partners.(04-Sep-2023), Escalation of key issues to NHSE regional team for support(04-Sep-2023), Close monitoring of Elective Recovery Fund (ERF) activity and	High	Treat	Risk transferred from Dat	01-Apr-2022
RSK-202	IF Financial Efficiency schemes are not fully developed THEN There is a risk that the Trust will not delver the required level of savings	LEADING TO potential cash shortfall and non-delivery of its key targets	Organisation		Karan Hotchkin	10-May-2024	10-Jun-2024	Planned	20	20	8		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), Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partner. There are no cross-cutting transformation schemes yet identified and savings of around £9.2m as the end of Oct 223 have been identified against the £17m target. Whilst this shortfall can be mitigated this year, the risk is around the underlying financial position.(16-Nov-2022)	Medium	Treat	Risk transferred from Dat	01-Apr-2022

Reference	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-305	If there is insufficient strategic capital funding available in relation to NHP 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		Karan Hotchkin	10-May-2024	10-Jun-2024	Planned	16	20	10		The trust has a process to target investment of available capital finance to manage risk and safety across the hospital(06-Dec-2021), Trust is discussing this with the regional Capital Team and with the ICB capital allocations for 23/24.(16-Nov-2022), The Trust has established management processes to prioritise investment of available capital resources to manage emerging risk and safety across the hospital.(04-Sep-2023), The Trust is responsive in pursuing additional NHSE capital programme funding as/when additional funding is available.(04-Sep-2023), The Trust is agile in responding to alter notified capital slippage from across the ICS and wider region to take advantage of additional capital budget(04-Sep-2023)	Medium	Treat	On-going conversations v	01-Apr-2022
RSK-457	If there are insufficient staffing levels (radiographers) THEN there will be reduced capacity in the department resulting in closure of the 3rd CT Scanner	LEADING TO delays to patient diagnosis and treatment, potential missed diagnosis; increased stress / increased sickness and potentially inability to retain staff	Organisation		Mike Pashler	28-Apr-2024	31-Jul-2024	Planned	20	20	6	Recruitment of staff (28-Apr-2024)	Prioritising 2WW patients at the expense of urgent, routine and planned/cancer follow-up patients(27-Jun-2023), Signposting patients to PALS Team, where appropriate(27-Jun-2023)	Low	Treat	JD reviewed and planned	22-Jun-2023
RSK-472	IF staff and service users (Trustwide) are subject to violence and unacceptable behaviour THEN staff/services users may sustain physical/psychological injury	LEADING TO potential significant harm; increased staff sickness/reduction in morale, recruitment and retention difficulties, lack of staff; increased length of stay for patients and poor patient experience; HSE enforcement notice; complaints and litigation; adverse publicity	Organisation		Anthony Marsh	09-Apr-2024	26-Apr-2024	Overdue	25	20	10	Widen environmental study to consider patients with mental health, learning disability, dementia etc – holistic approach to care, environment, distraction therapies (10-Jan-2024), Review breakaway training provision ensure rolling programme in place Update to Conflict resolution training to include what to do in the event of an incident, support, what happens next (18-Dec-2023), Training for staff in managing patients with mental health, learning disability, dementia etc De -escalation procedure/techniques (22-Mar-2024), Listening events on the road, staff engagement sessions (11-Dec-2023), Ensure feedback from incidents to staff and lessons learnt shared amongst wider organisation (22-Mar-2024)	CCTV in high-risk areas(04-Aug-2023), Presence of security in Emergency Department (ED)(04-Aug-2023), Posters displayed in wards/department(04-Aug-2023), Staff communicate patient behaviours during handovers and not on patients notes(04-Aug-2023), Follow conflict resolution training(04-Aug-2023), De-escalate/Staff withdraw from situation if person becomes challenging(04-Aug-2023), Where known aggressor – dynamic assessment, have an escape route, consider seeing patient in twos, do not work alone, do not work in a closed space, consider screens/barriers between aggressor and staff, consider security presence to see patient Ensure panic alarms/call bells within easy reach Call for assistance where situations are escalating(04-Aug-2023), Application of 3 tier warning system – verbal, behavioural, red card – overseen by Head of Security(04-Aug-2023), Enforcement/criminal prosecution where possible(04-Aug-2023), Conflict resolution training mandatory for all staff and Breakaway training available adhoc(04-Aug-2023), Security available - Code victor 2222 Police available – 999 Support for staff through managers/Occupational Health &	Low	Treat	Reviewed by Associate Di	31-Jul-2023
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;	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		Tina Worth	08-Apr-2024	30-Jun-2024	Planned	20	16	12		Incident Reporting Policy(06-Sep-2021), Incident Reporting Mandatory/Induction Training(06-Sep-2021), Incident Reporting Training Guide and adhoc training as required. 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), Staff competence and confidence with Radar reporting, with improved reporting rate, reduction in inaccurate reports on system and/or failure of incidents being reported(01-Apr-2022)	Low	Treat	Risk reviewed - reporting 06-Sep-2021	

Reference	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-036	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		Helen Smith	05-Mar-2024	01-May-2024	Overdue	16	16	6	Recruitment of staff (05-Mar-2024)	Use of remote bank staff to update policies(28-Sep-2021), Business Case for additional Pharmacy staff(19-Apr-2022)	Low	Treat	governance gap analysis i	01-Oct-2021
RSK-126	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		Lazarus Anguvaa	10-Apr-2024	30-Apr-2024	Overdue	25	16	9		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), Refurnishing of Milk Kitchen and Sluice(04-Nov-2021)	Low	Treat	Reviewed and will be rea	19-Dec-2022
RSK-142	IF there is insufficient capacity and ongoing unsustainable demand for dietetic input for Paediatric patients (both inpatient and outpatient) . IF Home Enterally Fed Paediatrics patients continue to be seen our outpatient structure which is not adequate to meet their demands and needs. 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		Elizabeth Pryke	03-Jun-2024	01-Jul-2024	Planned	15	16	6	In contact with commissioners to discuss service provision Collecting additional data (feedback from stakeholders, benchmarking etc) to support business case (13-May-2024), Business Case for paediatric Home enteral feeding service (13-May-2024)	Existing staff are working some additional hours but this remains insufficient to meet the needs of the service(04-Nov-2021)	Low	Treat	Insufficient time to take f	01-Nov-2021
RSK-424	IF the new information standard regarding SDEC is released without significant operational and technical changes to the way the relevant information is collected THEN MKUH may not be able to submit the dataset in the required format with the required content LEADING TO a potential financial and reputational impact to MKUH	Potential financial, reputational, contractual, or operational impacts.	Organisation		Craig York	05-Jun-2024	04-Sep-2024	Planned	12	16	4	Review of data needs, implications on workflow in eCARE, needs to be undertaken before any known work can be scoped. New data standard has been released, work required on SDEC data collection before consideration for meeting national standards.		Medium	Treat	Work has started on und	25-Jan-2023
RSK-526	IF the Trust does not have a sufficient capital expenditure limit (CDEL) Then the Trust will not be able to complete the level of planned capital investment	Leading to insufficient capital expenditure putting a risk on the trusts backlog maintenance and planned clinical replacement programme	Organisation		Karan Hotchkin	10-May-2024	10-Jun-2024	Planned	16	16	6		Trusts 24/25 planning process will prioritise capital based on clinical need and key maintenance risks(20-Mar-2024), The trust will pro-actively manage in-year underspend across other capital schemes(20-Mar-2024), Discussions are on-going with the National NHSE Capital team about the CDEL allocation(20-Mar-2024)	Medium	Treat		20-Mar-2024
RSK-158	IF the escalation beds are open across the medical and surgical divisions. Then the additional patients that will need to be seen will put additional demand on the Inpatient Therapy & Dietetic Services that are already stretched due to long term vacancies.	LEADING TO: Patients deconditioning, nutritional needs of patients may not be met and increased Length Of Stay (LOS), high volume of patients will not be seen daily, priority will be given to new assessments, discharges and acute chests. Majority of patients may only be seen once a week for rehabilitation which is insufficient to maintain a patient's level of function. Staff morale will reduce as they will not be providing the appropriate level of assessment and treatment to their patients.	Organisation		Laura Sturgeon	29-Apr-2024	16-Jun-2024	Planned	16	15	6	inpatient improvement project- aiming to review patient pathways to optimise staffing (03-Jun-2024)	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), Closure or Reduction in Escalation Beds(19-Apr-2022), To ensure that inpatients teams are aware of open escalation areas and patient are prioritised in line with agreed criteria(12-Apr-2023), agency physiotherapist and occupational therapist to cover additional workload.(09-May-2023)	Medium	Treat	escalation and reverse bc	27-Nov-2018

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RSK-250	IF staff across MKUH continue to use eCARE in the same way, that the volumes of requests made to the IT Department remain at their current rate, and the volume of change and project work continues at the current volume THEN the IT Department will become less responsive and a range of functions within eCARE will continue to be left without action	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		Craig York	05-Jun-2024	04-Sep-2024	Planned	15	15	3	Identification of staff time and resources (11-Apr-2023), Business case being written by the end of spring 2023 to identify the amount of staff time required. Update Aug 2023 - being reconsidered during early stages of DQ review., Review volumes against historical figures to reflect reality of challenge. Include in business case. Consider additional posts for all.	Prioritisation of workload is in place to cover the most impacting of issues or projects, however this only reduces the potential impact slightly(26-Nov-2021)	Low	Treat	Issues related to low leve	25-Jan-2023
RSK-275	IF The Trust does not recruit suitably qualified estates personnel THEN there will be a shortfall of qualified skilled estates staff to perform Statutory Maintenance, Emergency On-Call & Day to Day reactive Breakdown requests and Appointed Persons	LEADING TO the Trust being at risk and service delivery systems will increasingly fail directly affecting clinical service and patient care	Organisation		Mike Stark	31-May-2024	30-Jun-2024	Planned	15	15	5		Agency staff option to back fill to current vacancies, whilst recruitment process continues if required(30-Nov-2021), Current vacancies in Estates Services - 1 x Estates Officer Mechanical & 1 x Capital Projects(30-Nov-2021), Change paper put through to TEG for additional resources, better R&R payments and to bring 7 day working over longer hours by introducing a shift pattern which should protect the service availability, enhance remuneration closer to market rate and make on-call sessions less onerous. Approved subject to funding like date March 2022(30-Nov-2021), Validation pending on some changes to funding going through(30-Nov-2021)	Low	Treat	Electrician & Electrical Su	23-Apr-2024
RSK-459	IF there is insufficient capacity to maintain a core team of trained radiographers THEN there will be a decreasing number of trained CT staff within the department.	LEADING TO a potential inability to provide a 24-7 emergency CT service	Organisation		Mike Pashler	30-Apr-2024	28-May-2024	Overdue	15	15	4	Recruit substantive staff to increase capacity for training (28-Apr-2024)	Offering fast-track training to allow staff to volunteer for extra duties to facilitate training(28-Jun-2023), Employ agency staff to cover substantive staff(28-Jun-2023)	Low	Treat	JD review and planned re	27-Jun-2023
RSK-527	If there is inaccurate and late recording of clinical activity on the trusts E-Care system Then there is a risk that the Trust's clinical activity will be understated	LEADING to a loss of income through the ERF	Organisation		Daphne Thomas	10-May-2024	10-Jun-2024	Planned	15	15	8		Training and a SOP for the clinical staff entering patient data on E-Care(20-Mar-2024), Checking and feedback of activity volumes to relevant teams to address issues(20-Mar-2024)	Medium	Treat		20-Mar-2024
RSK-543	There is a national shortage of contrast for PET PSMA tests causing a minimum of 4-6week delay in treatment stat for prostate cancer patients	Increase anxiety for patients causing psychological harm Low risk of harm for cancer progression	Organisation		Sally Burnie	23-May-2024	20-Jun-2024	Pending	15	15	2			Medium	Treat		23-May-2024
RSK-547	The retinal camera has become extremely temperamental, meaning that we cannot rely on this camera to be used in the clinic.	Due to this, it will cause a loss in capacity.	Organisation		Kirsty Kirby	05-Jun-2024	01-Jul-2024	Planned	15	15	15			Medium	Treat		31-May-2024
RSK-003	IF existing Radar governance system does not support meeting Trust/legal/stakeholder requirements and are unsupported by the Trust IT department or an external IT provider; THEN the Trust is unable to meet statutory and mandatory Good Governance requirements and accreditations;	LEADING TO potential delays in care, inappropriate/incorrect/sub-optimal treatment; potential increase in incidents, complaints and claims; reduced CQC rating and potential enforcement actions	Organisation		Tina Worth	08-Apr-2024	30-Jun-2024	Planned	25	12	4		SharePoint and Q-Pulse in place(06-Sep-2021), Scheduled implementation of new system Radar(06-Sep-2021), Implementation of Radar Documentation Module(24-Mar-2022), Implementation of Radar Audit Module(24-Mar-2022)	Low	Treat	Risk reviewed and uncha	06-Sep-2021
RSK-093	IF there is insufficient staffing within the dietetics department in paediatrics THEN they will be unable to assess and advise new outpatients and review existing outpatients 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		Elizabeth Pryke	03-Jun-2024	01-Jul-2024	Planned	16	12	6	review of patient pathways to reduce need for outpatient appointments (13-May-2024)	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), additional paediatric dietitian employed on bank contract for 2 sessions / week to help with long waiting lists - monitor waiting lists on a monthly basis(05-Feb-2023)	Low	Treat	Waiting list still high - rev	01-Oct-2021
RSK-206	IF the Trust is unable to recruit staff of the appropriate skills and experience; there continues to be unplanned escalation facilities; There are higher than expected levels of enhanced observation nursing; and there is poor planning for peak periods / inadequate rostering for annual/other leave. THEN the Trust may be unable to keep to affordable levels of agency and locum staffing	LEADING TO Adverse financial effect of using more expensive agency staff and potential quality impact of using temporary staff	Organisation		Karan Hotchkin	10-May-2024	10-Jun-2024	Planned	16	12	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), Weekly Agency review by Executive Directors(10-Jul-2023)	Medium	Treat	Additional controls are in	01-Apr-2022

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RSK-219	IF metal butterfly needles are used for administering subcutaneous infusions via syringe drivers, and bolus subcutaneous injections, particularly in palliative and end-of-life care THEN there is a risk that the member of staff (hospital or community) may sustain a needle stick injury as they are withdrawing the needle when the infusion is stopped	LEADING TO the staff being at risk of coming into contact with contaminated blood	Organisation		Emma Codrington	28-May-2024	08-Jul-2024	Planned	4	12	3	Purchasing and implementation of Neria Guard giving sets for subcutaneous needle management	MKUH Sharps Management Policy ICM/GL/34 – advises use of safer needle alternatives wherever practical. Alerting ward staffs to be careful when inserting and removing the butterfly needles.(25-Nov-2021)	Low	Treat	No change to risk current	25-Nov-2021
RSK-226	IF the Research Nurses have a clinic room without a couch or trolley THEN they will be unable to perform their procedures and examinations	LEADING TO safety risk to patients, decrease patients recruitment	Organisation		Antoanela Colda	15-Apr-2024	20-Sep-2024	Planned	20	12	3		Phlebotomy procedures will be undertaken in the Blood Taking Unit(25-Nov-2021), Physical assessment using consultant's clinic rooms(25-Nov-2021), Request submitted to the Space Committee for additional space(25-Nov-2021)	Low	Treat	Requested presented to S	25-Nov-2021
RSK-229	IF there is poor quality of data input into the eCare system THEN there could be consequential impact on the data flow into the Trust data warehouse and reporting for both performance management and contracting (commissioners) data	LEADING TO Impacts all performance reporting. Impacts “Contracts” reporting leading to a loss of income for the Trust	Organisation		Ian Fabbro	05-Jun-2024	04-Sep-2024	Planned	12	12	4	Ongoing review of quality of data in eCARE	Extensive list of data quality reports to identify poor data quality(25-Nov-2021), Data Quality team is in place, who undertake a compliance function to review sample records to ensure early capture of data quality issues(25-Nov-2021), Control scripts to identify data quality issues when the data is loaded into the Data Warehouse(25-Nov-2021), On-going review of the quality of data(11-Apr-2023), Data Quality team within the Information team are working regularly with the PTL team to review the quality of outpatient referral data. New working group, looking at all elements of this topic started early Aug 2023, with the expectation that this action may close or change as a result. To be reviewed next quarter.(03-May-2023)	Medium	Treat	Data quality support requ	25-Jan-2023
RSK-230	IF a major incident was to occur requiring the trust to respond above service levels THEN there could be an impact to normal service. Eg/elective and inpatient care.	LEADING TO changes in routine working processes and procedures across the Trust for the duration of the major incident response and recovery phases.	Organisation		Adam Biggs	17-Apr-2024	18-Aug-2024	Planned	16	12	8		Major incident response plan (IRP)(25-Nov-2021), Action Cards have been removed from the Major Incident Response Plan and are held as a separate annex(25-Nov-2021), CBRN arrangements outlined within the IRP(25-Nov-2021), Mass casualty response outlined within the IRP(25-Nov-2021), Regional casualty dispersal process in place(25-Nov-2021), Local resilience Forum working group meetings attended, with tactical and strategic levels represented by CCG and NHSE&I(25-Nov-2021), Training and Exercise programme in place to ensure the Trust meets national best practice and statutory obligations(25-Nov-2021), EPRR annual work plan in place and agreed with Accountable Emergency Officer (AEO) that is scrutinised and reviewed through the Emergency Planning Steering Committee on a quarterly basis attended by senior and key staff(25-Nov-2021), Annual NHSE&I EPRR Core Standards review conducted by BLMK CCG to ensure MKUH is meeting its statutory obligations, with internal report sent to Managing Board and Trust Public Board for sign-off(25-Nov-2021), Development and delivery of EPRR Work Programme 2024 - to be signed off by Emergency Planning Steering Committee in February 2024.(15-Nov-2023)	Low	Tolerate	Review to take place in li	25-Nov-2021
RSK-232	IF there is an extreme prolonged weather conditions (heat/cold) THEN there is potential for wards/departments to be unable to maintain/provide effective service provision at required standards during prolonged extreme weather conditions	LEADING TO Service disruption/delays, Staff health & wellbeing, Patient safety, Adverse media publicity Breaches of Health & Safety at Work Act, Management of Health & Safety at Work Regulations, Workplace Health, Safety & Welfare Regulations	Organisation		Adam Biggs	03-Jun-2024	14-Oct-2024	Planned	12	12	12		Business continuity plans in some areas(25-Nov-2021), Heat wave plan(25-Nov-2021), Extreme weather policy(25-Nov-2021), Cold Weather Plan(25-Nov-2021), Development and delivery of new national Adverse Weather and Health Plan to be implemented into EPRR Work Programme 2024 - to be signed off by Emergency Planning Steering Committee in February 2024.(15-Nov-2023)	Low	Tolerate	All current Adverse Weat	10-Apr-2022
RSK-254	If Nursing staff do not follow the correct medication administration workflow, and do not scan the patient wristband... THEN patients could receive medication which is prescribed for another patient.	LEADING TO potential harm to patients	Organisation		Craig York	05-Jun-2024	04-Sep-2024	Planned	12	12	9	Drive adoption of CareAware Connect, including the support from senior Nursing Leadership. (05-Jun-2024)	eCARE alert if mismatch between wrist band & electronic drug chart. Correct workflow taught in eCARE training. Monthly scanning compliance report(26-Nov-2021), CareAware Connect going live by August 2023(11-Apr-2023)	Low	Treat	Adoption support for Car	25-Jan-2023

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RSK-263	IF the Trust Fire Compartmentation are not surveyed and remedial works funded THEN remedial work not being completed	LEADING TO the travel of fire between compartments causing risk to life, greater damage to the estate, poor public image and subsequent interventions from the Fire Brigade with potential enforcement notices	Organisation		Mike Stark	14-May-2024	14-Aug-2024	Planned	20	12	8	Outstanding items from last survey to be prioritised on risk basis, on a rolling program (26-Mar-2024)	fire door maintenance, fire alarm system, compartmentation inspections and remedials, fire damper inspections and remedials, automatically closing fire doors, emergency lighting, fire extinguishers and other elements of the fire strategy mitigates the reliance on any one component of fire safety(29-Nov-2021), Mandatory fire training(29-Nov-2021), Fire wardens(29-Nov-2021), Annual Capital bids rolling program(29-Nov-2021), Annual audit regime in place(29-Nov-2021), Authorised Engineer (AE)appointment made March 2020(29-Nov-2021), Annual audit in place(29-Nov-2021), Annual Remedial programme in place, risk based priority(29-Nov-2021), Identified remedials were completed Jan 2021(29-Nov-2021), 21/22 programme approved at May 2021 Trust Exec Group(29-Nov-2021), Audit completed June 2021, included all plant room spaces(29-Nov-2021), 20% of Hospital streets audited annually on a rolling program(29-Nov-2021), Works identified including 140 fire doors to be fitted on electrical cupboards. Prioritisation on risk basis, Order for £10K placed with Nene Valley(29-Nov-2021)	Low	Treat	Reviewed by Associate Di	25-Aug-2021
RSK-264	IF the Trust Fire Doors are not regularly surveyed and remedial works funded THEN remedial work not being completed	LEADING TO the travel of fire between compartments causing risk to life, greater damage to the estate, poor public image and subsequent interventions from the Fire Brigade with potential enforcement notices.	Organisation		Mike Stark	29-Apr-2024	26-Jul-2024	Planned	20	12	8		A combination of fire door maintenance, fire alarm system, compartmentation inspections and remedials, fire damper inspections and remedials, automatically closing fire doors, emergency lighting, fire extinguishers and other elements of the fire strategy mitigates the reliance on any one component of fire safety(29-Nov-2021), Mandatory fire training(29-Nov-2021), Fire wardens(29-Nov-2021), Pre commitment to continual rolling program of updates and refurbishment. BAU funding. £300k invested on Phase 2 2023/24(29-Nov-2021), Plant Room Doors surveyed(29-Nov-2021), Guaranteed Capital agreed brought service in house January 2020(29-Nov-2021), Authorised Engineer (AE) appointed April 2023(29-Nov-2021), Many Fire Doors have been replaced since Jan 2020 as part of the prioritisation programme(29-Nov-2021), Rolling programme with backlog to overcome issues, on annual business case.(29-Nov-2021), 21/22 programme approved at May 2021 Trust Exec Group(29-Nov-2021), Options for new AE, out to tender(29-Nov-2021)	Low	Treat	Risk reviewed by Associa	29-Nov-2021

Reference	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-269	IF the Trust fails to comply fully with current DoH HTM 04-01 Parts A&B, Addendum relating to Water Systems and HTM 00 as identified in the Water Risk assessment THEN The Trust will be unable to provide assurance of a fully compliant water safety system	LEADING TO Increased risk to patients and staff, loss of reputation, financial loss to the Trust.	Organisation		Benjamin Hazell	29-Apr-2024	01-Jul-2024	Planned	16	12	8	Water Coolers being changed across the Trust to direct feed and Healthcare environment recommended.	A Water Services Management Group operates quarterly, with agreed membership and agenda items(30-Nov-2021), Audit document and action plan has been circulated to the Group for discussion and progression at the next meeting(30-Nov-2021), Independent contractor commissioned to regularly test water outlets. Controls and testing regimes in place(30-Nov-2021), Review and Water Services Management Group membership includes independent contractor and Authorising Engineer(30-Nov-2021), Whole site risk assessments are current and risk reviewed at each meeting(30-Nov-2021), Risk assessment undertaken of augmented care areas(30-Nov-2021), House keepers are flushing water out lets in clinical areas and return flushing sheets to estates, Hotel Services Audit manager to track progress and compliance(30-Nov-2021), Tender awarded to Evolution, 2 year contract commenced 1st July 2019. extended for 6 months. New tender to be drafted(30-Nov-2021), Phase 1 and Cancer Centre risk assessments completed(30-Nov-2021), Phase 2 Risk Assessment completed June 2021, actions underway(30-Nov-2021), Audit and Risk assessments for outlying buildings planned 2022(30-Nov-2021), Ben Hazell is trained and appointed Appointed Person (AP)(22-	Low	Tolerate	Revised Water Hygiene p	21-Dec-2022
RSK-274	IF the Trust worn flooring is not replaced THEN there is a risk of failure of flooring	LEADING TO trip hazard & infection control issues	Organisation		Paul Sherratt	24-May-2024	30-Jun-2024	Planned	15	12	6		Capital bid to be placed annually(30-Nov-2021), Ward 6 and Ward 1 full floor replacement completed(30-Nov-2021), Business Case written, funded 21/22(30-Nov-2021), Adhoc floor repairs made with temporary taping of any failures occurring(30-Nov-2021), Going to the market for new contractor, out to tender(30-Nov-2021), Crown Industrial flooring making small repairs(30-Nov-2021), 3 year + 1 +1 . contract awarded. Annual audit of Common areas, corridors and circulation, includes repairs(03-Mar-2022), Ongoing rolling annual program. Major works funded by Capital, smaller repairs funded under revenue repairs(20-Sep-2023)	Low	Tolerate	Risk reviewed, no change	25-Aug-2021
RSK-281	If the lift located in Outpatients (servicing levels 3, 4 of yellow zone, and Staff Health & Wellbeing) fails THEN disabled & mobility reduced/sight impaired individuals unable to access workplace or services – unable to fulfil contractual obligations. Persons entrapped in lift unable to exit. Delayed access/treatment of an individual taken ill whilst trapped. Claustrophobia, panic attacks, psychological harm, deterioration of condition	LEADING TO Reduced availability of staff, unable to carry out duties, reduced clinical input/unable to see clients (internal/external) in a timely manner – increased workload for other staff leading to increased work pressure/stress Loss of income of external clients who cannot be seen due to absence of clinician Service user dissatisfaction – complaints/reputation of service and organisation affected Adverse publicity if unavailability of service reported to local press/reputation of organisation and service affected The organisation would be in breach of statutory duties under Health & Safety At Work etc Act 1974, Equality Act 2010 – failure to provide safe access/egress/safe place of work – potentially leading to enforcement action/further interest of Health & Safety Executive Inspectorate	Organisation		Steven Sluter	24-May-2024	30-Jun-2024	Planned	12	12	9	Luing Cowley Lift awaiting upgrades, parts delivered, to be installed FY 24/25 (29-Aug-2023)	There is an SLA is place that states that the lift will be repaired within 4 hours, normally 1-2hours(30-Nov-2021), ResQmat are on the landings on floors 3 & 4 and should be used in the event disabled persons and those with limited mobility, are unable to leave their respective floors, although staff are not trained in their use(30-Nov-2021), Call bell/telephone in lift to call for assistance(30-Nov-2021), Monthly lift inspections in place(30-Nov-2021), 6 Monthly PPM in place(30-Nov-2021), Annual insurance inspections in place(30-Nov-2021), ResQmat training video in place created by Manual Handling adviser(30-Nov-2021), Refurbishment of ward 14 lift carried out(30-Nov-2021), On the Capital Programme(30-Nov-2021), Outpatients Business Case approved for M&E study, with any identified anticipated to be completed end of FY 2022(30-Nov-2021), Tender raised to replace control panels, hydraulic tanks(03-Mar-2022)	Medium	Treat	Reviewed no change to ri	25-Aug-2021
RSK-425	IF the current mechanisms used for reporting on RTT status continue, along with the current use (and third-party support) of the tools to populate PTL reporting, pathways can 'drop' from the PTL due to legacy logic and rules deeply embedded in the PTL build to cleanse the PTL THEN the data available for submission will continue to require significant overhead to review, rectify and improve (i.e. veracity etc.) LEADING TO an inability to submit with short turnarounds, continued challenges in seeing patient pathways, prioritizing care etc. and potentially a risk to patient safety as a result.	Potential impact to patient care due to an inability to see patient pathways at a system level.	Organisation		Craig York	05-Jun-2024	04-Sep-2024	Planned	9	12	6	DQ Working Group Focus on RTT and PTL content will scope work required. Action delayed while clinic outcome forms web tool is replaced and waiting list task and finish groups continue.	Business Case being submitted by late spring to implement RTT functionality.(11-Apr-2023)	Medium	Treat	Investigations continue ir	25-Jan-2023

Reference	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-007	IF the team Fire Warden is not adequately trained or they are not present during a related emergency; THEN there would be no focal point for fire safety matters for local staff and supporting line managers on fire safety issues, and the team may not be represented in Fire Safety Committee meetings, and they will not be able to organise and assist in the fire safety regime within their local area	LEADING TO staff and other individuals visiting level 1 in Oak House potentially not being evacuate in a timely manner due to the lack of oversight. The lack of single focused oversight could cause confusion, delays in evacuation and people being left behind. This could lead to smoke inhalation, burns, death. Fire checking and prevention procedures may not be robust enough to identify potential hazards and prevent a fire from happening. Breach of statutory regulations	Organisation		Tina Worth	08-Apr-2024	30-Jun-2024	Planned	15	10	5		Fire Warden advised to work within current knowledge and skill gained through mandatory fire training(06-Sep-2021), No team member to attempt to fight fires with equipment untrained to use(06-Sep-2021), Risk assessment shared with team / Staff awareness(06-Sep-2021), Quarterly fire safety audits completed(06-Sep-2021), Good housekeeping practicalities - reiterated at team huddle(06-Sep-2021), Fire safety signage displayed -action cards and assembly points identified, clearly visible to team members and others visiting corridor(06-Sep-2021), Fire alarm system checked regularly in line with Trust policy and is audible in corridor(06-Sep-2021), Team members have undertaken and are up to date with mandatory training (compliance checked monthly)(06-Sep-2021), Team risk assessment for lone working on back of Covid changes which covers fire(06-Sep-2021), Risk & Clinical Governance Team Fire Warden to attend Fire Warden Training(06-Sep-2021), There was a suggestion that posters were put up for staff to follow when Kevin is not in.(21-Dec-2021), There was a recommendation that in light of the working from home arrangements, it might be appropriate for everyone to have the training so that there is adequate cover.(21-Dec-2021), Staff awareness information. Staff have all read & received	Low	Treat	Team compliant with ma	06-Sep-2021
RSK-242	IF a chemical, biological, radiological, nuclear (CBRN/HAZMAT) incident was to occur through either intentional or unintentional means THEN the Trust would require specialised response through national guidelines and expert advice	LEADING TO potential impact on Trust services and site safety to patients and staff; Possible impact on closing or disrupting ED operations, with further risk to all operations on how the Trust operate depending on the nature of the incident (e.g., Novichok incident at Salisbury)	Organisation		Adam Biggs	17-Apr-2024	28-Jun-2024	Planned	10	10	5	The outstanding areas identified in South Central Ambulance Service bi-annual audit will be incorporated into revising the CBRN SOP and training programme to be embedded with MKUH EPRR Work Programme 2024. This programme will be presented at the Emergency Planning Steering Committee in February 2024 for sign-off. (04-Mar-2024)		Low	Treat	To be reviewed following	26-Nov-2021
RSK-260	IF people working at height are not correctly trained THEN there is a risk from fall from height	LEADING TO staff/contractor injuries, potential claims, non compliance with statutory regulations and loss of reputation	Organisation		Paul Sherratt	24-May-2024	30-Jun-2024	Planned	15	10	5	Refresher Ladder Training to be arranged and delivered. Quote to be obtained from Alan Hambridge. (20-Sep-2023), Manual alternative to Cherry Picker to be sourced.	Staff training. Ladder/equipment inspections(29-Nov-2021), Written processes and Working at Height Policy reviewed regularly(29-Nov-2021), New lifting equipment purchased(29-Nov-2021), General H&S training conducted(29-Nov-2021), Cherry Picker obtained- staff trained(29-Nov-2021), RAMS from contractors reviewed by Compliance Manager(29-Nov-2021), Edge protection in place in all locations where plant or PV panels exist(29-Nov-2021), On going Contract in place for Edge Protection and Latchways systems Inspections and Maintenance.(29-Nov-2021), Trained RP in August 2021(29-Nov-2021), RP has been appointed by Alan Hambridge(29-Nov-2021), Cherry Picker is being sold, and will be replaced with a hire in service with operator as and when needed. This will negate the need for staff training, storage and maintenance of the kit, and reduce the risks to the workforce.(20-Sep-2023)	Low	Treat	Risk reviewed, no change	25-Aug-2021
RSK-510	IF MKUH does not have a reliable temperature monitoring systems that covers all medicines storage locations (room, fridge and freezers) THEN the Trust is unable to have assurance that medicines are stored appropriately and the Trust will not be compliant CQC recommendations made in 2019	LEADING TO Potential patient safety event due to administration of inappropriately stored medicines; Failure to resolve a previous CQC recommendation; Potential larger financial loss due to delay in noticing temperature excursion events leading to increased dispose of medicines.	Organisation		Andrew Tse	08-May-2024	30-Jun-2024	Planned	15	10	5	Trust-wide temperature monitoring system for the monitoring of temperature in all medicine storage locations (room, fridge and freezer) to be implemented	Redesign of temperature monitoring forms(18-Jan-2024), Redesign of temperature monitoring guidance and disseminated to clinical areas(18-Jan-2024), Teaching sessions in senior nurses meeting & pharmacy(18-Jan-2024), Safe and secure handling audit to gain assurance and identify deficiencies(18-Jan-2024), The use of stand-a-lone thermometers for temperature monitoring (but requires user to manually record temperatures)(18-Jan-2024), Escalation to Chief Pharmacist for issue awareness at executive level(18-Jan-2024)	Low	Treat	Risk reviewed at Quality I	15-Jan-2024

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RSK-010	IF the Radar Risk Management System does not meet the needs to the Trust and of legal reporting requirements THEN the Trust will not have an appropriate system to manage incidents, complaints, claims, compliments, safety alerts, documentation, audits, risks and other risk/governance related activity.	LEADING TO an inability for the Trust to defend itself against future claims/litigation leading to potential financial penalties, improvement notices, PFD notices from HM Coroner, adverse publicity etc., an inability to evidence compliance with CQC regulations and freedom of information requests, and potential for an increase in incidents, complaints and claims due to lack of learning from incidents.	Organisation		Paul Ewers	29-May-2024	28-Jun-2024	Planned	20	9	6	Redesign of Analytics to meet the needs of the Trust (23-Feb-2024)	Project Manager identified along with 3 members of staff to provide cover and support to the project where necessary(06-Sep-2021), Radar Project Plan in place(06-Sep-2021), Radar Risk Assessment in place(06-Sep-2021), Working Groups identified to support design/build of system in line with Trust's requirements(06-Sep-2021), Radar Healthcare have a dedicated Project Manager and team in place to support MKUH with implementation(06-Sep-2021), Clearly defined roles added to the Project Plan(06-Sep-2021), Escalation process in place to Exec Sponsor(06-Sep-2021), Communication Strategy Developed(06-Sep-2021), Enhancements / Developments to Radar System required to support staff in reporting incidents.(23-Dec-2022), Radar moving server from Windows to Linux to provide more stable analytics system, with improved speed and functionality(23-Dec-2022), System redesign to meet the needs of the new Patient Safety Incident Response Framework (PSIRF)(08-Jun-2023), Training and Comms in relation to Documentation Process (including, how to access the latest versions)(09-Aug-2023), MKUH/Radar Programme Board(29-Jan-2024)	Low	Treat	Risk reviewed, no change	28-Apr-2021
RSK-033	If the laundry contractor (Elis) can not provide an efficient and effective service. Then there may be: Delayed deliveries from Elis 2. Shortage deliveries from Elis 3. Lack of contingency stock	Leading to: 1. Delayed linen distribution throughout the trust. 2. Delayed personal care – negative impact on patient experience. 3. Delayed clinics and surgical lists (theatres). 4. Staff health and wellbeing – stress. 5. Waste of staffing resources – staff without linen to distribute. 6. In case of a Major Incident there would not be enough laundry to provide a good level of patient care.	Organisation		Aiden Ralph	06-Mar-2024	12-Jun-2024	Pending	8	9	6		1. Escalated issue internally and externally.(27-Sep-2021), In daily contact with laundry company to ascertain their position.(11-Feb-2022), There is a lock on the dirty linen store to prevent employees/patients/ visitors entering.(11-Feb-2022), Contract review meetings with Elis every quarter.(15-Dec-2022), MKUH has a contract with Elis which has contingency plans in place.(15-Dec-2022)	Low	Treat	Risk Owner changed to A	01-Dec-2022
RSK-215	IF Child Protection (CP) Medicals are not completed THEN there is potential for delay in proceedings for Child Protection which may lead to compliance issues for the Trust and impacts on children, families and staff	LEADING TO legal and regulatory issues for MKUH, the police, and Social Services. Delays in appropriate multi-agency safeguarding children actions being taken and potential for increased risk to the child's safety and potential litigation against the Trust	Organisation		Julie Orr	09-Nov-2023	08-Dec-2023	Overdue	9	9	6	Head of safeguarding and Named Doctor to review the CP medical internal MKUH process for booking CP medicals and data capture as part of gap analalysis (09-Nov-2023), Ongoing discussions are being held with BLMK and CNWL and Designated Doctor to progress toward an agreeable pathway (09-Nov-2023)	Social Service made aware that the earlier we know about CP Medicals the easier it is to get them in and out(24-Nov-2021), A interim process has been agreed that SW requesting CP Medical contacts the SGC Lead who will coordinate booking through ward 4 and discuss with on call consultant(24-Nov-2021)	Low	Treat	Discuss with the Head of	24-Nov-2021
RSK-216	If agreed safeguarding processes/ practice and staffing are not in place which includes multi-agency working and information sharing THEN the Trust may be non-compliant with key regulatory and legislative processes including information-sharing agreements.	LEADING TO potential failures in care provision which may have a detrimental effect on patients, their families, staff, and the Trust. The complexities of multi-agency working especially within safeguarding require information sharing between multiple agencies. Currently, there are multiple pathways for sharing of information. Failure to comply with regulations/legislation and information-sharing processes has potential legal and financial implications for the Trust.	Organisation		Julie Orr	07-Mar-2024	31-Mar-2024	Overdue	9	9	6	Ongoing training programme for all staff (10-Jan-2024), Named leads -staff development and training in safeguarding roles needed	Memorandum of understanding for the MK Safeguarding adult and children's board and for the subgroups that feed into this multi agency board, of which the Trust is a signatory(24-Nov-2021), There are electronic safeguarding forms available to staff to raise safeguarding concerns to the relevant external safeguarding adult or children's teams, SABR1, MARF. MARF now go to what is known as the Multi-Agency Hub and that has POLICE, EDUCATION, HEALTH AND SOCIAL SERVICES(24-Nov-2021), The Safeguarding Leads attend MARAC AND MARM COMMITEES which are Multi-Agency(24-Nov-2021), Safeguarding has an electric promoting welfare tab on EDM to identify individuals at risk(24-Nov-2021), Safeguarding children have a sharing information electronic form to help identify to school nurses and health visitors children who have attended or may be at risk due to the child behind the adult(24-Nov-2021), Maternity services use confidential communique on the Amalga system This has been widened to include children's and also the safe storage and collection of the MARF forms(24-Nov-2021), Trust Safeguarding Committee is multi agency(24-Nov-2021), MKHFT sits on the Milton Keynes Safeguarding Adults and Children's Boards(24-Nov-2021), MKHFT has named leads for Safeguarding Adults and Children	Low	Treat	Review risk with the Hea	24-Nov-2021

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RSK-233	IF we are unable to recruit sufficient staff THEN we may not have safe staffing levels in the hospital	LEADING to reduced service delivery, reduction in patient experience and care.	Organisation		Helen Bass	01-May-2024	31-Aug-2024	Planned	16	9	3	Recruitment plans by role (03-May-2024), Maintain current headcount of recruitment team by making FTC employees substantive	Apprenticeship routes for nursing(25-Nov-2021), System in place to recruit student nurses from placements at MKUH(25-Nov-2021), Enhanced adverts, social media and recruitment open day tool kit for Divisions to use(25-Nov-2021), NHS People Plan strengthens action on education and new roles(25-Nov-2021), National NHS England recruitment publicity(25-Nov-2021), International Recruitment of 100 Nurses in 2023(31-Oct-2022), Recruitment and retention premia or certain specialties(11-May-2023), Advanced Nurse Practitioner development and integration in progress(11-May-2023), New SAS grade established(11-May-2023), New publication for International Medical Graduates developed(11-May-2023), Action down policy in place(11-May-2023), Routine/Regular evidence based trends inform early recruitment activity(11-May-2023), Shared recruitment campaigns for HCSW(19-Jul-2023), Recruitment Specialists impacting hard to recruit areas(19-Jul-2023)	Low	Tolerate	Risk merged with RSK-23:	01-Nov-2021
RSK-236	IF there is inability to retain staff employed in critical posts THEN we may not be able to provide safe workforce cover	LEADING TO clinical risk. Increasing temporary staffing usage and expenditure Increased turnover Decreased stability rates Increased stress levels within trust Reduced morale	Organisation		Louise Clayton	10-Apr-2024	30-Jun-2024	Planned	16	9	9	Creation of retention toolkit (10-Apr-2024), Review of local induction/onboarding process (10-Apr-2024)	Variety of Organisational Development and Reward initiatives, including Event in the Tent, P2P, Schwartz Rounds, Living our Values, Annual Staff Awards and feedback from staff being acted upon(25-Nov-2021), Monitoring via staff survey feedback and local action plan based outcomes(25-Nov-2021), Health and Wellbeing promotion, education and prevention via Staff Health and Wellbeing(25-Nov-2021), Online onboarding and exit interview process in place(25-Nov-2021), Flexible working and Agile Working policies in place(25-Nov-2021), MK Managers Way in place(25-Nov-2021), Recruitment and retention premia in place, including Golden Hello for Midwives(25-Nov-2021), Enhanced social media engagement in place and ongoing(25-Nov-2021), Annual funding initiatives to upskill staff and retain them through ongoing education e.g. Chief Nurse Fellowships, PGCE and Rotary Club Bursary fund(25-Nov-2021), Refer a Friend Scheme introduced in 2022 to improve retention and recruitment.(10-May-2022), International Recruitment ongoing to recruit 125 nurses in 2022,	Low	Tolerate	Risk Reviewed - Controls	02-Jan-2023
RSK-276	If the flat roofs identified in the Langley Roof report and 6 facet survey as requiring replacement or upgrading, are not replaced THEN there is a risk of roof failure in relation to flat roofs across the Trust	LEADING TO Water ingress - Potential damage to equipment, disruption to service, damage to reputation	Organisation		Anthony Marsh	25-May-2024	31-Aug-2024	Planned	15	9	3	Replacement/upgrade of flat roofs identified in the 6 facet survey. Ongoing replacement works since Jan 24. Funder in 2024/25 Programme (25-May-2024)	Inspections and repairs as needed(30-Nov-2021), Updated annual 6 facet survey by Oakleaf(30-Nov-2021), Large patch repairs undertaken as emergency business cases(30-Nov-2021), 1 x Post Grad roof fully replaced 19/20(30-Nov-2021), Ward 10 - 50% of roof patch repairs completed 19/20(30-Nov-2021), Phase 1, Phase 2 and Community Hospital survey completed.(52 roof leaks noted in 12 months Jan 19 -Aug 20) 16 leaks in 1st week of October 2020(30-Nov-2021), Pharmacy small roof replaced September 20(30-Nov-2021), Business Case approved for 4 to 5 year rolling programme(30-Nov-2021), Community Hospital work completed July 2021(30-Nov-2021), Phase 1 and Phase 2 of the hospital works outstanding. Funding to be approved(30-Nov-2021), Funding for phase 2 included in carbon zero funds to be announced Jan 2022/ Bid not successful for roof work(30-Nov-2021)	Low	Treat	Reviewed by Associate Di	21-Dec-2022

Reference	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-279	IF pedestrians in the hospital grounds walk over the verges, grassed areas, mounds, slopes, sloped/high curbs and do not stick to the designated pathways THEN Patients, visitors and staff could slip, trip or fall causing injury including fractures, sprains, strains	LEADING TO legal and enforcement action against individuals/and or the Trust leading to fines/compensation/exposure in local press leading to adverse publicity	Organisation		Mike Stark	29-Apr-2024	28-Jun-2024	Planned	12	9	6	Areas suitable to install knee high fencing identified. High risk areas with slopes actioned. Continual review to identify and prioritise for installation in future years. (26-Mar-2024)	Sloping curbs painted yellow where they may be crossed(30-Nov-2021), Fencing or railings in some areas to deter access(30-Nov-2021), Rolling Paths annual program to repair paths and roads(30-Nov-2021), Grass kept cut by grounds team(30-Nov-2021), Ongoing review of grounds to control access(30-Nov-2021), Keep off the Grass signage in place(30-Nov-2021)	Low	Treat	Risk reviewed by Associat	25-Aug-2021
RSK-283	IF medical equipment is damaged due to misuse, inappropriate use, storage, transportation, and/or inappropriate cleaning THEN the medical equipment may be unavailable due to damage	LEADING TO delay in patient care and treatment; cost of parts; cost of repairs; purchasing replacement	Organisation		Ayca Ahmed	20-May-2024	20-Jun-2024	Planned	12	9	9		Training in the use of medical equipment(01-Jul-2022), Auditing PPMs(01-Jul-2022), Medical Devices Management policy- following processes(01-Jul-2022), Discuss at the monthly MDG meetings(31-Aug-2023)	Low	Tolerate	Reviewed by Medical Dev	16-Oct-2018
RSK-284	IF staff members do not adhere to the Medical Devices Management Policy THEN they may not follow the correct procurement procedures for Capital and Revenue medical equipment purchases	LEADING TO them being not fit for purpose equipment being purchase; more costly; non-standardised; lack maintenance contract; lack of training for staff; incompatible/lack of consumables and accessory; additional IT integration costs	Organisation		Ayca Ahmed	20-May-2024	20-Jun-2024	Planned	12	9	6		Medical Devices Group meetings are held monthly to discuss procurement(01-Jul-2022), BC review for capital medical equipment purchase(18-Dec-2023), Checklist for procurement team to make sure prior to purchase they liaise with the MEM team(21-Dec-2023), AUDITING PPMS(16-Feb-2024)	Low	Treat	Reviewed by Medical Dev	16-Oct-2018
RSK-300	IF the call bell system is not replaced/upgraded THEN the call bell system could fail as parts obsolete for some systems to obtain	LEADING TO increased risk to patients and possible service disruption and poor patient experience	Organisation		Steven Sluter	24-May-2024	30-Jun-2024	Planned	9	9	6	Wards with obsolete equipment require replacement. Spares have increased as old system been replaced.Upgrade programme to be included in rolling Capital bid of £50K for 24/25 (03-May-2023)	An emergency back up system of 30 units has been purchased in the event of current system failing. There is also an additional spare unit(30-Nov-2021), Ward 4, 5 and Milton Mouse & A&E Majors were replaced in FY18/19(30-Nov-2021), ADAU replaced as emergency business case October 2019(30-Nov-2021), Endo replaced in Jan 2020(30-Nov-2021), Vizcall no longer in business, plan to replace all Vizcall systems in 20/21 - Vizcall test equipment and spares purchased for in house support(30-Nov-2021), Above the line funding for 2 x wards and ED agreed for 2021 with Ascom. Ward 2A and ED will be completed in 2023/2024(30-Nov-2021), Milton Mouse and Urology have been added to the Ascom system 2024(26-Mar-2024)	Low	Treat	Reviewed no change to ri	25-Aug-2021
RSK-434	IF there is insufficient capacity of outpatient appointments THEN Patient Access will be unable to provide patients within designated timescales	LEADING TO a delay in diagnosing and treating patients; cancellation of appointments to ensure patients are appropriately prioritised; increasing waiting lists; breach in national appointment timescales; patients being moved in clinics without clinical validation.	Organisation		Felicity Medina	14-May-2024	13-Nov-2024	Planned	9	9	6		Fortnightly ASI reports are produced and circulated at a senior level identifying polling ranges and patients waiting on e-Referral worklists.(10-Feb-2023), Divisions reviewing capacity & demand planning.(10-Feb-2023), WLIs are being held in services to expedite long waiting patients.(10-Feb-2023), Patients are booked according to referrals priority and wait time(10-Feb-2023), Many services have referral assessment services in order to clinically triage referrals(10-Feb-2023), All services have been requested to ensure that there are firebreaks within their clinic templates to mitigate disruption due to clinic cancellations(10-Feb-2023), Daily 78+ week report circulated to monitor longest waiting patients.(10-Feb-2023), Capacity & Demand planning for all services to be completed(10-Feb-2023), Cleanse of the Patient Tracking Lists for the following services to be undertaken, utilising additional non-recurrent resource - Ophthalmology; ENT; Urology; Trauma & Orthopaedics; Gynaecology(10-Feb-2023)	Low	Treat	As per email from Felicity	06-Feb-2023
RSK-448	IF the GE Voulson E10 obstetric ultrasound machines are more than 5 years old THEN there may be reduced accuracy in imaging and reduction in image quality; ongoing further costing to replace probes and complete maintenance; higher risk of equipment breakdown	LEADING TO potential unnecessary further testing and patient stress; potential withdrawal from service and cancelation of lists; breach of Public health England's Fetal anomaly screening programme (FASP) guidance	Organisation		Alexandra Godfrey	05-Jun-2024	31-Jul-2024	Planned	9	9	6	Replacement obstetric ultrasound machines (05-Jun-2024)	Regular servicing and QA programming to ensure accuracy and functionality(17-Apr-2023), Ensuring probes are repaired and maintained.(17-Apr-2023), Switch older machine with newer machine for those undertaking the 12 and 20 week screening scans(17-Apr-2023)	Low	Treat	OPU2 ultrasound machin	21-Mar-2023

Reference	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-002	IF recommendations and actions from audit are not evidenced, monitored and completed in the Trust; THEN required changes to practice may not implemented and we may not be meeting best practice criteria;	LEADING TO potential impact on the top 3 Trust objectives (patient Safety, Clinical Effectiveness, Patient Experience), potential poor quality of service and associated impact on resources and potential CQC concerns re audit activity and learning from national audits	Organisation		Jacqueline Stretton	07-May-2024	31-Aug-2024	Planned	15	8	2		Audit report templates available to identify audit action plans(06-Sep-2021), Monitoring via Clinical Audit & Effectiveness Committee (CAEB)(06-Sep-2021), Terms of Reference (ToR) for Clinical Audit & Effectiveness Board revised to include quality improvement, GIRFT etc(06-Sep-2021), Escalation/exception reporting to Management Board(06-Sep-2021), Refresh of SharePoint data base to assist with data capture, with Level 1 audit a priority(06-Sep-2021), Structure review - Staff realignment to support audit agenda(06-Sep-2021), Scheduled implementation of Radar audit module(06-Sep-2021), Pilot of new governance approach to reports/CIG meetings(06-Sep-2021)	Low	Treat	Risk reviewed. Audit mo	06-Sep-2021
RSK-020	IF there are ligature point areas in ED for Adult and C&YP in all areas of department THEN ED patients may use ligature points to self harm. There has been an incident where a mental health patient used a door closer as a ligature point.	LEADING TO increased safety risk to patients, safe and adverse publicity	Organisation		Kirsty McKenzie	04-Jun-2024	08-Jul-2024	Planned	9	8	4	Mental Health pathway to be reviewed by the Corporate Team (04-Jun-2024)	Patients assessed and those at risk of self harming are placed in an area they can easily be observed.(22-Sep-2021), New mental health room has been ligature and risk assessed by CNWL team(22-Sep-2021), Remind all staff about keeping swipe doors closed so they don't access rooms where they are not observeble Last ligature audit was April 2019 and actioned.(22-Sep-2021), Risk Assessment of adult and C&YP areas reviewed April 2019(22-Sep-2021), Check list in place to risk asses each Adults and C&YP attending with MH/DSH issues to identify personalised action plan(22-Sep-2021), Follow up ligature RA completed as advised by H&S lead for trust Risk Assesment completed - identified need for collapsible clothes hangers in public toilets - request to estates to install and completed; x1 non-compliant cord pull also in toilet - changed(22-Sep-2021), Repeat Ligature Risk Assessment for 2020 required(22-Sep-2021), ensure all staff are aware of the new Policy - "Ligature Risk Awareness"(22-Sep-2021), E-Care Risk Assessment Tool to be reviewed/adapted(10-Aug-2022)	Low	Treat	discussed with safeguard	05-Aug-2014
RSK-159	Patients referred to the Occupational Therapy and Physiotherapy inpatient services covering medical and surgical wards are not being seen in a timely manner due to the number of long term vacancies and national challenges to recruit to vacant posts. 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. patient experience and long term quality of life will also be impacted as patients are being discharged as more dependent on care.	Organisation		Laura Sturgeon	29-Apr-2024	09-Jun-2024	Pending	20	8	3		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), Review of Governance Structure(19-Apr-2022), Review Model of Care(19-Apr-2022), Review Equity Tool - Safe Staffing(19-Apr-2022), Review Workforce Model and Structure(19-Apr-2022), Recruitment and Retention of staff(19-Apr-2022), Education and Training of staff(19-Apr-2022), workforce plan to improve retention(09-May-2023), inpatient improvement programme- to ensure optimal staffing and allocation(09-May-2023), use of agency staff for any gapped posts(09-May-2023), each team to review skill mix to provide resilience in team, introduce support workers where required(09-May-2023), winter proposal for therapy services- enhanced number of support workers for winter period.(09-May-2023), regular attendance at MADE (Multiagency Discharge Event) to improve flow of patients and safe timely discharge.(09-May-2023)	Low	Treat	long term sickness contin	04-Mar-2019

Reference	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-262	IF the Trust Fire Dampers are not surveyed and remedial works funded THEN remedial work not being completed	LEADING TO the travel of fire between compartments causing risk to life, greater damage to the estate, poor public image and subsequent interventions from the Fire Brigade with potential enforcement notices.	Organisation		Mike Stark	14-May-2024	14-Aug-2024	Planned	20	8	8	Fire Damper O&M to be checked for Ward 22/Endo and added to maintenance schedule if appropriate (21-May-2024)	A combination of fire door maintenance, fire alarm system, compartmentation inspections and remedials, fire damper inspections and remedials, automatically closing fire doors, emergency lighting, fire extinguishers and other elements of the fire strategy mitigates the reliance on any one component of fire safety(29-Nov-2021), Mandatory fire training(29-Nov-2021), Fire wardens(29-Nov-2021), Authorised Engineer (AE)appointed March 2020(29-Nov-2021), Annual inspections(29-Nov-2021), Funded annual remedial programme(29-Nov-2021), Site wide Damper annual audit, risk based approach to any remedials(29-Nov-2021), £10K of repair work ordered and new inspection(29-Nov-2021), Changed Theatre 5 Damper, remaining 6 faults to be replaced 2022/2023(03-Mar-2022)	Low	Tolerate	Reviewed by Associate Di	25-Aug-2021
RSK-265	IF there is local power failure and failure of emergency lights, due to age of existing fittings and lack of previous investment THEN there may be a failure to protect persons allowing a safe evacuation of the area	LEADING TO poor patient experience and safety, non-compliance with regulation, loss of reputation	Organisation		Steven Sluter	24-May-2024	30-Jun-2024	Planned	20	8	8	P4 reporting being connected., C&B to replace failed lights and remedial works 24/25 Budget of £20K identified.	Future investment requirements identified by PPM , reactive maintenance and Estates Specialist Officer(30-Nov-2021), PPM checks in place with regular testing by direct labour(30-Nov-2021), Rolling program of capital investment(30-Nov-2021), Rolling PPM program PPM 3 hour E-light testing program in place(30-Nov-2021), List of known remedials to be completed and prioritised(30-Nov-2021)	Low	Tolerate	Reviewed no change to ri	25-Aug-2021
RSK-266	IF the Trust are unable to take up the New Hospital Plan THEN The Trust would have to fund all future developments from either internally generated funding defined for backlog investment or borrow the money	LEADING TO the Trust being unable to meet the needs of the future MK population with regard to the size and quality of the estate	Organisation		Rebecca Grindley	15-Apr-2024	30-Sep-2024	Planned	16	8	8		Seed funding approved by DHSC to support the development of a Strategic Outline Case (SOC)(30-Nov-2021), SOC has been formally completed(30-Nov-2021), Regular monthly meetings on a formal basis with NHSE/I and DHSC(30-Nov-2021), Regular dialogue taking place with NHSE/I Strategic Estates Advisor(30-Nov-2021), Regular dialogue taking place at Board level(30-Nov-2021), Monthly reporting structure in place with NHSE/I(30-Nov-2021), Programme Board chaired by CEO set-up with agreed ToR(30-Nov-2021), Wider engagement with MK Council(30-Nov-2021), Wider engagement with senior colleagues in the Trust commenced(30-Nov-2021), Engagement with CCG undertaken(30-Nov-2021), SOC Submitted to NHSEI, OBC to be progressed in quarter 4(30-Nov-2021), Funding for Outline Business Case (OBC) agreed in Jan '22. Due for completion by March 2023.(04-Mar-2022)	Medium	Tolerate	SOC Submitted, OBC par	30-Nov-2021
RSK-291	IF the existing surface water drainage system is not suitably maintained or repaired THEN the surface water drainage system could fail	LEADING TO flooding and contamination and loss of service	Organisation		Mike Stark	29-Apr-2024	26-Jul-2024	Planned	12	8	4	Full site has been surveyed and remedial works planned. (31-Mar-2023)	Reactive maintenance repairs(30-Nov-2021), CCTV works has indicated areas of root re-growth with pipe damage to storm water pipes, works being undertaken during summer/autumn 2021(30-Nov-2021), BDP created scope for full site survey under the HIP program to identify shortfall in current data and future plan requirements. A new link is likely to be required as part of South Site development(30-Nov-2021), Road Gulley on PPM(30-Nov-2021)	Low	Treat	Risk reviewed by Associa	25-Aug-2021
RSK-293	IF the current fuse boards are not updated to miniature circuit breakers THEN existing fuse-boards could fail	LEADING to delays in repairs/replacement resulting in possible service disruption and poor patient experience	Organisation		Steven Sluter	24-May-2024	30-Jun-2024	Planned	12	8	4	Ongoing rolling program of refurbishment, subject to funding in Trust Capital programme (23-Mar-2023)	PPM testing and repairs(30-Nov-2021), Fixed electrical testing program in place to identify any potential risks and actions required(30-Nov-2021), Replaced Circuit breakers/fuses FY 20/21(30-Nov-2021), Ward 1 completed 2021(30-Nov-2021), Wards 15, 16 and Milton Mouse have replacement circuit boards fitted as part of ward refurbishment in 2022/2024(21-Dec-2022)	Low	Treat	Reviewed no change to ri	25-Aug-2021
RSK-301	IF the existing foul water drainage system is not suitably maintained or repaired THEN the system could fail	LEADING TO cause flooding, contamination and loss of service	Organisation		Mike Stark	29-Apr-2024	28-Jun-2024	Planned	8	8	4		Reactive maintenance repairs, using Trust owned CCTV for inspections and remedial works.(30-Nov-2021), Wards 1-5 identified as risk areas(30-Nov-2021), Some CCTV inspection has been completed(30-Nov-2021), Proactive maintenance commitment(30-Nov-2021), Multiple areas descaled ongoing programme(30-Nov-2021)	Low	Treat	Reviewed by Associate Di	25-Aug-2021

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RSK-421	Ongoing shortages of medicines with minimal notice or little warning	Possibility of cancellation of patient appointments/operations or a delay to treatment/discharge. Increased cost to the trust in sourcing medicines off of contract prices, courier charges, staff time	Organisation		Nicholas Beason	26-Mar-2024	24-Jun-2024	Planned	10	8	6		Actively working on reducing any impact from medicines out of stock - sourcing where possible. Regional procurement, NHS England and mutual aid all being used.(20-Jan-2023), increase capacity of pharmacy procurement team(09-Jun-2023), Additional team members trained in procurement(30-Oct-2023)	Low	Treat	significant shortages con	27-Nov-2022
RSK-005	IF policies, guidelines and patient information are not reviewed and amended in a timely manner; THEN staff will be working with out of date information	LEADING TO potential error in patient care, non-compliance with legislative, national requirements, potential litigation and potential loss of reputation to Trust	Organisation		Jacqueline Stretton	09-Apr-2024	27-Jun-2024	Planned	12	6	3		Trust Documentation Policy(06-Sep-2021), Library resource to source current references(06-Sep-2021), Governance Leads provide support to staff reviewing guidelines and policies(06-Sep-2021), Monthly trust documentation report shared with Governance Leads(06-Sep-2021), New process via Trust Documentation Committee for 'removal' of significantly breached documents(06-Sep-2021), Work plan in place to check approval of documents/links to national leaflets(06-Sep-2021), Implementation of Radar Document Management System to improve engagement and access to the documentation process(06-Sep-2021)	Low	Treat	Reassigned to J Stretton i	06-Sep-2021
RSK-115	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		David Baker	26-Mar-2024	30-Sep-2024	Planned	20	6	6		Estates management informed and plans in place to receive reports on time and to standard. Independent monitoring system in place monitoring machine performance. Weekly PPM carried out on machinery. An action plan has been created by estates, to include training the specialist estates officer so he can gain the recognised qualification he needs to carry out the role of the Authorised person for decontamination (AP(D)) and for additional training of the estates competent persons (CP(D) who test the decontamination equipment.(29-Oct-2021), 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. Estates nominated person AP is undergoing training and awaiting final sign off and official appointment to role.(21-Jan-2022), Mechanical Engineer is trained and appointed as AP, for HSDU.(04-Apr-2023), Appointed AP(D)(27-Jul-2023), AE(D) to appoint AP(D) for Endoscopy.(20-Sep-2023)	Low	Tolerate	Reviewed by Associate Di	25-Aug-2021
RSK-204	IF data sent to external agencies (such as NHS Digital, Advise Inc and tenders) from the Procurement ordering system contain patient details THEN there is a risk that a data breach may occur with reference to GDPR and Data Protection Act as the procurement department deals with large volumes of data.	LEADING TO a data breach and potential significant fine	Organisation		Lisa Johnston	10-May-2024	10-Jun-2024	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	Ongoing risk	01-Apr-2022
RSK-205	IF there is Incorrect processing through human error or system errors on the Procurement systems THEN there is risk that there may be issues with data quality within the procurement systems	LEADING TO Incorrect ordering resulting in a lack of stock and impacting on patient safety	Organisation		Lisa Johnston	10-May-2024	10-Jun-2024	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	Risk transferred from Dat	01-Apr-2022
RSK-207	IF there is major IT failure internally or from external providers THEN there is a risk that key Finance and Procurement systems are unavailable	LEADING TO 1. No Purchase to pay functions available ie no electronic requisitions, ordering, receipting or payment of invoices creating delays for delivery of goods. 2. No electronic tenders being issued. 3. No electronic raising of orders or receipting of income	Organisation		Karan Hotchkin	10-May-2024	10-Jun-2024	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	Risk transferred from Dat	01-Apr-2022
RSK-209	IF staff members falsely represent themselves, abuse their position, or fail to disclosure information for personal gain THEN the Trust/Service Users/Stakeholders may be defrauded	LEADING TO financial loss and reputational damage	Organisation		Karan Hotchkin	10-May-2024	10-Jun-2024	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	Risk transferred from Dat	01-Apr-2022

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RSK-211	The presence of colonisation with pseudomonas aeruginosa, identified during routine water sampling from any outlets in the Cancer Centre will present an increased risk of infection in immuno-suppressed cancer patients. Mitigations in place to avoid risk to patients and staff in Cancer Centre	LEADING TO susceptible patients within augmented care units such as Ward 25 and chemotherapy Suite potentially coming to harm	Organisation		Angela Legate	13-May-2024	10-Jun-2024	Pending	16	6	6	replacement of pipework not yet removed/ replaced remains an option (21-May-2024)	For direct contact with patients water where testing has shown absence of P.aeruginosa(23-Nov-2021), For direct contact with patients water supplied through a point of use (POU) filter(23-Nov-2021), For direct contact with patients sterile water (for wound washing if required)(23-Nov-2021), Signs at all taps alerting people to refrain from drinking or brushing teeth with water(23-Nov-2021), Bottled water available(23-Nov-2021), Correct installation and commissioning of water systems in line with HTM 04-01 is adhered to. Schematic drawings are available for water systems(23-Nov-2021), Flushing of water outlets is carried out daily and documented (07:00 – 09:00 HCA)(23-Nov-2021), Plans for sampling and microbiological testing of water is in place(23-Nov-2021), replacement of pipework to hand wash basins in patient bays(27-Feb-2023), close monitoring of cleaning by domestic team (taps) and water sampling by external authorised company. pt. information includes safe use of drinking water(17-Apr-2023)	Low	Tolerate	enhanced monitoring of \	16-Mar-2021
RSK-238	IF poor moving and handling practice happens, THEN staff and patients may get injured due to poor moving and handling	LEADING TO litigation, sickness absence and increased temporary staffing backfill. Staff and/or patient injury Subsequent reduction in staff numbers Poor reputation and publicity Potential risk of litigation and prosecution	Organisation		Joanna Klimera	10-Apr-2024	31-May-2024	Overdue	12	6	6	Triangulate Data, Create action plans for top areas identified through group (10-Apr-2024)	Currently manual handling training is carried out every three years and the Manual Handling and Ergonomics Advisor visits all departments to carry out risk assessments, offer advice and ad-hoc training as required(25-Nov-2021), Training is currently being provided ad-hoc by an external company(10-May-2022), Occupational Health are employing a MSK Physio to provide staff support post injury.(10-May-2022), The Trust is exploring bank contracts for trainers to meet demand(10-May-2022), Set up standing agenda for Manual Handling Steering Group(18-Oct-2023)	Low	Treat	Risk reviewed - Controls \	01-Nov-2021
RSK-252	IF eCARE does not prevent non-prescribers from prescribing medication which could then be administered to a patient THEN there could be limitations in restricting access to individual Smart Card holders permissions or individuals do not adhere to the correct workflow	LEADING TO Medications could be prescribed and administered to a patient that are not clinically required & could be contraindicated	Organisation		Craig York	05-Jun-2024	04-Sep-2024	Planned	9	6	6	Accepted risk & continue to do as a monthly audit, with assistance identified and acted on.	eCARE training of correct process -eCARE training includes advice on only performing tasks related to professional registration and job role(26-Nov-2021), Code of conduct - NMC -eCARE pop up requires staff to state who advised them to prescribe medication & how (verbally/written)(26-Nov-2021), Monthly audit of in place a mechanism where medications prescribed by non-physicians are audited monthly against the known list of Non-Medical Prescribers/pharmacists/Midwives. Inconsistencies will be escalated to CNIO for investigation(15-Dec-2021), SOP to be produced to support monthly audit.(16-Feb-2022)	Low	Tolerate	The on-going mitigation f	25-Jan-2023
RSK-258	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		Alan Brooks	26-Mar-2024	30-Sep-2024	Planned	20	6	3		Re-profiled staff rotas(29-Nov-2021), Trained 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 with Security Manager and Switchboard Manager to confirm current status, If adequate then change the risk profile to tolerate.(04-Mar-2022)	Low	Treat	Reviewed by Associate Di	25-Aug-2021
RSK-272	IF the Passenger Lifts are not maintained THEN there is a risk of failure of components	LEADING to malfunction. Patients or visitors could get stuck in the lift, this could potentially cause panic or delay treatment. The public image of the trust could be affected.	Organisation		Steven Sluter	26-Mar-2024	30-Sep-2024	Planned	15	6	3		Maintenance Contracts are in place(30-Nov-2021), Insurance inspections are place(30-Nov-2021), Lift modernisation inspection has been completed and 5 year plan underway since FY17/18(30-Nov-2021), Eaglestone lift upgraded and some remedial and safety upgrades during FY19-20(30-Nov-2021), W14 upgraded 2020(30-Nov-2021), Luing Cowley Lift awaiting upgrades, difficult as no alternative when lift not in service.(30-Nov-2021), Maintenance contract awarded.(30-Nov-2021), AE (Authorising Engineer) to be identified.(01-Jul-2022), Remedial works are prioritised on a risk basis. Business case foe funding produced, variation to be updated(20-Sep-2023)	Low	Treat	Reviewed by Associate Di	25-Aug-2021

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RSK-273	If the Trust Wards and Departments fail to demonstrate their medical equipment is maintained to correct standards THEN there is a risk of the Trust not complying with CQC Regulation 15 Premises and Equipment and risk to patient care	LEADING TO non-compliance and negative impact on the reputation of the Trust	Organisation		Ayca Ahmed	18-Mar-2024	30-Jun-2024	Planned	15	6	3		Robust PPM maintenance schedule in place, audits of the rolling programme(30-Nov-2021), Audits monitored at Medical Devices Committee(30-Nov-2021), Escalation process in place to respond to 'unfound items'(30-Nov-2021), September 2018 , 6 Years contract approved(30-Nov-2021), Contract KPI's agreed as part of new contract(30-Nov-2021), Annual review of asset base and contract base reset linked to Capital Programme(30-Nov-2021), Loan Medical Equipment Arrangement with Supplier(01-Sep-2023)	Medium	Treat	Reviewed by Medical De\	16-Oct-2018
RSK-299	IF the Summary Record of Estates 5 year and Prioritised Backlog Maintenance risk based priority programme is not fully implemented THEN plant and equipment may fail in various areas of the hospital	LEADING TO infection control, financial implications, loss of services and reputation damage	Organisation		Anthony Marsh	26-Mar-2024	30-Sep-2024	Planned	9	6	4	Ongoing reviews, identified backlog issues driving Capital Plan. Outstanding funding of Capital works required. Operational impact of significant works to be considered. (29-Jan-2024)	All areas are reviewed on a monthly basis by Estates Service Manager, or sooner if equipment/plant breakdown demands(30-Nov-2021), Business cases for plant replacement to be put forward FY21/22(30-Nov-2021), Compliance Officer reviewing to identify significant costs(30-Nov-2021), Annual review of recent 6 Facet Survey to identify future funding requirements e.g. Roof, Ventilation, Plant, HV, drainage(30-Nov-2021), n/a(30-Nov-2021), Annual Physical 20% of site 6 facet survey undertaken, remainder of site updated with desktop exercise(03-Mar-2022), NOT IMPLEMENTED - New Hospital Programme guidance indicates funding to clear CIR backlog programme to be included as part of the project.(01-Jul-2022)	Low	Treat	Reviewed by Associate Di	25-Aug-2021
RSK-217	IF patients are unable to meet their nutritional requirements orally nasogastric tube feeding may be required to meet their nutritional needs; staff may not be confident or competent passing Nasogastric Tubes (NG Tubes) or correctly confirming the position of the Nasogastric tube tip THEN there is a risk that Nasogastric (NG) Feeding Tubes are not inserted and/or positioned correctly	LEADING TO 1) A Never event if feed/medication or water are inserted into the nasogastric tube and it is incorrectly positioned in the lung. This could result in death. 2) Patients would experience a delay in feeding if staff are not competent placing nasogastric tubes and checking the position of the tube tip.	Organisation		Jane Radice	07-Mar-2024	04-Oct-2024	Planned	15	5	5		All NPSA recommendations were acted upon in 2011 in the Trust as per NPSA requirements by the ANP for Nutrition(24-Nov-2021), Nutrition Committee overseeing this alert and is standard item on agenda from Dec 16. Clinical Medical and Nutritional ANP leading on the action plan(24-Nov-2021), Policies, protocols and bedside documentation reviewed to ensure compliance(24-Nov-2021), Ongoing programme of audit. Previous audit data presented to NMB Spring 2016(24-Nov-2021), Dietetic Amalga database identifies patients who require Nasogastric feeding(24-Nov-2021), Trust declared compliance with 2016 Nasogastric Tube Misplacement: Continuing Risk of Death or Severe Harm Patient Safety Alert (NHS/PSA/RE/2016006)(24-Nov-2021), The NG tube used by the trust was changed in 2020 to a tube that is more radiopaque and is therefore easier to interpret on X-ray(24-Nov-2021), pH strips are purchased from one supplier to avoid confusion with colour interpretation(24-Nov-2021), Two nutrition nurses available to place NG tubes if there are no trained clinical staff available(24-Nov-2021), Radiographers trained to interpret x-rays for confirmation of NG tube tip position. This speeds up reporting and avoids junior medical staff having to assess X-rays(24-Nov-2021)	Low	Tolerate	Risk reviewed at Therapie	23-Apr-2014
RSK-006	IF completed NICE guideline baseline assessment evidence is not available to support compliance assurance and NICE guidance is not acted upon (updating Trust documentation, ensuring 'don't do' recommendations are assessed and not done where applicable); THEN the Trust are unaware of the benefits, risks and cost savings with implementing NICE guidance, and there is no supportive evidence for external auditor assurance	LEADING TO potential impact on Patient Safety, Clinical Effectiveness and Patient Experience.	Organisation		Jacqueline Stretton	07-May-2024	31-Aug-2024	Planned	20	4	3		NICE policy(06-Sep-2021), NICE is part of the Clinical Governance standard Agenda(06-Sep-2021), Governance Leads have access to a NICE database which monitors NICE compliance(06-Sep-2021), Linked reports which can be pulled by Division/CSU(06-Sep-2021), Escalation Process to Trust Executive Group(06-Sep-2021), Implementation of Radar Risk Management System with potential for effective management of NICE(06-Sep-2021)	Low	Treat	NICE monitored in Radar.	06-Sep-2021

Reference	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-120	IF medical devices are not correctly cleaned/disinfected/decontaminated/sterilised THEN the devices will not be sufficiently cleaned	LEADING TO possible patient and staff safety issues and cross contamination	Organisation		Marea Lawford	05-Apr-2024	04-Apr-2025	Planned	9	4	4		Trust Decontamination Policy in place and accessible to staff(29-Oct-2021), Low risk medical equipment are cleaned on the wards in line with Decontamination Policy(05-Jan-2023), HSDU and Endoscopy Decontamination Unit are accredited to IS0 13485(04-Jan-2024), Specialist equipment used in wards/departments is identified at point of purchase using the PPQ to determine what methods of decontamination are required.(04-Jan-2024), Equipment unsuitable for reprocessing must have an individual Risk Assessment(04-Jan-2024), Quarterly Decontamination Group(04-Jan-2024)	Low	Tolerate	No change to the risk	05-Jan-2023
RSK-160	IF the existing Bag Valve Masks (BVM) look similar to the Lung Volume Recruitment (LVR) bags that the department want to introduce as a Physiotherapy treatment modality for airway clearance THEN they could be used in error during resuscitation procedures	LEADING TO patient requiring resuscitation with a BVG could have resuscitation attempted with a LVR bag and could suffer consequences of incorrect treatment initially and delay to correct treatment procedures	Organisation		Robert Baddeley	07-Sep-2023	03-Jun-2024	Overdue	15	4	4		•The bag has “not for resuscitation purposes” printed on the bag by the manufacturers and also comes with a yellow “not for resuscitation purposes” tag attached to it. •There are clear differences in the two bags appearances - All staff that work in the ward environments will have completed BLS training at least so will be familiar with the BVM equipment. They will have seen and used the BVM in practice during resus training and therefore would know that it has an oxygen reservoir bag and tubing that connects to an oxygen flow meter which an LVR bag does not have. •BVM is kept in its packaging hung on the resus trolley. When an LVR bag is provided to a patient it would be kept in their bedside locker in the navy blue drawstring bag it comes from the manufacturer in. •The resus trolley is checked daily by ward staff so if the LVR bag mistakenly was put in the resus trolley by nursing staff that would be recognised. •All physio staff that would be issuing this equipment out would have specific training before being able to use with patients. •The patient would be seen daily by Physio who would recognise if the LVR bag was missing from that patients locker. •If an LVR bag was issued to a patient then the nurse involved in that patients care would be informed of the equipment being kept in the patients locker (but not expected to use the equipment with the patient) •Once the LVR is not longer being used with the patient we	Low	Tolerate	No changes to risk score,	17-Jan-2020
RSK-237	IF the Trust is unable to spend the full amount of the Apprenticeship Levy each month THEN money which could have been used to develop our staff will be forfeit	LEADING failure to maximise taxpayers money. The Trust may not be able to use the apprenticeship levy to fund staff education, training and development. Inability to maximise the new apprenticeship standards may impact on recruitment, retention and career development	Organisation		Joanna Klimera	23-Apr-2024	31-May-2024	Overdue	15	4	4	Creation of Apprenticeship Strategy (10-Apr-2024)	Apprenticeship Manager attends the Nursing, Midwifery and Therapies Education Forum to promote apprenticeship benefits(25-Nov-2021), NHS People Plan commitment to support apprenticeships and other key national entry routes(25-Nov-2021), There is a national tender for the radiography apprenticeships underway led by HEE(25-Nov-2021), Apprenticeship strategy approved, maximising Levy use going forwards(25-Nov-2021), Medical apprenticeship consultation ongoing(25-Nov-2021), Review of the Nurse Apprenticeship pathway is underway with newly appointed Head of Practice Education(10-May-2022), New apprenticeships have been created for IT, Data Analyst roles and HR.(10-May-2022), Increase in advertising of apprenticeships across the Trust and through the network through widening participation.(10-May-2022), Increase available apprenticeships(19-Jul-2023)	Low	Treat	Risk reviewed - Additiona	25-Nov-2021
RSK-261	IF adequate PAT testing is not carried out in a systematic and timely manner THEN untested faulty equipment could be used	LEADING TO poor patient and staff safety and increased claims against the Trust	Organisation		Steven Sluter	26-Mar-2024	31-Mar-2025	Planned	8	4	4		Visual checks carried out by user(29-Nov-2021), 100% PAT testing of all available devices at time of testing annually by contractor(29-Nov-2021)	Low	Tolerate	Reviewed by Associate Di	29-Nov-2021
RSK-288	IF the medical oxygen supply fails to function or becomes non-compliant with HTM requirements THEN the oxygen plant may not be available	LEADING TO potential loss of service, reduced patient safety and substandard care	Organisation		Mike Stark	26-Mar-2024	31-Mar-2025	Planned	12	4	4		PPM Schedule, and reactive repairs as required(30-Nov-2021), Robust contingency plan is in place with liquid O2(30-Nov-2021), Steve Goddard has been appointed as Authorised Engineer(30-Nov-2021), Estates Officer has been appointed as AP(30-Nov-2021), SHJ appointed as maintenance contractor(30-Nov-2021), AP training booked for and additional estates officer and estates service manager(30-Nov-2021), VIE capacity upgrade 2021(30-Nov-2021), Draft feasibility to achieve second VIE, and conversion of site to ring main, linked to HIP programme(30-Nov-2021)	Low	Tolerate	Reviewed by Associate Di	25-Aug-2021

Reference	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-294	IF staff do not carry out either informal (i.e. experience-based) or formal risk assessments before attempting a work task THEN there is a risk of personal injury to staff carrying out routine work	LEADING TO poor staff safety, injury and financial loss	Organisation		Mike Stark	26-Mar-2024	31-Mar-2025	Planned	12	4	4		All staff receive formal risk assessment training, and are competency assessed for their roles. Independent External Advisor contractor commissioned to review estates risk assessments and arrangements regularly.(30-Nov-2021), Risk awareness training is performed annually along with asbestos awareness training for all workshop staff as part of the H&S training package(30-Nov-2021), Training plan updated and implemented(30-Nov-2021), Risk Assessments by task type pop up on MICAD PPM tasks for workshop staff.(30-Nov-2021), Weekly huddle meeting with maintenance staff to include H&S(30-Nov-2021)	Low	Tolerate	Reviewed by Associate Di	30-Nov-2021
RSK-295	IF there is a lack of knowledge on use or poor condition of ladder THEN there is a risk of fall from height from ladders	LEADING TO risk of harm to staff, poor public image, a potential investigation by HSE	Organisation		Paul Sherratt	26-Mar-2024	31-Mar-2025	Planned	12	4	4	A competent training person needs to be identified to provide continual training (26-Mar-2024)	Staff issued with safe use of ladder guidance(30-Nov-2021), Ladder inspections PPM schedule in place to check(30-Nov-2021), New replacement ladders have been installed, tagged and registered(30-Nov-2021), RP Appointed(30-Nov-2021)	Low	Tolerate	Reviewed by Associate Di	30-Nov-2021
RSK-402	IF there is a lack of Orthopaedic Therapy staff to provide rehabilitation, discharge planning and equipment to patients in the trauma and elective orthopaedic pathways. THEN fractured NOF patients may not be able to be offered daily mobilisation; may not have a functional OT assessment within 7 days; elective Orthopaedic patients may not be seen twice a day	LEADING TO potential for length of stay for both trauma and elective patients to increase and reduce patient experience.	Organisation		Vijayalakshmi Babu	10-May-2024	30-Jun-2024	Planned	15	3	3	Pathway review (15-May-2024)	Recruitment of vacant posts(01-Dec-2022), Recruitment(01-Dec-2022)	Low	Treat	1 OT post remains vacant	01-Dec-2022
RSK-008	IF the Trust does not have an appropriate system to record mortality and morbidity data; THEN the Trust will not be able to record and/or provide accurate reports for governance or the Trust Board	LEADING TO non-compliance with the National Mortality & Morbidity 'Learning from Death' Framework	Organisation		Nikolaos Makris	09-Apr-2024	01-Jul-2024	Planned	15	2	2		Governance Team putting forward deaths for Structured Judgement Reviews (SJRs) based on previously agreed clinical criteria e.g. sepsis related(06-Sep-2021), Learning from Deaths policy as a tool to indicate required processes and cases that require review(06-Sep-2021), Implementation of the new system - CORs(06-Sep-2021), M&M review meetings on a regular basis with all required SJRs completed(01-Apr-2022)	Medium	Tolerate	CORS system now functic	06-Sep-2021

Meeting Title	**Audit Committee**	**Date: 21st June 2024**
Report Title	**Board Assurance Framework**	**Agenda Item Number: 16**
Lead Director	Kate Jarman, Chief of Corporate Services	
Report Author	Paul Ewers, Senior Risk Manager	

Introduction	Assurance Report		
Key Messages to Note	• There are two new risks proposed for the board to approve onto the BAF for 2024/25 (page 2). • SR2 (page 9). Decision for FIC to monitor risk cautiously. There is potential for the risk to increase to 5x5=25 risk over the next quarter. To remain at 20 currently.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Review** [x]

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*

Report History	Regular Committee cycle
Next Steps	N/A
Appendices/Attachments	Board Assurance Framework

Monthly Report to Board

This report includes the new Board Assurance Framework risks that were identified by the Board and Executive Directors to take through the Committee cycle for discussion and challenge.

Current BAF Risks: There are currently eight risks against the achievement of the Trust's strategic objectives in 2024:

1. Continued industrial action resulting in significant disruption to service/ care provision
2. Insufficient capital funding to meet the needs of the population we serve
3. Future NHS funding regime is not sufficient to cover the costs of the Trust
4. Patients experience poor care or avoidable harm due to delays in planned care
5. Patients experience poor care or avoidable harm due to inability to manage emergency demand
6. System inability to provide adequate social care and mental health capacity
7. Political instability and change
8. Head & Neck cancer pathway

Proposed New Risks: In addition to the above risks, it is proposed that the following risks are added to the BAF:

1. Deteriorating quality of the estate
2. Data/Cyber Security

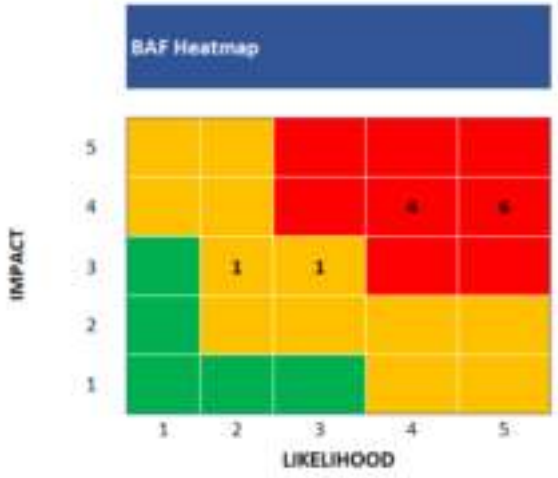
Longer-term Risks: Seven longer-term risks have been identified.

1. Conflicting priorities between the ICS and providers
2. Lack of availability of skilled staff
3. Increasing turnover
4. Lack of time to plan and implement long-term transformational change
5. Long-term financial arrangements for the NHS
6. Growing/ageing population
7. A pandemic

Risk Landscape: Bedfordshire, Luton and Milton Keynes Integrated Care Board

Below is the System Board Assurance Framework Dashboard. The system wide BAF currently incorporates 12 strategic system risks. There have been no changes since the previous meeting.

Risk Ref	Risk Title	Current Risk Rating	Trend
BAF0001	Recovery of Elective Services Risk	20	→
BAF0002	Developing suitable workforce	20	→
BAF0003	System Pressure & Resilience	20	→
BAF0004	Widening Inequalities	16	→
BAF0005	System Transformation	20	→
BAF0006	Financial Sustainability & Underlying Financial Health	20	→
BAF0007	Climate Change	16	→
BAF0008	Population Growth	20	→
BAF0009	Rising Cost of Living	16	→
BAF0010	Partnership Working	9	→
BAF0011	Health literacy - Denny Review	16	→
BAF0012	System Collaboration	6	→



Risk Movement Over Time (23/24)

- BAF Dashboard (28th March 2024)

During 2024/24 there will be deep dives and risk assessments scheduled. The Risk Assessments will be conducted in partnership with System Risk Leads and the deep dives will be in the appropriate forum with system partners.

Potential further deep dives include:

- Backlog of maintenance issues
- Long waits for elective care
- Cyber Security
- Digital Transformation
- VCSE sector financial sustainability
- Specialised Commissioning

BAF0003 - Urgent and Emergency Care
A deep dive was conducted during April 2024. The BAF risk will be updated to reflect the changes identified following the deep dive.

BAF0005 – System Transformation
This will be updated in light of final Operational Plan 24/25

BAF007 – Climate Change
Progress with adaptation plan to be reviewed by Audit & Risk Assurance Committee in October 2024.

Risk Profile (2024)

	1 Insignificant	2 Minor	3 Significant	4 Major	5 Severe
1 Rare					
2 Unlikely			SR7 Political instability and change		
3 Moderate			SR1 Continued industrial action resulting in significant disruption to care/ service provision		SR8 Head & Neck cancer pathway
4 Likely					SR2 Insufficient capital funding to meet the needs of population we serve. SR4 Patients experience poor care or avoidable harm due to delays in planned care. SR5 Patient experience poor care or avoidable harm due to inability to manage emergency demand. SR6 System inability to provide adequate social care and mental health capacity
5 Almost Certain				SR3 Future NHS funding regime is not sufficient to cover the costs of the Trust.	

The Board Assurance Framework: Explanatory Notes

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

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

Strategic Objectives

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

Risk treatment strategy: Terminate, treat, tolerate, transfer

Risk appetite: Avoid, minimal, cautious, open, seek, mature

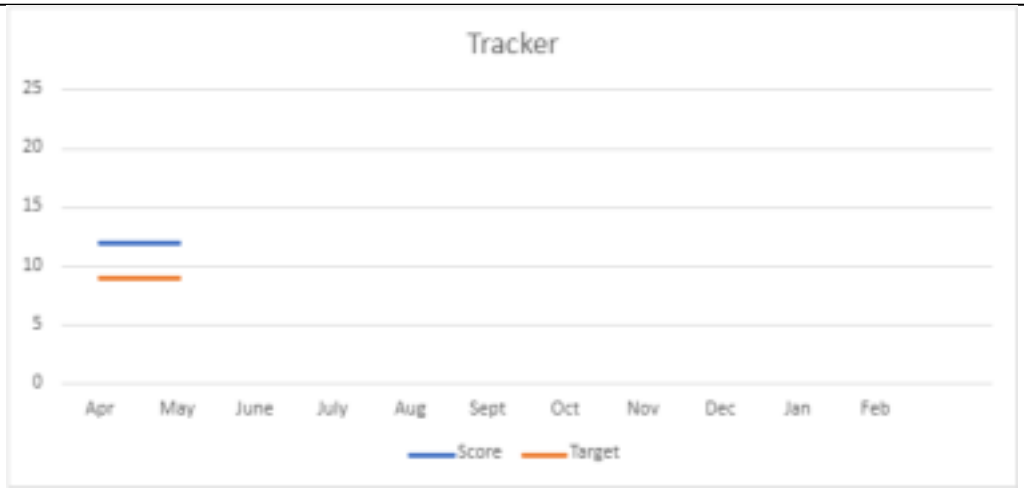
Assurance ratings:

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

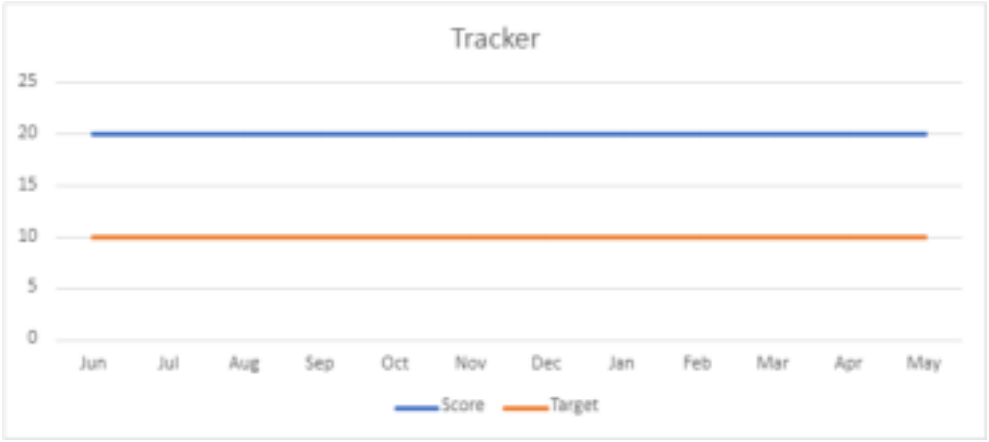
5X5 Risk Matrix:

			Likelihood				
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost certain
Consequence	1	Insignificant	1	2	3	4	5
	2	Minor	2	4	6	8	10
	3	Moderate	3	6	9	12	15
	4	Major	4	8	12	16	20
	5	Catastrophic	5	10	15	20	25

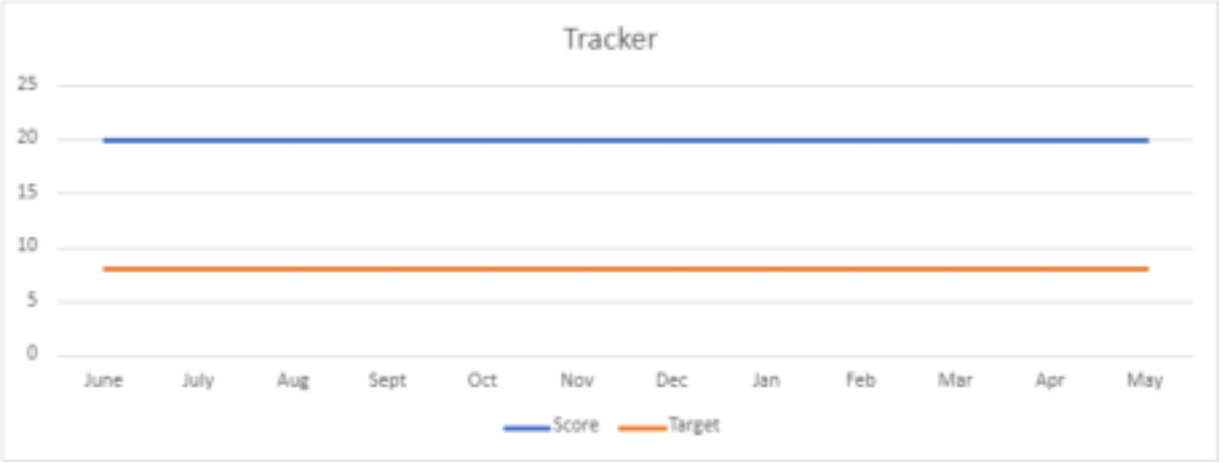
BAF 2024/25

Strategic Risk 1	**Continued industrial action resulting in significant disruption to care/ service provision**						
Lead Committee	Workforce & Development Assurance Committee	**Risk Rating**	**Inherent**	**Current**	**Target**	**Risk Type**	Patient Harm
Executive Lead	Chief People Officer	**Consequence**	4	3	2	**Risk Appetite**	Avoid
Date of Assessment	April 2024	**Likelihood**	3	3	1	**Risk Treatment Strategy**	Tolerate
Date of Review	April 2024	**Risk Rating**	12	9	3	**Assurance Rating**	Positive Assurance
Linked Trust Objectives	1. Keeping you safe in our hospital 2. Improving your experience of care 3. Ensuring you get the most effective treatment 4. Giving you access to timely care 8. Employing the best people to care for you						
Linked Corporate Risks	None identified						
Trend							

Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
• Trade unions call for industrial action resulting in some staff not being available to work as planned	• Planned care levels amended to minimise patient presence on site (e.g. clinic cancellations) • Non-striking staff are asked additional shifts – at agreed rates of pay. • Divisional "self-rostering" to ensure adequate essential staffing. • Divisional risk assessment per period of industrial action – risks identified mitigated/ managed in advance. • Derogations agreed as necessary. • Plan as per tried and tested internal industrial action process should another strike be announced	None Identified	None required	**First Line:** • Divisional teams and planning processes **Second Line:** • COO led operational oversight. • Head of HRBP led staffing oversight. **Third Line:** • Reporting to ICS/Region	None Identified	None required

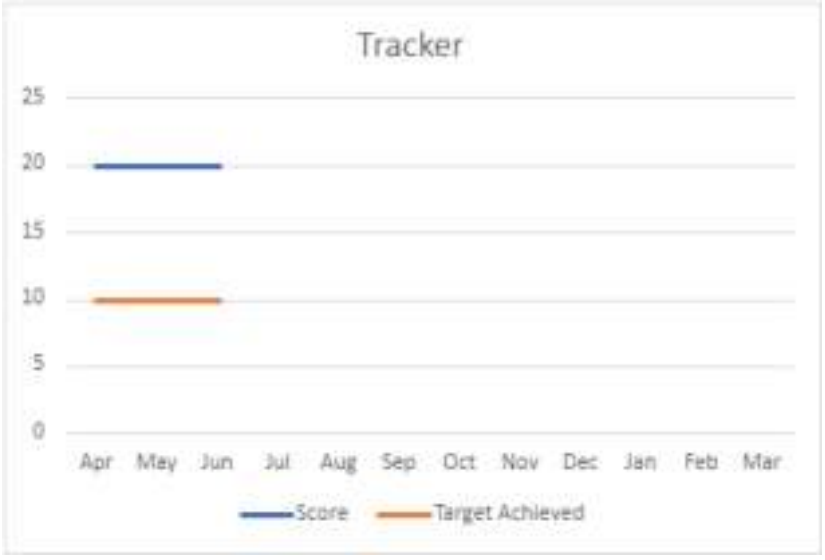
Strategic Risk 2	**Insufficient capital funding to meet the needs of population we serve**						
Lead Committee	Finance & Investment Committee	**Risk Rating**	**Inherent**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	Chief Financial Officer	**Consequence**	5	5	5	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	5	4	2	**Risk Treatment Strategy**	Treat
Date of Review	May 2024	**Risk Rating**	25	20	10	**Assurance Rating**	Negative Assurance
Linked Trust Objectives	1. Keeping you safe in our hospital 2. Improving your experience of care 3. Ensuring you get the most effective treatment 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						
Linked Corporate Risks	RSK-305 RSK-526						
Trend							

Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
• The current NHS capital regime does not provide adequate certainty over the availability of strategic capital finance. • The capital budget available for 2024/25 is not sufficient to cover the planned depreciation requirement for operational capital investment. Consequently, it is difficult to progress investment plans in line with the needs of the local population without breaching the available capital budget.	• Established management processes to prioritise investment of available capital resources to manage emerging risk and safety across the hospital. • Established processes to ensure responsive pursuit of additional central NHSE capital programme funding as/when additional funding is available. • Established processes to ensure agile in response to late notified capital slippage from across the ICS and wider region to take advantage of additional capital budget.	• The Trust does not directly control the allocation of operational or strategic NHS capital finance and has informal influence only over local ICS capital. • The ICS has limited control on the allocation of operational capital from NHS England. • The Trust's plan is £6m in excess of its approved allocation which is a source of concern for the Trust, ICB and Region.	• *Continued dialogue with Regional and National Capital teams at NHS England by CFO from MKUH and BLMK ICB during 2024/25*	**First Line:** • Internal management capital oversight provided by capital scheme leads. • Regular meeting with BLMK and Regional Finance teams to alert them to the Trust's desire to this this additional £6m authorised. **Second Line:** • Monthly Performance Board reporting • Trust Executive Committee reporting • Finance and Investment Committee reporting. **Third Line:** • Internal Audit Reporting on the annual audit work programme. • External Audit opinion on the Annual Report and Accounts	• Limited oversight of ICS capital slippage until notified by partner organisation. • BLMK and regional team unable to provide authorisation of the £6m spend in excess of allocation at this stage.	• Continued dialogue at an ICB CFI level reading in year slippage from partner organisations

Strategic Risk 3	**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.**						
Lead Committee	Finance & Investment Committee	**Risk Rating**	**Inherent**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	Chief Financial Officer	**Consequence**	4	4	4	**Risk Appetite**	Cautious
Date of Assessment	March 2023	**Likelihood**	5	5	2	**Risk Treatment Strategy**	Treat
Date of Review	May 2024	**Risk Rating**	20	20	8	**Assurance Rating**	Negative Assurance
Linked Trust Objectives	1. Keeping you safe in our hospital 2. Improving your experience of care 3. Ensuring you get the most effective treatment 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						
Linked Corporate Risks							
Trend							

Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
• Increase in operational expenditure initially in response to COVID-19 (sickness/enhanced cleaning etc.) • Additional premium costs incurred to treat accumulated patient backlogs. • Prolonged premium pay costs incurred in a challenging workforce environment, including impact of continued industrial action. • Increased efficiency required from NHS funding regime to support DHSC budget affordability and delivery of breakeven financial performance. • Risk of unaffordable inflationary price increases on costs incurred for service delivery.	• Internal budgetary review/financial performance oversight processes to manage/mitigate cost pressures. • Financial efficiency programme identifies headroom for improvement in cost base. • Close monitoring/ challenge of inflationary price rises. • Continuing medium term financial modelling with ICS partners. • Escalation of key risks to NHSE regional team for support. • National NHS/E	• Ability to influence (negotiate) and mitigate inflationary price rises is modest at local level. • Effective local pay control diminished in a competitive market. • No direct influence national finance payment policy for 2024/25 • Limited ability to mitigate cost of non-elective escalation capacity. • Ability to increase block contract value in line with demand	• Delivery of CIP programme of £18.4m in 2024-25 • Maximisation of ERF income • Pro-active procurement to minimise inflationary pressures • Workforce planning in areas of where market forces are a significant inflationary factor • Discussion with commissioners regrading block contract value and demand pressures thereon	**First Line:** • Financial performance oversight at budget holder and divisional level management meetings • Resource Control Process for management oversight/approval • Controls for discretionary spending (e.g., WLIs) • Financial efficiency programme 'Better Value' to oversee delivery of savings schemes. • BLMK ICS monthly financial performance reporting (year to date and forecast) **Second Line:** • Monthly Performance Board reporting	• Systematic monitoring of inflationary price changes in non-pay expenditure. • Limited ability to directly mitigate demand for unplanned services. • If there is a financial gap for 2024-25 at the end of the planning process this will need further action and escalation to be determined.	• MKUH working with NHSE to finalise the 2024-25 financial which is currently reported as a deficit of £12.1m. • The cash implications and need for cash support are also being progressed with NHSE so that any cash drawdowns are planned in advance. • Service reviews are planned as part of CIP planning as well as demand management and access to diagnostics both internally and by GP's.

• Affordability of 2024/25 planning objectives (e.g., backlog recovery) in the context of the evolving financial regime for 2024/25	re-forecasting process in relation to additional system funding in November 2023 • Management oversight of escalation capacity and controlled decision-making on additional capacity. • Optimisation of elective recovery funding through optimising elective resources (bed capacity, Theatres, Outpatients clinical areas and elective clinical staff) • Continued dialogue with BLMK ICS on sufficiency of the block element of the service contract			• Trust Executive Committee reporting • Finance & Investment Committee reporting. • Trust, BLMK system and regional planning reviews until planning is concluded for 2024-25. **Third Line:** • Review of drivers of deficit by external consultancy		

Strategic Risk 4	**Patients experience poor care or avoidable harm due to delays in planned care**						
Lead Committee	Quality Clinical Risk Committee	**Risk Rating**	**Inherent**	**Current**	**Target**	**Risk Type**	Safety
Executive Lead	Chief Operating Officer – Planned Care	**Consequence**	5	5	5	**Risk Appetite**	Avoid
Date of Assessment	May 2024	**Likelihood**	5	4	2	**Risk Treatment Strategy**	Treat
Date of Review	June 2024	**Risk Rating**	25	20	10	**Assurance Rating**	Inconclusive Assurance
Linked Trust Objectives	1. Keeping you safe in our hospital 2. Improving your experience of care 3. Ensuring you get the most effective treatment						
Linked Corporate Risks							
Trend							

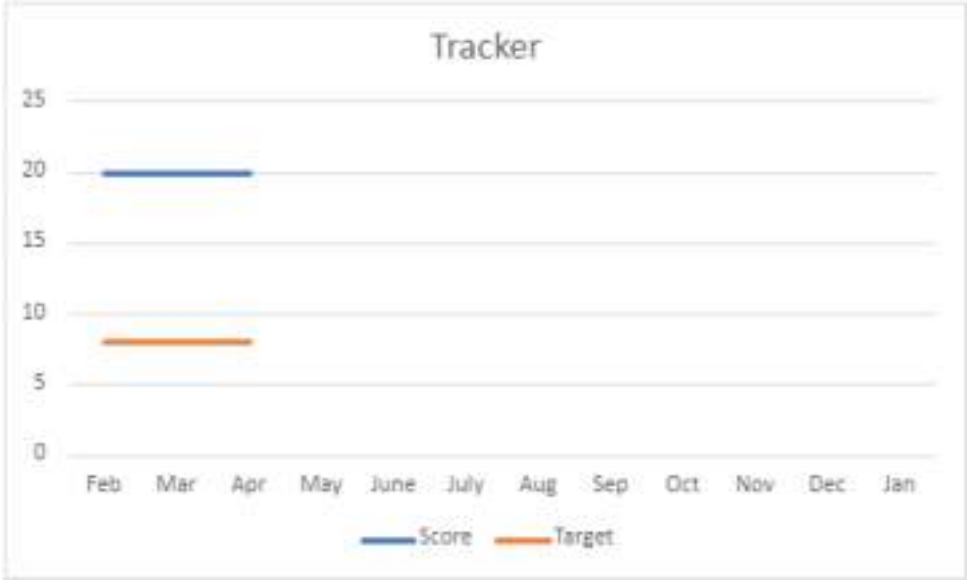
Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
• Patients delayed in elective backlogs (including cancer)	• Routine and diligent validation and clinical prioritisation of patient records on waiting lists. • Daily/Weekly management of PTL (Patient Tracking List) up to Executive level. • Restore and recovery weekly cancer meetings. • Clinical reviews and full harm review of long waiting patients, including root cause analysis (RCA).	• Capacity and available resource to meet the demand post pandemic and strike action. • Commissioning challenges to meet the required local demand of patient needs. • Capacity limitations to meet demand. • Further strike action impacting planned care capacity.	• Additional executive capacity to provide greater scrutiny and oversight. • Detailed capacity and demand analysis at specialty level • Development of specialty level action plans based on capacity and demand outputs. • Short term provision of additional resources to clear backlogs • Additional investment and capacity being sourced through alternative options outside the Trust, support by the Cancer Alliance.	**First Line:** • Internal escalation meetings with performance monitoring of key indicators. • Designated OPEL status agreed across the MK system daily. **Second Line:** • Specialty validation and weekly PTL meetings. • ICB & regional scrutiny via performance meetings. **Third Line:** • National performance profile monitoring. • External intervention from national		
• Inability to treat elective (planned) patients due to emergency demand.	• Daily bed management of the hospital site to ensure both elective and emergency pathways are maintained in	• Capacity limitations to meet demand in other providers (health and social care). • IPC outbreaks such as flu/	• Maximise potential of discharges with partner agency and escalate where issues. • Due diligence in IPC procedures and			

	equilibrium with Executive oversight. • Effective daily discharge processes to keep elective capacity protected and avoid cancellations – Board rounds. • Additional WLI initiatives where there is resource and capacity to maintain reduction of the pandemic induced backlog. • Daily review and MK system call of all Non-Criteria to Reside patients.	norovirus • Staffing vacancies in different professions required to meet specific needs. • Unplanned short term sickness absence. • Increased volume of ambulance conveyances and handover delays. • Capacity limitations to meet demand in other providers (health and social care).	uptake of national vaccination programmes. • Ongoing recruitment drive and review of staffing models and skill mix. • International recruitment • Bank and agency staffing deployed. • Increase availability of HALO. • Spot purchase additional capacity within MK. • Send patients out of area ICB support processes.	teams via the tiering process.		
• Inability to discharge elective patients to onward care settings.						

Strategic Risk 5	**Patients experience poor care or avoidable harm due to inability to manage emergency demand.**						
Lead Committee	Quality Clinical Risk Committee	**Risk Rating**	**Inherent**	**Current**	**Target**	**Risk Type**	Safety
Executive Lead	Chief Operating Officer – Planned Care	**Consequence**	5	5	5	**Risk Appetite**	Avoid
Date of Assessment	June 2024	**Likelihood**	5	4	2	**Risk Treatment Strategy**	Treat
Date of Review	June 2024	**Risk Rating**	25	20	10	**Assurance Rating**	Inconclusive Assurance
Linked Trust Objectives	1. Keeping you safe in our hospital 2. Improving your experience of care 3. Ensuring you get the most effective treatment						
Linked Corporate Risks							
Trend							

Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
• Inadvertently high demand of emergency presentations on successive days • Overwhelm or service failure (for any reason)	• Development and use of SHREWD system to track and monitor activity levels across the health system. • Adherence to national OPEL escalation management system • Adherence to Trust capacity policies • Integrated system planning for Winter. • Continued development of admission avoidance pathways, SDEC and ambulatory care service provision	• Full scope of SHREWD to be implemented. • Higher than expected staff sickness or absences. • Staffing vacancies in different professions to meet specific needs. • Increased volume of ambulance conveyances • Overcrowding in ED waiting areas at peak times • Lack of exit flow from ED • Unexpected reduction in bed capacity / configuration	• MKUH SHREWD project to be completed. EL – Dec 2024 • Risk assessed redeployment of staff to where there is greatest need. EL – ongoing. • Review alternative pathway options into community and admission avoidance. EL – March 2025 • Completion of Integrated Discharge Hub project. EL - December 2024 • Transformation project to reduce LOS. EL - March 2025	**First Line:** • Internal escalation including: daily huddle / silver command & site meetings in hours. • Designated OPEL status agreed across MK system. • Out of hours on call management structure. • Major incident plan. **Second Line:** • System escalation calls with partners. • MADE's: Multi-agency Discharge Events. • MK Place transformation & redesign projects. • ICB challenge. **Third Line:** • Audit accreditation & national benchmarking. • Regional and		

				National intervention on poor performance (National Tiering).		

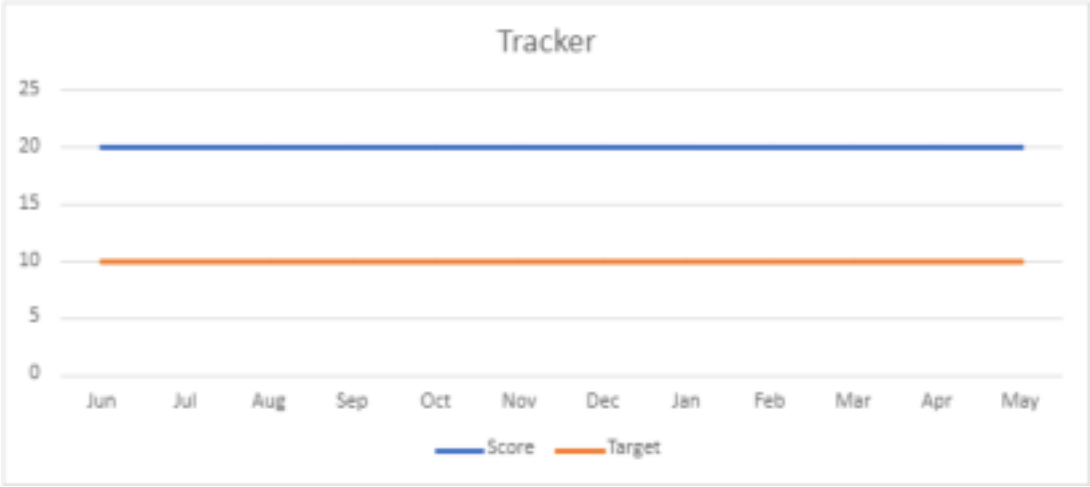
Strategic Risk 6	**System inability to provide adequate social care and mental health capacity.**						
Lead Committee	Quality Clinical Risk Committee	**Risk Rating**	**Inherent**	**Current**	**Target**	**Risk Type**	Safety
Executive Lead	Chief Operating Officer – Planned Care	**Consequence**	5	5	4	**Risk Appetite**	Avoid
Date of Assessment	June 2024	**Likelihood**	4	4	2	**Risk Treatment Strategy**	Treat
Date of Review	June 2024	**Risk Rating**	20	20	8	**Assurance Rating**	Inconclusive Assurance
Linked Trust Objectives	4. Keeping you safe in our hospital 5. Improving your experience of care 6. Ensuring you get the most effective treatment						
Linked Corporate Risks							
Trend							

Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
• Lack of inpatient mental health provision (including in specialist settings) leading to patients in mental health crisis with no physical health need remaining in the ED or inpatient beds	• Lower risk rooms in ED and on some inpatient areas • Close working with CNWL around provision of appropriately qualified staff • Ensuring a sound legal basis under the provisions of the Mental Health Act	• Inappropriate care setting for patient need – although some risk can be mitigated the Trust is not a mental health hospital and the environment is therefore higher risk and less suitable for patient need. • Trust treated as a 'safe place' which exacerbates delays in finding an appropriate bed in a specialist setting.	• Formal system escalation process and SOP to manage the safety of patients inappropriately left in the Trust's care (awaiting a specialist bed/ placement) which all partners adhere to. EL - TBC	**First Line:** • Operational information (data) on numbers of patients inappropriately in the ED/ wards and time to appropriate care setting **Second Line:** • Oversight of management activity • Third Line: • Independent/ Objective assurance (e.g. Internal Audit) **Third Line:**	• Lack of system action and assurance	• System-wide mental health care meeting to be convened by September 2024 to agree escalation model and SOP. EL - TBC
• Lack of social care capacity for patients with complex needs (adult and child) including patients under Deprivation of Liberty Safeguards or other court orders who require specialist care settings or	• Safeguarding expertise in the Trust, with well established relationships with social care	• Inappropriate care setting for patient need – although some risk can be mitigated the Trust is not a mental health hospital and the environment is therefore higher risk and less suitable for patient need. • Trust treated as a 'safe place' which exacerbates delays in finding	• Formal system escalation process and SOP to manage the safety of patients inappropriately left in the Trust's care (awaiting a specialist social care bed/ placement) which all partners adhere to. EL - TBC			• System-wide social care meeting to be convened by September 2024 to agree escalation model and SOP. EL - TBC

placements		an appropriate bed in a specialist setting.				

Strategic Risk 7	**Political instability and change**						
Lead Committee	Trust Board	**Risk Rating**	**Inherent**	**Current**	**Target**	**Risk Type**	Macro environment
Executive Lead	CEO	**Consequence**	3	3	3	**Risk Appetite**	Cautious
Date of Assessment	June 2024	**Likelihood**	5	2	2	**Risk Treatment Strategy**	Tolerate
Date of Review	June 2024	**Risk Rating**	15	6	6	**Assurance Rating**	Positive Assurance
Linked Trust Objectives							
Linked Corporate Risks	• None identified						
Trend							

Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
• Change in government with change in national NHS regulatory or management (performance, quality, finance, governance) regime	• Close working with system partners, regional and national teams to understand. • Maintain strategic agility at Board. • Ensure robust, early communication with Board members as issues/ change arise. • Maintain flexibility in Board agendas/ time. • Maintain close working relationships with system partners – including on risk share.	• Inability to predict change and impact	• No current action identified (out of control of Trust)	**First Line:** • Board agendas. **Second Line:** • NHS regional and national management oversight. **Third Line:** • External audit	• No current gaps identified	• No current action identified

Strategic Risk 8	**If the pathway for patients requiring head and neck cancer services is not improved, then users of MKUH services will continue to face disjointed care, leading to unacceptably long delays for treatment and the risk of poor clinical outcomes**						
Lead Committee	Quality & Clinical Risk Committee	**Risk Rating**	**Inherent**	**Current**	**Target**	**Risk Type**	Patient Harm
Executive Lead	Chief Medical Officer	**Consequence**	5	5	5	**Risk Appetite**	Avoid
Date of Assessment	December 2022	**Likelihood**	5	3	2	**Risk Treatment Strategy**	Treat
Date of Review	May 2024	**Risk Rating**	25	15	10	**Assurance Rating**	Inconclusive Assurance
Linked Trust Objectives	1. Keeping you safe in our hospital 2. Improving your experience of care 3. Ensuring you get the most effective treatment 4. Giving you access to timely care						
Linked Risks	RSK-080						
Trend							

Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
• Milton Keynes University Hospital NHS FT does not provide head and neck cancer services but acts as a spoke unit to the hub at Northampton. Northampton faces: • Increased demand related to the pandemic. • Staffing challenges in the service. • Reduced capacity as a consequence of having reduced the scope of work permissible at MKUH as the spoke site.	• Milton Keynes University Hospital NHS FT (MKUH) clinicians have escalated concerns (both generic and patient specific) to the management team at Northampton. MKUH clinicians are advocating 'mutual aid from other. • Cancer Centres (Oxford, Luton) where appropriate. The issue has been raised formally at Executive level, and with East of England specialist cancer Commissioners. • Safety-netting for patients in current pathway • CEO to regional director escalation • Report into cluster of serious incidents produced by	• No reliable medium to long term solution is yet in place (no definitive position has yet been made by Commissioners) • Ongoing delays in response from Oxford University Hospitals NHS FT to NHSE on the potential way forward and the suboptimal process in terms of collaboration / engagement with Milton Keynes University Hospital NHS FT on the proposed service model. Continued concerns with delays in patient pathways and a failure to fully implement the recommendations of the serious incident review investigation commissioned by NHS Midlands (reported November 2022).	• Ongoing safety netting for patients in current pathway. • Regular operational meetings (with OUH) to articulate the service model going forward to the satisfaction of commissioners and others.	**First Line:** • Active monitoring and review of clinical incidents **Second Line:** • Regional quality team or independent review of pathway **Third Line:** • To be confirmed	• Lack of visibility of outputs of NHS Midlands quality work in relation to the wider pathway.	• CMO to follow up with East of England Specialised Commissioners in light of meeting on 10/05/2024

	Northampton and shared with Commissioners. • Joint commitment confirmed at Milton Keynes University Hospital NHS FT /Oxford University Hospitals NHS FT exec-to-exec team meeting on 02 October 2023 • Commissioners visit to MKUH scheduled May 2024 in order to validate findings of East of England review of Northampton pathway. • Regional Commissioners and Quality Assurance Teams reviewed the pathway and joined the MDT (10/05/2024)					

TRUST BOARD IN PUBLIC

Virtual/Teams

Thursday, 04 July 2024

Board Committees Assurance Reports

- Quality & Clinical Risk Committee

Dev Ahuja

Assurance/Information

TRUST BOARD IN PUBLIC

Virtual/Teams

Thursday, 04 July 2024

Board Committees Assurance Reports

- Workforce & Development Assurance Committee

Heidi Travis

Assurance/Information

TRUST BOARD IN PUBLIC

Virtual/Teams

Thursday, 04 July 2024

Board Committees Assurance Reports

- Finance & Investment Committee

Gary Marven

Assurance/Information

Meeting Title	**TRUST BOARD (PUBLIC)**	**Date: 4 July 2024**
Report Title	Use of Corporate Seal	**Agenda Item Number: 18**
Lead Director	Kate Jarman, Director of Corporate Services	
Report Author	'Kemi Olayiwola, Trust secretary	

Introduction	To update the Trust Board on the use of the Corporate Seal in accordance with the Trust's Constitution		
Key Messages to Note	Trust Board to NOTE.		
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)*	1. *Spending money well on the care you receive* 2. *Expanding and improving your environment* 3. *Innovating and investing in the future of your hospital*

Report History	
Next Steps	
Appendices/Attachments	Schedule of Use of Corporate Seal

	Acronyms	

TheMKWay

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

SCHEDULE OF USE OF CORPORATE SEAL 2024/25

	Description	Parties	Purpose	Value	Date	Signatories
1.	Deed of Surrender for the Land at MKUH with MPML	Milton Keynes University Hospital NHS Foundation Trust and MPML	Deed of Surrender for the land at MKUH	**N/A**	4/3/24	Joe Harrison – Chief Exec Jonathan Dunk - CFO
2.	Revised Pathway Unit Grant Agreement requiring	Milton Keynes City Council and Milton Keynes University Hospital NHS Foundation Trust	Erection of new 2 storey building, in accordance with the attached Design and Access Statement, and in accordance with planning permission reference 20/01433/FUL to accommodate same day emergency care and short stay unit for adults at	Five Million Pounds (£5,000,000.00) to be paid to the Recipient in accordance with this Agreement.	13/5/24	Jonathan Dunk – CFO
3.	Wayleave Agreement	MKUH/City Fibre Metro Networks	Wayyleave Agreement for City Fibre Metro Networks to access Lloyds Court to bring Data Cables to the Premises	N/A	16/5/2024	Joe Harrison – Chief Exec John Blakesley – Deputy Chief Exec
4.	Wayleave Agreement	MKUH/BT Plc	Wayyleave Agreement for BT PLC to access Lloyds Court to bring Data Cables to the Premises	N/A	16/5/2024	Joe Harrison – Chief Exec John Blakesley – Deputy Chief Exec

Meeting Title	**Board of Directors**	**Date: 4th July 2024**
Report Title	**Modern Slavery and Human Trafficking Statement 2024**	**Agenda Item: 19**
Lead Director	**Name: Kate Jarman**	**Title: Chief Corporate Services Officer**
Report Author	**Name: Kate Jarman**	**Title: Chief Corporate Services Officer**

Key Highlights/ Summary	In accordance with section 54(1) of the Modern Slavery Act 2015, Milton Keynes University Hospital NHS Foundation Trust should publish a Modern Slavery and Human Trafficking Statement on the steps it has taken in the previous year to ensure that modern slavery (i.e. slavery and human trafficking), is not taking place in any part of its own business or any of its supply chains. This statement must be approved by the Board and made publicly available.			
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** [x]	**For Noting** ☐	**For Review** ☐

Strategic Objectives Links	*Objectives 1, 3, 7, 8*
Board Assurance Framework (BAF)/ Risk Register Links	

Report History	*N/A*
Next Steps	*Publication*
Appendices/Attachments	*Paper follows*

Modern Slavery and Human Trafficking Statement 2024/25

Introduction

Milton Keynes University Hospital (MKUH) NHS Foundation Trust is committed to preventing acts of modern slavery or human trafficking from occurring in any part of its business operations and supply chain.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 (the "Act") and constitutes MKUH NHS Foundation Trust's modern slavery and human trafficking statement for the financial year commencing 1 April 2024 and ending 31 March 2025. It aims to demonstrate that the Trust follows best practice and that all reasonable steps are taken to prevent slavery and human trafficking.

This statement has been approved by the Trust's Board of Directors, which together with the Audit Committee, will review and update it as necessary on an annual basis.

Structure and business of the organisation (summary)

Milton Keynes Hospital NHS Foundation Trust was founded on 1 October 2007 under the National Health Service Act 2006. The hospital has around 559 beds, including day acute and neonatal beds and employs around 4,152 staff, providing a full range of acute hospital services and an increasing number of specialist services to the growing population of Milton Keynes and surrounding areas. All in-patient services and most outpatient services are provided on the main hospital site. The Trust is organised into four clinical divisions (medicine, surgery, women and children and core clinical) and a number of corporate directorates. The executive directors, and clinical service unit (CSU) leadership teams, are responsible for the day-to-day management and running of the hospital's services, with ultimate management accountability resting with the Chief Executive.

Policies and procedures relating to modern slavery

All members of staff have a corporate responsibility for the prevention of slavery and human trafficking and human rights abuses.

The Trust has policies and procedures in place designed to provide guidance and advice to staff in assessing and managing risks in relation to modern slavery and human trafficking.

These policies additionally give a platform for staff to raise concerns about poor working practices.

Key policies and procedures include:

1. **Safeguarding**

   The Trust's commitment to contribute to the eradication of modern slavery is reflected in the Safeguarding Adults and Safeguarding Children policies, which have been developed in accordance with safeguarding legislation

(including the Care Act 2014 and The Children Act 1989) and national guidance. All staff can contact the Safeguarding Team for support and advice if they have a concern and the Trust's safeguarding intranet pages include information, guidance and the Modern Slavery Helpline.

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain the Trust provides mandatory safeguarding training for all staff and includes information on modern-day slavery and human trafficking in order to promote the knowledge and understanding of escalating concerns internally and externally via the Home Office national referral mechanism.

2. Freedom to speak up

The Trust promotes a culture of openness and accountability by encouraging reporting of concerns, including any circumstances that may give rise to risk of slavery or human trafficking.

The Trust's Freedom to Speak Up Policy offers guidance to staff on raising concerns confidentially and provides reassurance as to how the Trust will respond to them. Freedom to Speak up Guardians and Champions are available to provide immediate support and signposting for staff members raising concerns.

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain the Trust has systems to encourage the reporting of concerns and the protection of whistleblowers; provides all new staff with information on the Freedom to Speak Up Policy through corporate induction and the intranet provides further guidance and contact details for the Trust's Freedom to Speak Up Guardians and Champions.

In addition, staff have duties imposed upon them to raise such concerns by their respective professional regulatory bodies, such as the GMC, NMC, etc.

3. Recruitment and selection practices

Overseen by the Trust's Human Resources Department, the Trust has recruitment processes in place to ensure that staff are appointed subject to references, pre-employment checks (including immigration checks and identity checks). This ensures that we can be confident, before staff start their employment that they have a legal right to work within the Trust.

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain the Trust adheres to the national NHS employment checks/standards (this includes employees UK address, right to work in the UK and suitable references); follows NHS Agenda for Change terms and conditions to ensure that staff receive fair pay rates and contractual terms; agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency staff.

International recruitment is managed through NHS Professionals who manage the pre-employment check process.

4. Equality, diversity and inclusion and human rights

The Trust has a range of controls in place to protect staff from discrimination, poor and unfair treatment and/or exploitation. These comply with all respective laws and regulations, including the Equality Act 2010 and Human Rights Act 1998.

The Trust is committed to ensuring equality of access to employment and training opportunities for staff and access to personalised care that meets individual needs for our patients. We will eliminate unlawful discrimination, harassment and victimisation; advance equality of opportunity and foster good relations in all that we do.

All Trust activities and policies are required to have an Equality Impact Analysis (EIA) completed.

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain the Trust has a range of controls in place to protect staff from poor treatment and / or exploitation, which comply with relevant laws and regulations; undertakes consultation and negotiation with Trade Unions on proposed changes to employment, work organisation and contractual relations; promotes and provides support for the right for staff to raise concerns, for example about poor working practices.

5. Procurement

The Trust acknowledges that ethical standards are a core principle for procurement. Through its purchasing policies and by upholding professional practice the Trust sources goods and services in a manner that aims to ensure the wellbeing and protection of workforces across our supply chain.

Through a combination of purchasing through NHS Supply Chain and using NHS standard terms and conditions that include the requirement for suppliers to have modern slavery and human trafficking policies and processes in place, the Trust minimises the risk of social exploitation; ensuring that people are treated with respect and their rights are protected.

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain the Trust ensures the majority of our purchases utilise existing supply contracts or frameworks which have been negotiated by NHS Supply Chain or under the NHS standard terms and conditions of contract, which all have the requirement for suppliers to have modern slavery and human trafficking policies and processes in place; upholds professional practices relating to procurement and supply and ensures procurement staff attend regular training on changes to procurement legislation; requests all suppliers to comply with the provisions of the Modern

Slavery Act (2015), through agreement of purchase orders and tender specifications.

The Trust's Commitments

The Trust supports and respects the protection of human rights for all its employees and workers within its supply chain. We believe in treating individuals with respect and dignity, and do not condone the use of our products or services which infringe the basic human rights of others.

We expect our suppliers and business partners to adhere to the same high standards and to take all reasonable steps to combat slavery and human trafficking. The Trust has in place due diligence procurement and tendering processes to ensure all its selected suppliers and any third parties are compliant with the Model Slavery Act (2015).

Accordingly, we are committed to ensure that:

- We are not complicit in human rights abuses of any kind and that slavery or human trafficking are not taking place in our supply chain or any part of the Trust's business; this includes our subsidiary ADMK Ltd
- Employment with the Trust and our suppliers is voluntary
- Our workplace and those of our suppliers are free from discrimination or harassment based on race, colour, religion, gender (including pregnancy), sexual orientation, marital status, gender identity, national origin, age, disability, or any other characteristic protected by applicable law
- Our workplaces are safe and healthy
- Corruption in all its forms, including extortion and bribery, is prohibited
- Our policies and procedures are devised to reflect we take all reasonable steps to achieve these commitments. This includes, but is not limited to, the following policies: Procurement; Counter Fraud; Employment; Conflicts of Interest (including Sponsorship, Gifts and Hospitality); Safeguarding of Adults at Risk of Abuse.

The Trust's Board of Directors has approved this statement and will continue to support the requirements of the legislation.

Approved by the Board of Directors on 4th July 2025.

Meeting Title	Trust Board in Public	**Date:** 4 July 2024
Report Title	Integrated Quality Governance Report	**Agenda Item Number: 20**
Lead Director	Kate Jarman, Chief Corporate Services Officer	
Report Author	Corporate and Quality Governance Leads	

Introduction	This report is the first Integrated Quality Governance report, providing oversight of quality and corporate governance in a single report, rather than separate reports. This will be produced on a quarterly basis in future, with in-depth reports in specialist areas as requested, required or appropriate (e.g. an in-depth report on complaints and patient experience). Detailed reports in each area will also continue to be submitted to the Quality and Clinical Risk Committee and Audit Committee.		
Key Messages to Note	This report is designed to provoke questions and curiosity as well as provide information and assurance. Feedback on the style and usefulness of a report in this format is encouraged.		
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)*	Safety, experience, effectiveness (and well led).

Report History	This is the first submission of the report to a formal MKUH Committee or Board
Next Steps	Quarterly report
Appendices/Attachments	Paper follows

Integrated Quality Governance Report

This report provides an overview of quality governance and corporate compliance across the Trust. This report will be presented the Board every quarter (with future reports using quarterly data).

The report covers:

- Complaints and patient experience
- Health and safety reporting
- Inquests
- Claims and litigation
- Information governance
- Quality improvement
- Care Quality Commission compliance

Aim of the Report

The report aims to provide an overview of key issues, themes and areas of work to the Board. It aims to provoke curiosity as well as provide assurance.

Key Messages

There are some themes of note that emerge from the information in this report. Those are:

- We must focus on the **fundamentals of care provision** (making sure patients are well looked after, with their basic needs met). The final chapter in this report talks about consolidating actions and efforts under a programme provisionally called A Culture of Care, which will bring together a focus on fundamental **care provision; civility and safety** in the workplace/ care environment.

  This brings together existing programmes, sources of information and tools including Tendable ward metrics and audit, the PEP platform, survey data, staff feedback, complaints information, incidents and regulatory compliance requirements) and aims to provide clarity, focus and strong (but simple and clear) quality governance, putting care at the heart of everything we do.

- We must focus on **being responsive** – this is evident in complaints particularly, with delays in responses from divisional teams a persistent issue. New processes are in place for complaints, and the quality governance structure is being revised and refreshed to make it leaner, more focussed and action-oriented (as well as providing appropriate assurance through reporting).

- We must focus on **compliance** – a proactive focus on compliance is essential in ensuring we are doing what we must do, can robustly identify gaps that we can then proactively address, and can provide robust assurance. Current activity includes a new structure for health and safety, with focussed work on preventing and reducing violence and aggression; and a new quality management system and linked work with Tendable to monitor CQC compliance.

What is the Board being asked to do?

- Ask questions
- Request any further assurance required
- Consider deep dives into particular areas at Committee of Board level
- Use this information as prompts on walk arounds in wards and departments
- Make comments or recommendations for improvement

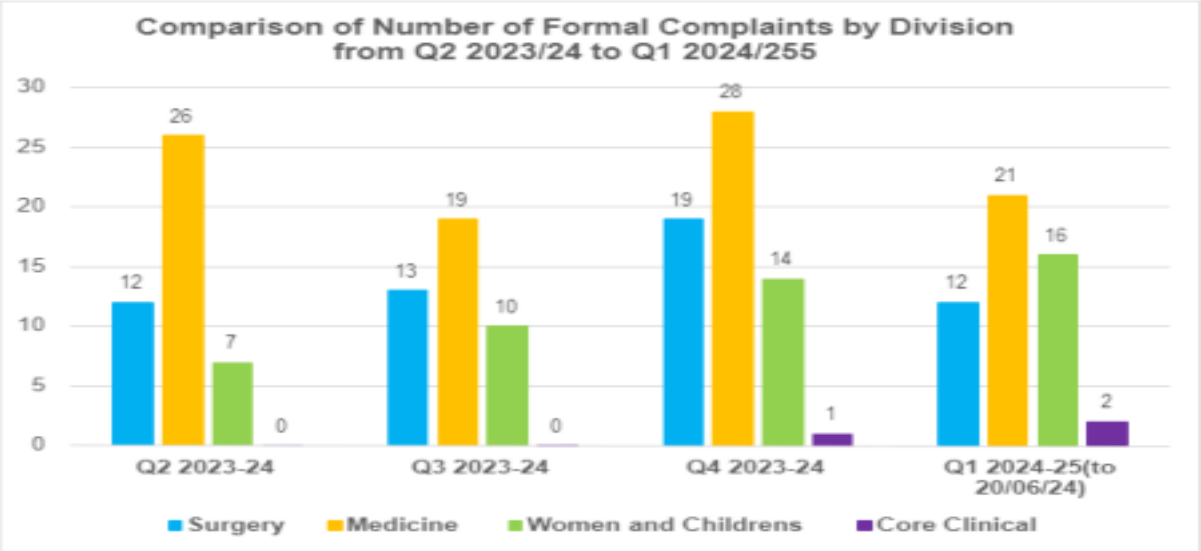
Complaints Report

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 2024/25 (up to and including 20th June 2024).

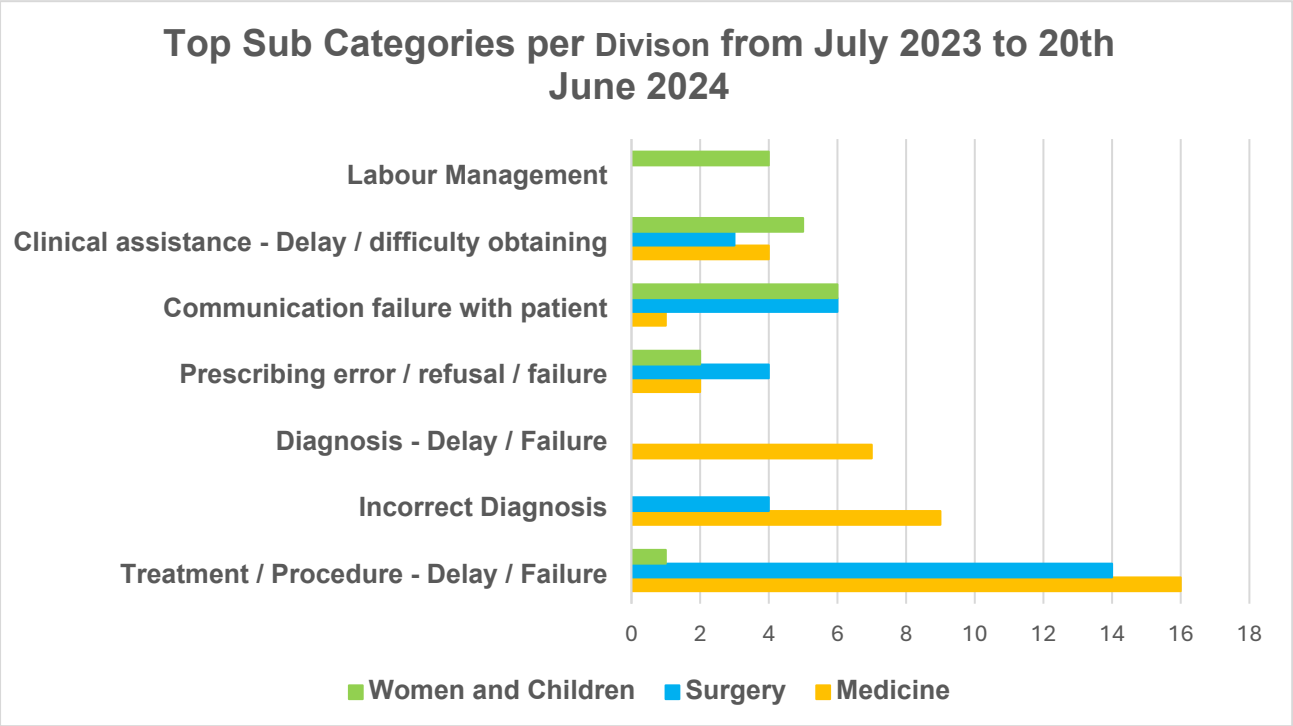
The purpose of the report is to highlight the number of complaints both formal and informal, and the trends in both in the issues being raised and the areas concerned.

1. Formal complaints

In Q1 2024/25 (up to and including 20th June 2024), 51 formal complaints have been received.



Upon receipt of each complaint, every issue that occurred which contributed to the complaint is recorded on Radar using a main category and a sub category to further understand the exact issues that occurred.



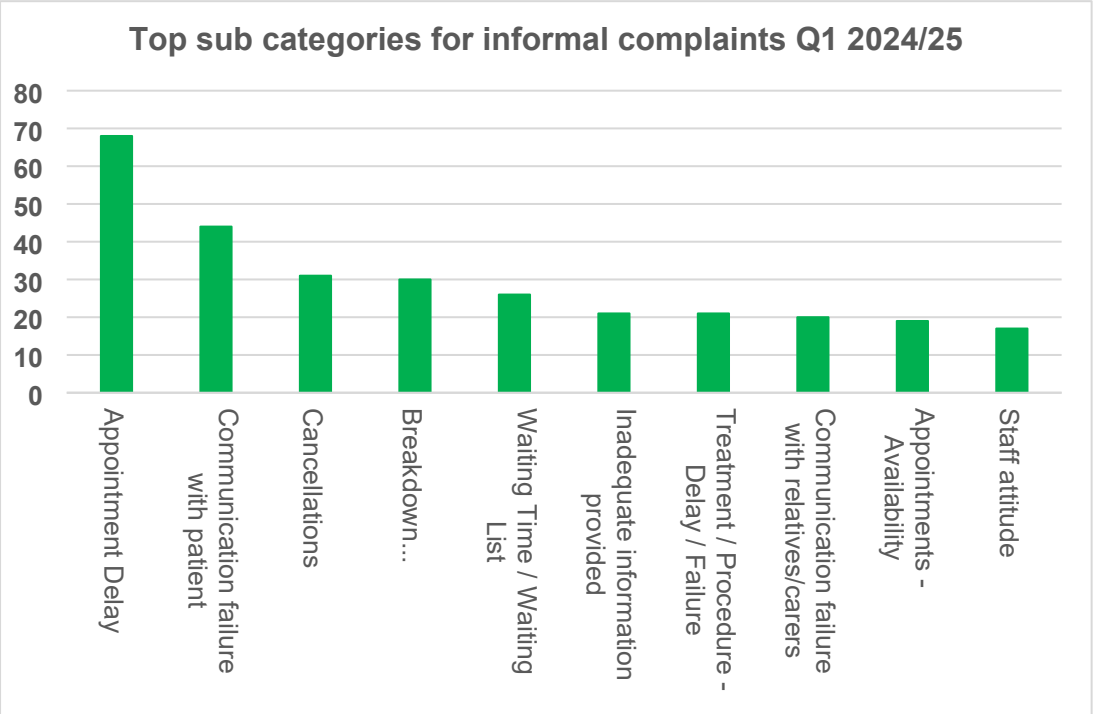
Responding to complaints on time

During Q1 2024/35, emphasis has been placed on each division 'owning' their complaints and responding on time, as performance in this respect had deteriorated in 2023/24.

To address the lack of timeliness in respect of responding to complaints, the process with regard to the checking of draft responses with the senior nursing teams has been revisited to ensure checks are made in a timely way - the results of this will be evidenced in subsequent reports. A weekly complaints panel and RAG report have also been put in place to ensure the divisions are aware of complaints due and any escalation required.

2. Informal Complaints

In Q1 2024/25 (up to and including 20th June 2024), 448 informal complaints have been received.



3. Trends – formal and informal

In both formal and informal complaints, the following areas are in the top areas receiving complaints: -

Imaging- the main sub-categories of all complaints include communication failures, delay in appointments, delay/failure to receive scans/x-rays/results/treatment, staff attitude.

Women's and Children's - the main sub-categories of all complaints are communication issues, difficulty on obtaining clinical assistance, waiting times, staff attitude and injury sustained during procedure.

ED - the main sub-categories of all complaints are difficulty in obtaining clinical assistance/lack of and delay in test results/treatment, diagnosis issues, pain management.

4. Specific examples of learning from complaints

- Review of the induction of labour patient information leaflet.
- Work on interface between the Pharmacy team and the Discharge team to tackle discharge related issues and transfer between care settings.
- Bespoke communication training for newly trained nurses.
- Enhanced recovery guidelines updated in maternity including which analgesia to be prescribed and recommendations for first and second line breakthrough pain.
- Sage and Thyme training for nurses on Ward 7.

5. Emerging themes/ areas of concern

Concerns around the provision of the fundamentals of care has been identified as an emerging theme – the **A Culture of Care Programme** seeks to bring together existing improvement work, as well as gain an in depth understanding of practice (positive and concerns) on each ward and department, alongside quality data, to deliver a Trust

Appointment delays and cancellations continue to be a trend across all specialities compounded by a breakdown in communications regarding appointments – improvement work in this area is being scoped.

6. Parliamentary and Health Service Ombudsman (PHSO) (the complaints regulator)

In Q1 2024/25, the PHSO have returned to the Trust on one case proposing to partly uphold the complaint. The complaint was around care provided in early 2021 on Ward 14 under the care of the medical team.

7. CQC Surveys

The following surveys have been completed and are subject to action plans across the divisions:

Inpatient Survey 2022 - divisional action plans in place which include improvements to discharge, and noise at night.

ED Survey 2022 - ED action plan in place including patients getting help whilst waiting, upon discharge patients being told what symptoms to look out for and patients being able to get food and drink.

Maternity 2023 – substantial action plan in place by Maternity Services in conjunction with the Maternity Voices Partnerships.

All action plans are monitored through the Patient and Family Experience Board.

The embargoed results of the Inpatient Survey 2023 have been received from the Trust's contractor, Picker, with the fully published results from the CQC expected in August 2023.

8. Friends and Family feedback/ PEP Health

Friends and Family Test (FFT) 01/04/2024 to 31/05/2024

The team continues to receive a large number of FFT responses following the successful launch of the use of SMS text messaging across all services for patients over 18 years of age.

The FFT asks patients to rank our services from ‘very good’ to ‘very poor’. It also asks why they have scored us that way and what we could do to improve our services. These free text comments form the majority of the feedback on our Patient Experience Platform (PEP).

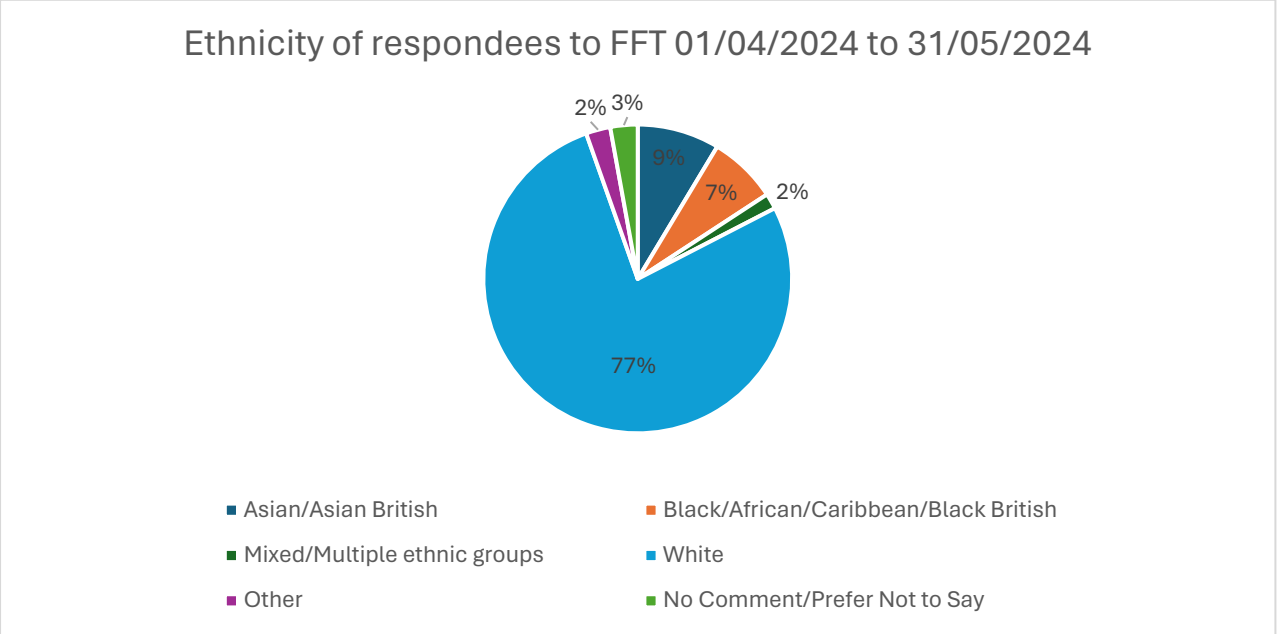
From 1 April 2024 to 31 May 2024 the Trust received 15,584 FFT responses.

During this period 91.4% of patients on average rated the Trust’s services as very good or good.

FFT- Ethnicity

From the 15,584 respondees to the FFT, and where an ethnic origin was stated, 66.8% of respondees described themselves as being White British. This is compared to 77.1% for the previous year.

The ethnicities reported are broken down as follows:

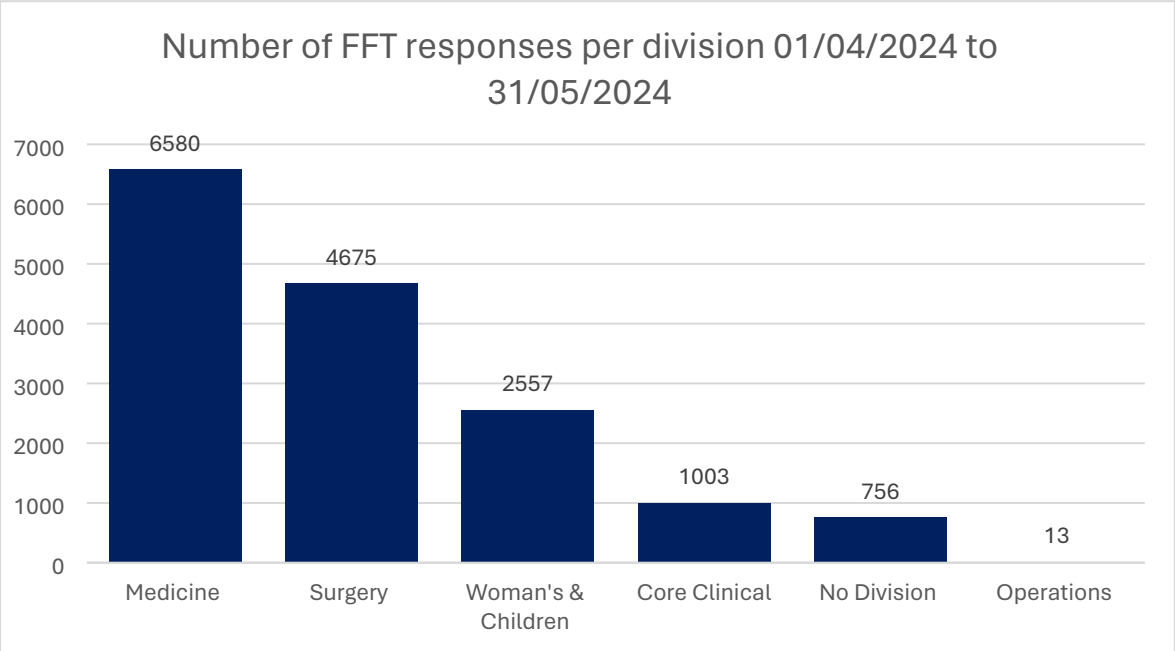


The ‘Tell Us About Your Care’ website pages have been improved with regard to providing information on how to get the FFT form in a different language, if required.

The Patient Experience Team have also been working on engagement with various community groups to ensure all patients are able to provide feedback

Divisonal FFT responses

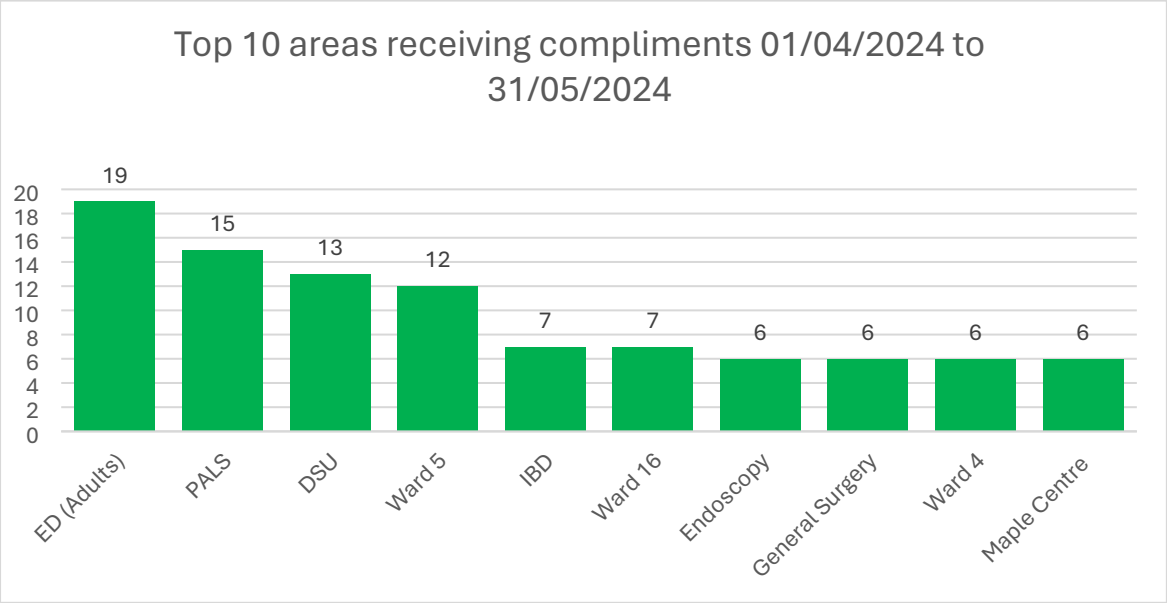
The chart below details the number of FFT responses per divison for 1 April 2024 to 31 May 2024:



Compliments

Between 1 April 2024 to 31 May 2024, the Trust received 193 compliments via email, letter, review sites or telephone calls. The Patient and Family Experience team continue to encourage wards and departments to share their compliments, and this is discussed with individual staff and at the Patient and Family Experience Board.

Areas receiving the most compliments are broken down as follows:



Patient Experience Platform (PEP)

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

PEP Health collect all free text comments from patient feedback received through the FFT route, and online review sites such as the NHS website and Google reviews, and the hospital's social media accounts and more recently from compliments received by the Trust.

PEP Health use their unique software package to theme the comments into eight quality domains. The comments and themes are available on a dashboard and can be filtered by date, theme, and division or individual service. The platform therefore offers the Trust a unique insight into patient experience and what matters to our patients and families. PEP Health were able to record historical data from our inhouse FFT database to allow for comparative analysis.

PEP enables staff to access their patients' feedback by area, compare against other areas, hospitals, and thoroughly analyse the data. Information from the dashboard is shared in reports to the Trust Board, divisional governance groups, divisional meetings and at the Patient and Family Experience Board to demonstrate how the dashboard is used to enhance and improve services and also allows for the celebration of positive comments.

The following is the latest report from PEP:

Patient experience report:

Milton Keynes University Hospital NHS Foundation Trust

PEP Health

Report for: **1 June 2024**

About this report:
This report is based on external (public comments) and internally-collected patient feedback which has been analysed and scored by PEP health.

About PEP Health:
PEP Health uses cutting-edge machine-learning technology to give healthcare trusts actionable insights they need to have an impact on patient experiences. Our empirically-proven platform provides real-time insights about patients' experience of care from large volumes of patient comments.

External data

Scores based on public comments (e.g. Facebook, Google, Twitter, NHS.uk). Star ratings are out of 5.

Overall moving averages

Milton Keynes University Hospital NHS Fo...	National average for England	East of England region
3.0 ★ →NC over the last 90 days	3.6 ★ ↑0.2 over the last 90 days	3.6 ★ ↑0.2 over the last 90 days

Bedfordshire Hospitals NHS Foundation Tr...	East and North Hertfordshire NHS Trust	West Hertfordshire Hospitals NHS Trust
3.4 ★ ↑0.6 over the last 90 days	3.5 ★ ↑0.1 over the last 90 days	4.0 ★ ↑0.4 over the last 90 days

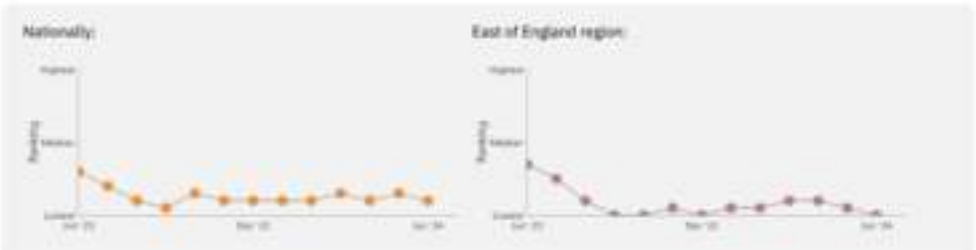
Averages over the last 12 months:

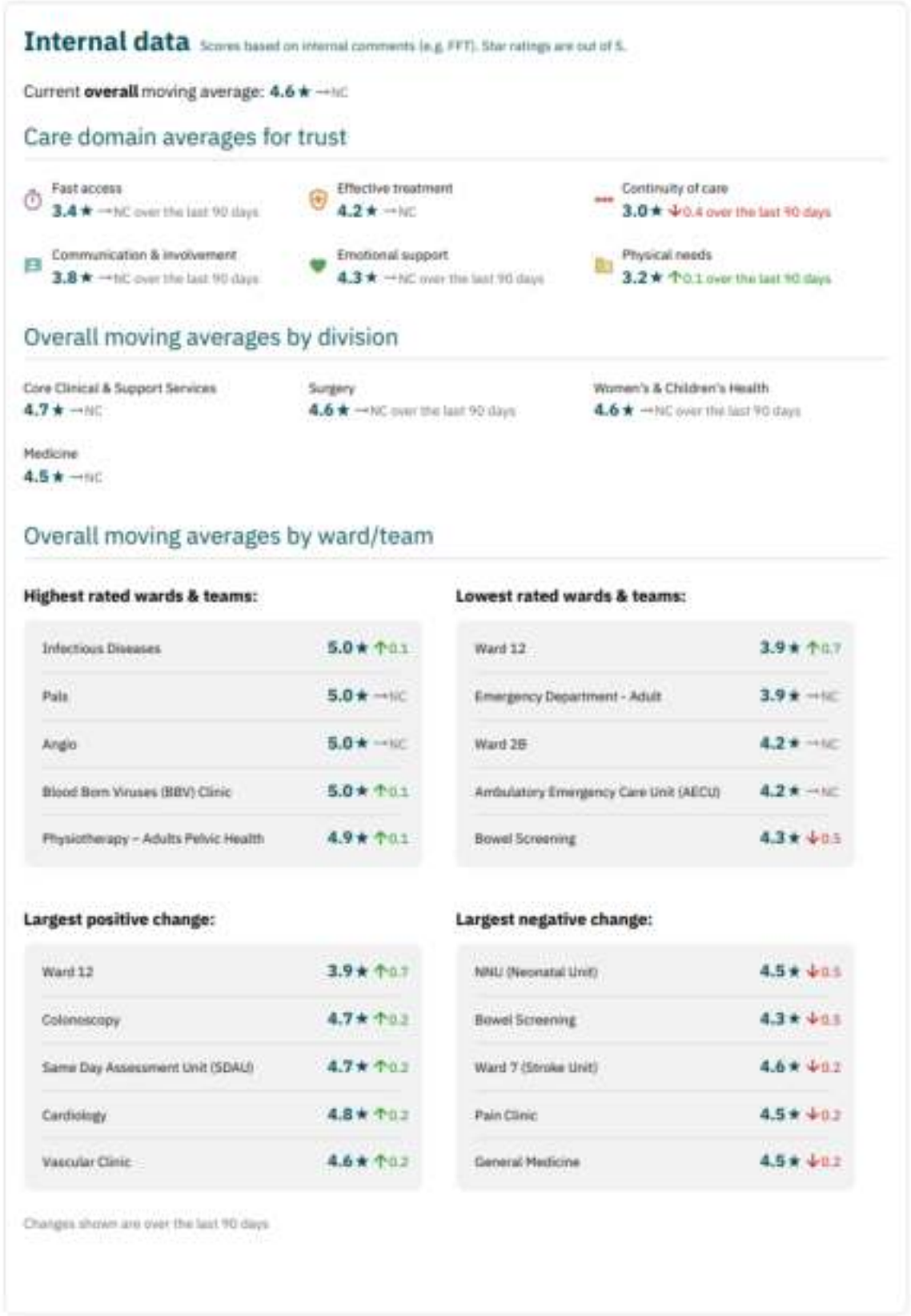
Rankings

Current national ranking
In the top 90%

Current regional ranking
In the top 100%

Rankings over the last 12 months:





Internal data

Scores based on internal comments (e.g. FFT). Star ratings are out of 5.

Current **overall** moving average: **4.6** ★ →NC

Care domain averages for trust

- Fast access: **3.4** ★ →NC over the last 90 days
- Effective treatment: **4.2** ★ →NC
- Continuity of care: **3.0** ★ ↓0.4 over the last 90 days
- Communication & involvement: **3.8** ★ →NC over the last 90 days
- Emotional support: **4.3** ★ →NC over the last 90 days
- Physical needs: **3.2** ★ ↑0.1 over the last 90 days

Overall moving averages by division

- Core Clinical & Support Services: **4.7** ★ →NC
- Surgery: **4.6** ★ →NC over the last 90 days
- Women's & Children's Health: **4.6** ★ →NC over the last 90 days
- Medicine: **4.5** ★ →NC

Overall moving averages by ward/team

Highest rated wards & teams:

Infectious Diseases	5.0 ★ ↑0.1
Pals	5.0 ★ →NC
Angio	5.0 ★ →NC
Blood Born Viruses (BBV) Clinic	5.0 ★ ↑0.1
Physiotherapy – Adults Pelvic Health	4.9 ★ ↑0.1

Lowest rated wards & teams:

Ward 12	3.9 ★ ↑0.7
Emergency Department - Adult	3.9 ★ →NC
Ward 28	4.2 ★ →NC
Ambulatory Emergency Care Unit (AECU)	4.2 ★ →NC
Bowel Screening	4.3 ★ ↓0.5

Largest positive change:

Ward 12	3.9 ★ ↑0.7
Colonoscopy	4.7 ★ ↑0.2
Same Day Assessment Unit (SDAU)	4.7 ★ ↑0.2
Cardiology	4.8 ★ ↑0.2
Vascular Clinic	4.6 ★ ↑0.2

Largest negative change:

NNU (Neonatal Unit)	4.5 ★ ↓0.5
Bowel Screening	4.3 ★ ↓0.5
Ward 7 (Stroke Unit)	4.6 ★ ↓0.2
Pain Clinic	4.5 ★ ↓0.2
General Medicine	4.5 ★ ↓0.2

Changes shown are over the last 90 days

The next stage will be to triangulate the data received from FFT, PEP, compliments, PALS and Complaints and Tendable to form a patient experience strategy.

9. Issues to be noted/ taken forward

- The number of issues being received by the PALs team continues to increase month on month. The challenge for the team continues to be keeping up with demand and responding in a timely manner, this is particulary diffiicult when the team are experiencing staff absence.
- Lack of timely action to respond to complaints in divisions.
- Communication and appointment issues continue to feature as the main reason for complaints - there has been no change in this position over an extended period.
- As the Trust expands its services the infrastructure of the complaints and information providing functions needs to be reviewed in view of the capacity/demand inbalance.

Health and Safety Report

Following the Trust's inspection the Trust HSE response has been sent and outlines the completed and ongoing work with regards to the two enforcement actions:

- Manual handling
- Violence and abuse

Work is underway to comply with the HSE health and safety direction and the wider Trust corporate compliance, due diligence and risk management. This has included the interim appointment of a highly experienced and qualified Health & Safety and Corporate Compliance/Governance professional to provide the Trust with competent expert advice and operational capacity to ensure the prevention and reduction of violence and aggression at work and Manual Handling programmes are robustly delivered and embedded across the organisation. This is being supported by a part time project manager who is focusing on key parts of the HSE action plan that was developed following the inspection.

Preventing Violence and Abuse HSE action plan progress to date

- The Preventing Violence and Abuse Working Group has been reconvened

- The Preventing Violence and Abuse Working Group is currently working on a new policy architecture for policies relating to the safety of people on hospital premises. This includes reviewing existing security policies, as well as relating policies including Deprivation of Liberty Safeguards and the Administration of the Mental Health Act

  The overall aim will be to bring policies together under a preventing violence and aggression strategy document, supported by guidelines, protocols and local procedures to support staff to manage situations safely and lawfully

- A new Restraint and Restrictive Practices (Adult) Policy has been introduced

- There is also significant work being carried out related to de-escalation, breakaway and intervention/restraint training provision, which will be addressed within the training section of this report

- A revised structure is being developed to increase the number of competent people (as defined under the Health and Safety at Work Act). This includes the appointment of a Preventing Violence and Abuse Lead; a Health and Safety Coordinator post to support the Health and Safety Manager; and the interim appointment of a Head of Health and Safety

- The recruitment process is currently underway with the aim of a competent person taking up the Preventing Violence and Abuse Lead and the Health and Safety Coordinator role by September 2024

- Following this appointment, it is intended that the interim Head of Health and Safety and Violence and Aggression Lead, in consultation with the Violence and Abuse Working Group will draft a short, medium and long-term violence and aggression reduction action plan for Trust Board/Committee Approval

Moving and Handling

- The Trust competent Moving, Handling and Ergonomics Advisor took up their role week commencing 17 June 2024 and is currently subject to Trust induction

- Drafting of new job description for substantive appointment for a competent Moving, Handling and Ergonomics Trainer has been carried out, mapped and approved for appointment

- The recruitment process is currently underway with the aim of a competent person taking up the role by September 2024

- Following the appointments it is intended that the interim Head of Health and Safety, Moving and Handling Advisor and the Moving, Handling and Ergonomics Trainer will draft a short, medium and long-term HSE response action plan including training plan for Trust Board/Committee Approval

Fire Safety

Fire safety governance responsibility currently falls under the Estates portfolio. The report author has noted that Buckinghamshire Fire and Rescue Service issued the Trust with an enforcement notice on 13 December 2023 with eleven areas of non-compliance of the Fire Reform Order 2005 to be resolved by Monday 13 May 2024. After drafting an action plan the Trust applied for an extension which was granted.

Corporate Compliance Team

Following the HSE and Fire Authority notices, the following actions have been agreed (in addition to specific action plans):

- Review of the corporate management structure for services/departments with regulatory compliance roles

- Review of governance and arrangements control in relation to regulatory compliance, this will include the Trust's Corporate Health and Safety Committee. Further recommendations to follow once the process has been drafted consulted upon and agreed with relevant stake holders and refreshed to ensure meets legislative and corporate requirements

Policy

- Restraint and Restrictive Practices Policy – the policy is in place; drafting of additional appendices including a decision tree on the use of restraint, staff guides on the safe use of physical and chemical restraint and how to avoid asphyxiation during restraint; exploration of a post restraint checklist to include observations and formal documentation of the event; and planned review of all policies that fall under the health and safety framework.

Training

- The Emergency Department (ED) has been identified as the priority area for staff training in preventing violence and aggression. This totals approximately 100 staff members. A plan is being established to ensure breakaway and conflict resolution training commences as soon as possible.

  The training will be delivered by the Trust established training provider in the first instance. Once this training has commenced; further work will be carried out to identify a more thorough training needs via analysis of other high-risk areas that have been identified. At this stage approaches to training will be explored to ensure that training meets the needs of specific areas and client groups. This will be supported by relevant in-house clinical specialists and discussions with external providers.

  We are also in discussion with mental health and dementia specialist providers, with a view to developing a bespoke, holistic training program where clinical and non-clinical stake holders can share their perspective/viewpoints whilst understanding each other's roles in the de-escalation/ intervention process.

  We aim to then establish a rolling programme of comprehensive appropriate group training to take place.

  This training will be regularly reviewed and benchmarked to ensure it is suitable as the needs of the Trust change and services evolve.

  Additional training by the Mental Health Liaison Team (MHLT) to support ED staff with scenario-based training is also currently being explored.

  It is intended training will be delivered in multi-disciplinary and multi professional groups in order to aid understanding of different roles and responsibilities.

  There is a need for the Trust to provide ad-hoc short sessions on managing patients with dementia and plans are being established in this regard.

General Health and Safety Issues

RIDDOR (Reporting of Injury, Disease and Dangerous Occurrences Regulations)

Between 1 April 2024 and 19 May 2024 There has been six RIDOOR reportable events, as follows:

Ref Number	Details	Location
INC-21392	Staff member slipped on wet floor	Ward 14
INC-21424	Estates team member burn to hand	Ward area
INC-23385	Staff fall on spilled food/drink	Hospital corridor
INC-24053	Patient fall compressing staff member's arm	Ward 7
INC-24319	Manual handling injury	Community maternity

Accidents/ incidents

In April 2024 and May 2024, the top reported health and safety related incidents on Radar were:

- Violence and abuse
- Sharps injuries
- Unsafe buildings/environment (includes temperature control, power outage, unlocked premises etc)
- Exposure to hazardous substances (chemicals, body fluids etc)
- Manual handling

With the introduction of the Patient Safety Incident Framework (PSIRF), non patient safety incidents are discussed at a weekly triage panel with representation from Risk Management, Health and Safety, Security, Staff Health and Wellbeing and corporate nursing, with the aim of an multi disciplinary (MDT) approach, recognition of key trends and themes, fresh eyes critique and definitive working groups set up on areas requiring further analysis/key learning.

Thematic Issues

There are several emerging issues being explored at present, however the report author is not able to formally report to the Board until the root cause is confirmed.

Issues under scrutiny:

- Needlestick injury
- Contractor control
- Asbestos management
- Failure in safe systems of working (after a scolding injury)
- Incident and near miss actions process shortfall

Inquests

All inquests and claims are managed through the Trust Litigation Office, working with external legal advisors and NHS Resolution where necessary.

Supporting Staff

Attending inquests can cause concern and anxiety for members of staff; and many will be unfamiliar with the rules and requirements of the Court. Following feedback from senior nursing staff, the Litigation Office is working closely with the senior nursing team, including matrons, to ensure nursing staff are informed of the need to attend an inquest face-to-face.

This will enable timely release of staff with protected time to write their statements and make sure that rosters can be updated when inquest dates are known.

An informal meeting will be arranged with the Head of Patient Safety and Legal Services to discuss what to expect when attending an inquest, and to address any questions staff may have. Whilst the inquest may be scheduled for many months in the future, this can help to allay some anxieties at an early stage and signpost staff to a senior member of staff as a point of contact for any future concerns.

Staff will also be encouraged to attend an inquest in advance so they get a real understanding and appreciation of the Court, before being required to attend as a witness.

His Majesty's Coroner is also attending the Trust in July to hold an educational forum for staff on the purpose of inquests and what is expected of staff members who may attend an inquest.

Inquests of Note:

MK 2912: (24 June)

Death of a patient under a deprivation of liberty safeguard/ inpatient fall.

Areas of focus:

- Transfer to ward, risk assessments completed in relation to falls, control measures put in place, the circumstances of the fall and immediate after care
- Mental health assessment and subsequent DOLS application.
- Diagnosis, assessment and treatment relating to the fall

The Trust is rolling out 'bay watch'/ bay-based nursing as a way of enabling close observation of patients assessed as being at risk of falling.

MK 2405: (pre inquest review 15/7/24 and inquest scheduled for March 2024)

Death in police custody in the Emergency Department.

MK 2806: Awaiting a pre-inquest hearing date

A concern was raised by family that the patient had been found with food in his mouth. He developed aspiration pneumonia and was treated with antibiotics, fluids, oxygen and pain relief. However, despite best efforts, sadly passed away. Cause of death was reported as follows:

1a) Aspiration pneumonia
1b) Chronic dysphagia
II) Learning disability, Type 2 Diabetes

Areas of focus:

- Dysphagia policies and practice
- Learning disability and autism strategy
- Safeguarding concern has been raised with the CQC by the family. CQC are an interested party. It is unclear if this is related to the learning from lives and deaths – people with a learning disability and autistic people (LeDeR).

There has been collaborative working with CNWL to draft an Eating and Drinking at Risk policy and supporting information, and the implementation of the Oliver McGowan training for all staff (levels 1 and 2).

The inquest was set to be heard in June but has since been adjourned by HM Coroner pending the receipt of an expert report commissioned by the legal team representing the family, to cover the risks of aspiration pneumonia, especially in patients with learning difficulties.

The Trust's Medical Director has commissioned an independent report of choking/ aspiration incidents in the Trust, including this case.

Learning from Inquests:

Staff are reminded of the need to make sure their statements can be understood by a lay reader – this is particularly important to enable families to understand the information they receive at inquests.

MK-2836 21/5/24 (note SI 2023/18364)

Patient underwent an endoscopic duodenal polypectomy. He remained in hospital for post-surgical care, became unwell at the hospital and subsequently sadly died. A post-mortem examination was performed, and the medical cause of death given as:

1a) Peritonitis

b) Perforated duodenum
c) Endoscopic duodenal polypectomy

HM Coroner gave a narrative conclusion detailing patient's death (complications from a necessary medical procedure). In his summing up he questioned junior staff feeling empowered to escalate to senior colleagues. Being able to escalate issues promptly in a supportive environment is critical and will be a continued area of focus for the Trust in cultural development programmes.

Litigation

A number of claims are received with little or limited information, with general requests for copies of medical records only. This is more common for litigant in person claims, which seem to have increased in the past few years and is also reflected in the number subsequently abandoned due to inactivity or no case to answer.

For all claims the Trust accepts liability and pays damages most frequently where there is limited evidence to repudiate the allegation or where there were clear failures of process or with regards to duty of care. Delays in diagnosis and/or treatment are also recurring themes.

Learning themes also include ensuring comprehensive and contemporaneous documentation in relation to decisions made, care provided and information and communications with patients and their families. The importance of this cannot be emphasised enough since medical records are the evidence used.

The Trust's most recent NHS Resolution litigation score card works on a traffic light system:

- Red - High value, high volume claims
- Amber - High value (£1 million+), low volume claims
- Blue - Low value, high volume
- Green - Low value, low volume claims

The red claims are recommended to be the area for priority focus. The Trust has eight of these all for maternity services (shoulder dystocia) dating back to 2014 and 2016. Nationally for district general hospitals, maternity are recognised as the main area for red claims, due the risks and associated subsequent payments for ongoing care where a baby has suffered a brain injury.

Litigation Cases of Note

MK 2620: Failure to put adequate measures in place to mitigate a patient deemed to be at risk from falling, resulting in £125,000 damages.

This was also an inquest case. Experts advised that one to one care was requested on numerous occasions but denied due to staffing issues, which constituted care below a reasonable standard.

The Trust Falls Action Group is working on a targeted work programme to reduce falls incidents, which includes the previously referenced ‘bay watch’ /bay-based nursing, staff education and the implementation of a Multifactorial Falls Risk Screen (MFRA) tool/ process in line with National Guidance.

There are two **staff personal injury claims** in relation to Covid 19 and there has been extensive work to try and provide evidence to support these claims in respect to:

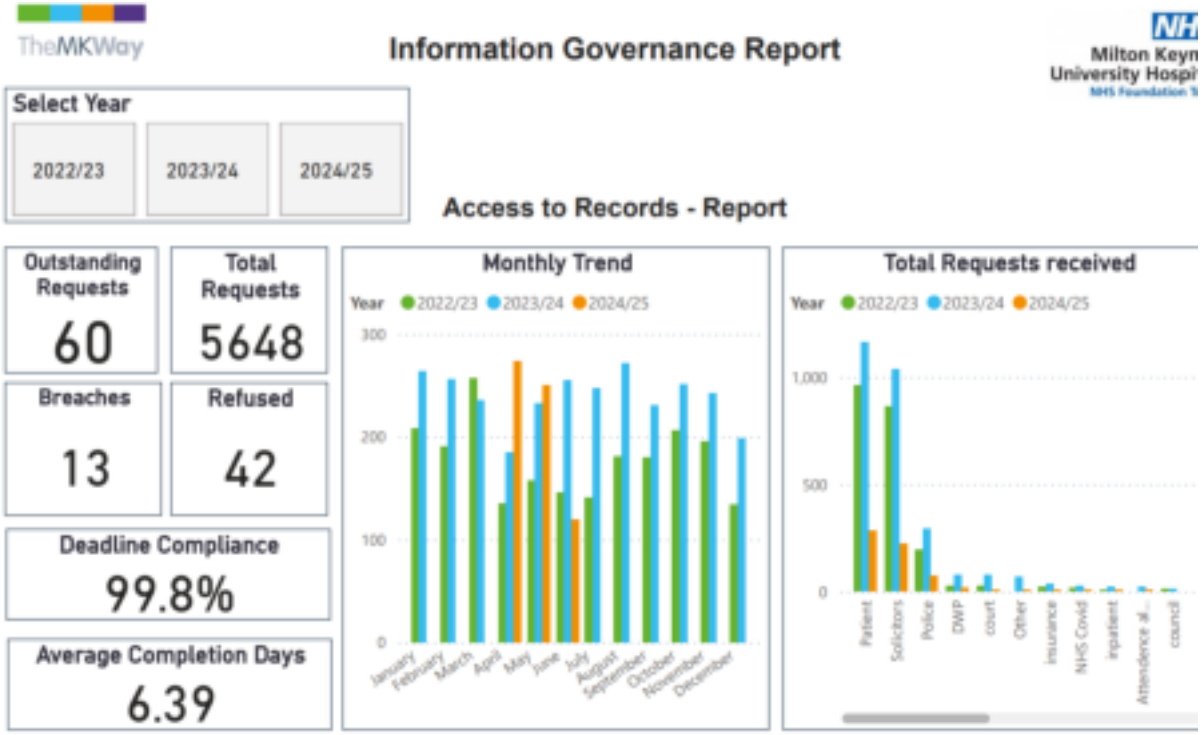
- Classification of wards for set date ranges
- Classification of personal protective equipment (PPE) for these areas for set date ranges
- Risk assessments for individual staff relating to work arrangements and for departments/wards
- Patient types on wards including if those with dementia
- Investigation of potential staff hospital acquired Covid 19 and if RIDDOR reportable
- Statistics on staff testing positive for Covid 19 for set date ranges

This has proven challenging to collate and it is expected that as these claims progress locally and nationally the volume will increase.

Information Governance

Reports for FOI compliance and Access to Health Records

The reports below show the trend of the past three years for Access to Health Records. You will see a clear increase on a yearly basis. The FOI report shows data from 2024 to date



The Data Security and Protection Toolkit

The Data Security and Protection Toolkit is a self-assessment tool that allows organisations to measure their performance against the National Data Guardians 10 Data Security Standards on an annual basis. As data security standards evolve, the requirements of the DSPT are reviewed and updated to ensure they are aligned with current best practice. Organisations with access to NHS patient data must therefore review and submit their annual assessment each year before the deadline. The assessment comprises of 10 standards incorporating 108 mandatory evidence items and 34 assertions.

We have recently undergone our DSPT audit for 2023/24 and awaiting the final report. DSPT submission date for 2023/24 is due on 30th June (and will be submitted to the Audit Committee post-submission).

Data Protection Officer for the Trust

As a public authority, MKUH is required to appoint a data protection officer (DPO). This is an essential role in facilitating accountability, and the organisations' ability to demonstrate compliance with the GDPR. The essential qualities of the role are to provide support, independent advice, and assurance of all our activities that involve processing personal data.

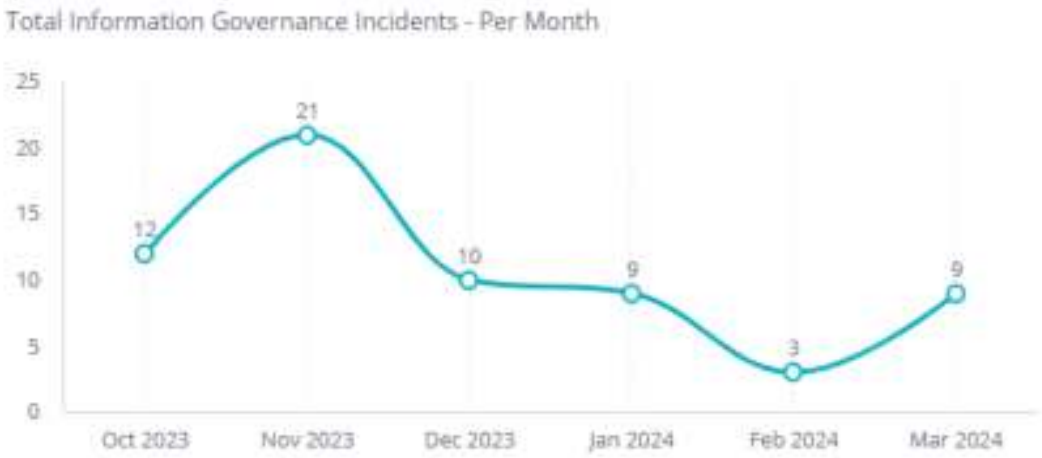
The DPO reports on compliance to our senior management teams and is empowered to raise data protection matters with our Board and or Information Commissioner's Office directly if necessary.

The DPO has expert knowledge of data protection law and practices, and a detailed understanding of how the Trust processes personal data. The Board may wish to

consider inviting the DPO to a Board meeting or Audit Committee meeting annually (or more frequently) to gain further assurance.

MKUH has a comprehensive suite of policies and procedures that addresses all aspects of information governance and data protection. These govern how we ensure that the personal data we are responsible for is processed and shared lawfully, and that peoples' data protection rights are respected.

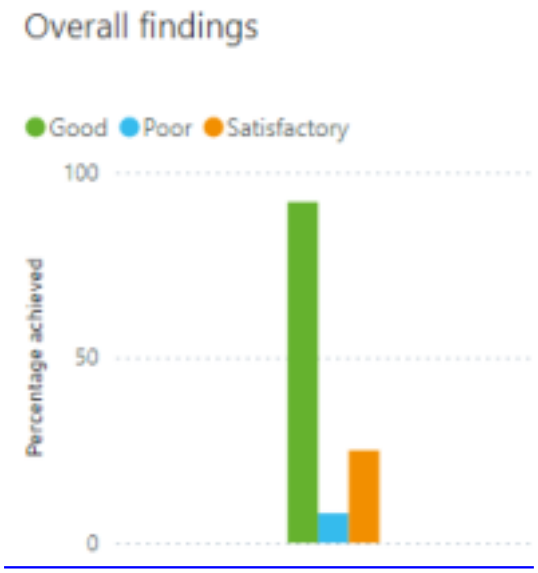
Incidents



The Information Governance department is currently seeing the following issues of note.

- Inappropriate access to patient data by staff members (a breach of policy and potentially unlawful)
- The inappropriate use of patient labels (a potential safety risk)
- Email traffic and the use of CC instead of BCC (a potential information governance breach)

The Information Governance department is conducting IG spot checks in line with the requirements of the DSPT which the graphs below show. The overall findings for 2023/24 are:



Information Governance Training

The DSPT has changed the way we comply with training and asks for various training methods based on staff demographics and roles. We are currently 93% compliant across the Trust, however due to the online training not meeting the requirements of specific job roles we need to evaluate other ways of delivering this. For example, Catering/ Housekeeping staff do not need the on-line training as most is not relevant to them, however they do need to know what is happening within the organisation and how to mitigate the risks. Previously this was carried out via booklet or face to face.

Quality Improvement Report

QI Highlights

- Divisional dashboards shared for Trust documentation. Staff can access all policies, guidelines, and standard operating procedures via Radar including those in date, pending review in the next three months (five months for Maternity) and overdue. Patient information is also being moved onto Radar for monitoring timely reviews.

- Clinical Audit Awareness Week started on 24th June. The QI team organised QI activities in the tent for Wednesday, Thursday and Friday, showcasing QI work and sharing QI tools for staff to use locally and Trust-wide.

- Corporate and clinical governance oversight and assurance groups review underway with Chief Corporate Services Officer, Trust Secretary, Interim Health and Safety Lead and Senior Nursing Leads to ensure oversight and assurance for statutory mandatory requirements and Trust Quality Account priorities. This work will further support development of a Trust Quality Management System and NHS Impact.

- Clinical audit half days to be structured to ensure improved governance oversight and assurance for statutory and mandatory national audits.

- National Epilepsy Audit of Seizures and Epilepsies for Children and Young People – the Trust is no longer an outlier and is now participating.

- National Heart Failure audit presented at Medicine audit half day. The Trust meet all national standards apart from patient referrals to cardiology and specialty Heart Failure Nurse follow up, ideally leaving hospital with their first appointment (74.4%).

- National Confidential Enquiries into Patient Outcomes and Death (NCEPOD) studies now being used for benchmarking the Trust against national recommendations to identify improvement work pathways.

QI Strategy

Quality Governance and Quality Accounts (QA)

- 2024-25 QA - review of local and Corporate Governance oversight and assurance groups to ensure statutory mandatory requirements are met in the Trust for H&S and CQC which will also support development of a Quality Management System
  - Audit half days – structuring to become 'QI forums' supported by QI team
  - Clinical Improvement Groups – structuring to become Safety, Risk and Experience groups. Supported by Patient Safety, Experience and Risk teams
    - QLIB – monthly oversight of all QI activity from ward to board

QI training

- Risk to PSIRF and NHS Impact if QI training isn't funded - HR advised no funding available from Trust NHS Elect budget to support Trust QI Training
- Risk mitigation – QI team deliver in house training programme when team are staffed for:
  - QI fundamentals,
  - QI practitioners
  - QI Coach

Risk (Radar) System developments

- Trust documentation dashboard oversight for all divisions for policies, guidelines, SOPs. Patient information moving onto Radar
- Audit and QI events module for monitoring National and local audit outcomes and local QIP improvement actions
- NICE actions model for monitoring NICE compliance
- National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) actions model

Clinical Audit Awareness week
24th to 28th June
3 day event in the tent for QI and audit. Various activities. Invites to QIP leads for Trust priorities to showcase work and engage with staff QI ideas/input

Cross system working – on going conversations with regional colleagues on shared learning and integrated QI work

Improvement actions on Radar for incidents – develop a process between PS and QI team for SMART action planning and oversight and assurance

Radar dashboards on going development for oversight and assurance for all QI workstreams and CQC assurance in addition to Trust documentation

Review of Audit lead roles and responsibilities required. No Trust Clinical Audit/QI lead

Increase Patient input QI activities – link in with
Healthwatch and Patient Experience
PSIRF outcomes

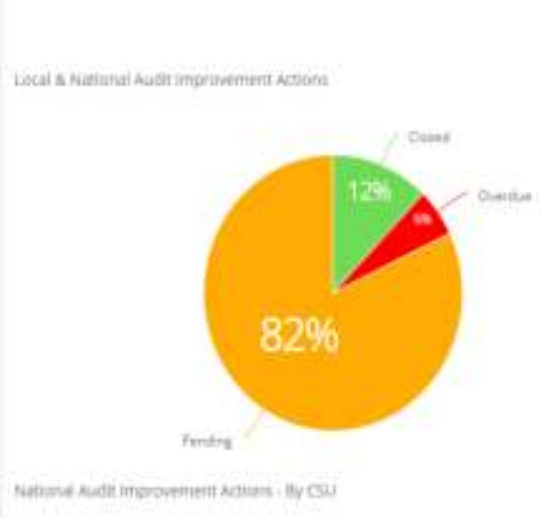
Audit/ QI projects registered on forward plan

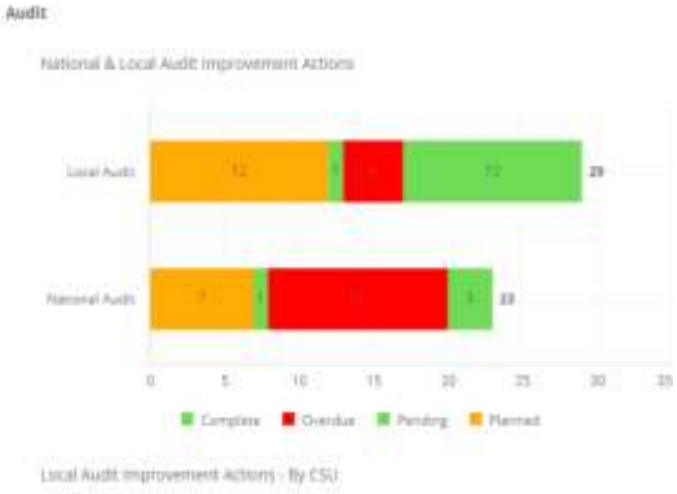
Type of project	Number
Local Audit	124
Priority 1 National Confidential Enquiry into Patient Outcomes and Death (NCEPOD)	1
Priority 1 National Quality Account NCAPOP Audit	29
Priority 2 National Quality Account NON NCAPOP Audits/Trust priority	30
Quality Improvement	47
Grand Total	**231**

Audit Compliance with standards status

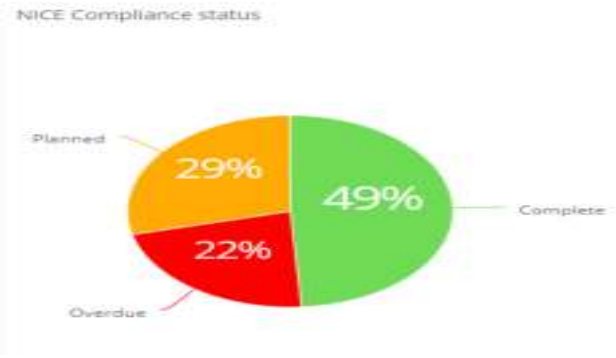
Fully Compliant - 95% and above. Acceptable standard achieved	15
Partially Compliant - 75-94%. Acceptable performance to comparator set	18
Poorly Compliant - 74% and below. Poor performance in comparison to comparator set e.g. National average / complex change required	17
Unknown	11
Grand Total	**61**

National and Local Audit actions status

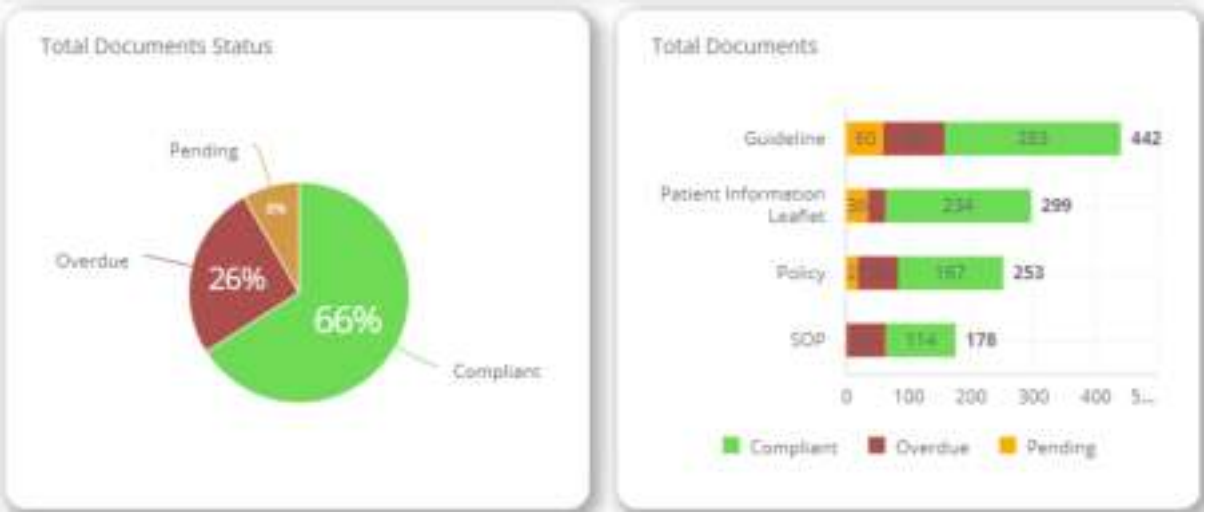




NICE compliance



Trust Documentation



N.B. not all patient information has been added to Radar. This is work in progress. There are 900 plus patient information leaflets to be moved onto Radar.

Care Quality Commission

Inspection Activity

The Trust had an unannounced inspection in the Emergency Department in February 2024. This was followed by a provider information request, which the Trust complied with, submitting data and information to support the inspection process. The report is awaited.

The Inspection Regime

The CQC has moved to a single assessment framework with new quality statements (which generally align to the previous key lines of enquiry). The new regime is risk-based and inspections are more likely to be 'deep and narrow', rather than the whole-hospital inspections we have seen previously.

The regulations underpinning the inspection regime remain unchanged and form a vital part of the legal regulatory framework for the Trust in care provision and quality governance (including Board governance).

The new inspection handbook, including all related legislation can be accessed here: full_book_single-assessment-framework-1719255701.pdf Board members are encouraged to read this document and consider the framework 'I statements' on ward and department visit/ walkarounds.

CQC Engagement

The Trust has been having monthly engagement meetings with the CQC. These have been changed to quarterly. The CQC are holding listening events in maternity services as part of their proactive and risk-based approach. These will take place in July and follow a series of similar events run by the Trust.

Proactive Compliance Monitoring

The Trust has run a series of mock inspections of wards and departments and held CQC programme board to launch the new assessment framework into the organisation and re-familiarise divisional teams with the refreshed requirements.

This is being consolidated into a programme provisionally called **A Culture of Care** – a programme focussing on the fundamentals of care as well as safety and civility in the workplace and care environment. This programme is currently being developed.

NHS
Milton Keynes
University Hospital
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TRUST BOARD MEETING IN PUBLIC

Forward Plan 2024-25

	Agenda Item	Lead	Purpose	Frequency Paper(P)/Verbal (V)	Seminar	Formal	Seminar	Formal	Formal	Seminar	Formal	Seminar	Formal	Seminar	Formal
					04-Apr-24	02-May-24	06-Jun-24	04-Jul-24	05-Sep-24	03-Oct-24	14-Nov-24	05-Dec-24	09-Jan-25	06-Feb-25	06-Mar-25
1	Apologies	Chair	Receive	Standing Item (V)											
2	Meeting Quorate	Chair	Note	Standing Item (V)											
3	Declaration of Interests	Chair	Note	Standing Item (V)											
4	Minutes of the previous meeting	Chair	Approve	Standing Item (P)											
5	Action Tracker	Chair	Note	Standing Item (P)											
6	Chair's Report	Chair	Information	Standing Item (V)											
7	Chief Executive's Report	Chief Executive	Receive and Discuss	Standing Item (V)											
8	Patient Story	Chief Nursing Officer	Receive and Discuss	Standing Item (P)											
9	Nursing Workforce Update	Chief Nursing Officer	Receive and Discuss	Standing Item (P)											
10	Performance Report	Chief Operating Officer	Receive and Discuss	Standing Item (P)											
11	Finance Report	Chief Finance Officer	Receive and Discuss	Standing Item (P)											
12	Workforce Report	Chief People Officer	Receive and Discuss	Standing Item (P)											
13	Serious Incident Report	Chief Medical Officer/Chief Corporate	Receive and Discuss	Standing Item (P)											
14	Objectives Update	Chief Executive	Assurance Receive and Discuss	(P)											
15	Equality, Diversity & inclusion (ED&I) Update	Chief People Officer	Assurance Receive and Discuss	(P)											
16	CNST Maternity Incentive Scheme and Board Assurance Framework	Chief Nursing Officer	Assurance Receive and Discuss	(P)											
17	Progress update – 2024/25 Quality Priorities	Chief Corporate Services Officer	Assurance Receive and Discuss	(P)											
18	Declaration of Interests Report	Chief Corporate Services Officer	Assurance Receive and Discuss	Annually (P)											
19	Maternity Patient Survey 2024 interim report	Chief Nursing Officer	Assurance Receive and Discuss	(P)											
20	Annual Claims Report	Chief Medical Officer	Assurance Receive and Discuss	Annually (P)											
21	Falls Annual Report	Chief Nursing Officer	Assurance Receive and Discuss	Annually (P)											
22	Freedom to Speak Up Guardian Report	Chief People Officer	Assurance Receive and Discuss	(P)											
23	Pressure Ulcers Annual Report	Chief Nursing Officer	Assurance Receive and Discuss	Annually (P)											

24	Green Plan Update	Chief Finance Officer	Assurance Receive and Discuss	(P)												
25	Green Plan Update (C/F from July 2024)	Chief Finance Officer	Assurance Receive and Discuss	(P)												
27	Mortality Update	Chief Medical Officer	Assurance Receive and Discuss	(P)												
28	Safeguarding Annual Report	Chief Nursing Officer	Assurance Receive and Discuss	Annually (P)												
29	Research & Development Annual Report		Assurance Receive and Discuss	(P)												
30	Emergency Preparedness, Resilience and Response Annual	Chief Operating Officer	Assurance Receive and Discuss	(P)												
31	Annual Complaints Report	Chief Corporate Services Officer	Assurance Receive and Discuss	Annually (P)												
32	Annual Patient Experience Report	Chief Corporate Services Officer	Assurance Receive and Discuss	Annually (P)												
33	Patient Safety Incident Response Framework, PSIRF – Policy and Plan	Chief Corporate Services Officer	Assurance Receive and Discuss	(P)												
34	Antimicrobial Stewardship - Annual Report	Chief Medical Officer	Assurance Receive and Discuss	Annually (P)												
35	Infection Prevention and Control Annual Report	Chief Nursing Officer	Assurance Receive and Discuss	(P)												
36	Patient Experience Report	Chief Corporate Services Officer	Assurance Receive and Discuss	Standing Item (P)												
37	Maternity Assurance Group Update	Chief Nursing Officer	Assurance Receive and Discuss	Standing Item (P)												
38	Summary Reports from Board Committees	Chairs of Board Committees	Assurance and Information	Standing Item (P)												
39	Significant Risk Register Report	Chief Corporate Services Officer	Assurance Receive and Discuss	Standing Item (P)												
40	Board Assurance Framework	Chief Corporate Services Officer	Assurance Receive and Discuss	Standing Item (P)												
41	Trust Seal	Chief Corporate Services Officer	As required	(P)												
42	Forward Agenda Planner	Chair	Administration and Closing Information	Standing Item (P)												
43	Questions from Members of the Public	Chair	Administration and Closing Receive and Respond	Standing Item (V)												
44	Motion To Close The Meeting	Chair	Administration and Closing Receive	Standing Item (V)												
45	Resolution to Exclude the Press and Public	Chair	Administration and Closing Approve	Standing Item (V)												
SEMINAR SCHEDULE																
	Annual Risk Seminar	Chief Corporate Services	Risk Management													
	Board Assurance Framework (BAF) Review	Chief Corporate Services	Assurance													
	Collaborative partnership/s—with whom and for what services. Future plans	Chief Executive	Assurance													
	The Trust role around, and contribution to, population health management/Place	Chief Executive	Assurance													
	Annual Objectives Review	Chief Executive	Assurance													
	Annual Strategy Review	Chief Executive	Assurance													
	Strategic links with community groups/organisations/ businesses	Chief Executive	Assurance													
	The Trust's representations on the BLMK ICB and ICP, and the implications thereof	Chief Executive	Assurance													

TRUST BOARD IN PUBLIC

Virtual/Teams

Thursday, 04 July 2024

Questions from Members of the Public

Heidi Travis
Chair

Verbal/ Receive/Respond

TheMKWay

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TRUST BOARD IN PUBLIC

Virtual/Teams

Thursday, 04 July 2024

Motion to Close the Meeting

Heidi Travis
Chair

Verbal/ Receive