Bundle Trust Board Meeting in Public 14 November 2024

1.1 10:00 - Agenda
0 Agenda Board Meeting in Public - 14.11.24

1.2 10:00 - Apologies
Chair
Item 1 Placeholder Apologies

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

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

4 10:22 - Minutes of the Last Meeting
Chair
Item 4.0 DRAFT Minutes Trust Board Meeting in Public 05.09.2024 KO

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

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

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

8 10:41 - Patient Safety Update
Chief Medical Officer/Chief Corporate Services Officer
Item 8 PSIRF Update TB November 2024 IR

9 10:46 - Mortality Update
Chief Medical Officer
Item 9 Board Mortality Nov 24

10 10:51 - Maternity Assurance Group Update
Chief Nursing Officer
Item 10 Placeholder Maternity Group Asssurance Update
Item 10.1 Cover sheet 6 month Midwifery Workforce Update
Item 10.2 6 month Midwifery Workforce Update Oct 2024

11 11:01 - Annual Patient Experience Report

Chief Corporate Services Officer

Item 11 Placeholder Annual Patient Experience Report

12 11:06 - Performance Report

Chief Operating Officer – Planned Care

Item 12 2024-25 Executive Summary M6 Coversheet

Item 12.1 2024-25 Executive Summary M6

Item 12.2 2024-25 Board Scorecard M06

13 11:21 - Finance Report

Chief Finance Officer

Item 13 Finance Report Month 6 Public Board

14 11:31 - Workforce Report

Chief People Officer

Item 14 Workforce Report M6 Nov Board 2024

15 11:36 - Antimicrobial Stewardship – Annual Report

Chief Medical Officer

Item 15 Antimicrobial Stewardship Annual Report 2023-24 - Final 1

16 11:41 - Infection Prevention and Control Annual Report

Chief Medical Officer

Item 16 Infection Prevention and Control Annual Report 2024 v3

17 11:46 - Risk Register Report

Chief Corporate Services Officer

Item 17 Risk Management Report - November 2024

18 11:51 - Board Assurance Framework

Chief Corporate Services Officer

Item 18 Board Assurance Framework Report - November 24

19 11:56 - Annual Review of Trust Board and Committees' Terms of Reference

Chief Corporate Services Officer

Item 19 Cover Report - Annual Review of Terms of Reference

Item.19.1 Board of Directors Terms of Reference 2024 - Review

Item.19.2 Audit & Risk Committee ToR November 2024 - Review

Item 19.3 Audit Forward Plan 2025-26

Item 19.4 FIC Terms of Reference November 2024 - Review

Item.19.5 QCRC Terms of Reference November 2024 - Review

Item 19.6 RemCom Terms of Reference October 2024

Item 19.7 CoG Terms of Reference July 2024 - Review
Item.19.8 CFC Terms of Reference November 2024 - Review
Item 19.9 WADAC ToR Nov 2024- Review

20 12:06 - Use of Corporate Seal
Chief Corporate Services Officer
Item 20 Use of Corporate Seal 14.11.2024

21 12:11 - Forward Agenda Planner
Chair
Item 21 Trust Board in Public Forward Plan 2024-25

22 12:16 - Questions from Members of the Public
Chair
Item 22 Placeholder Questions from Members of the Public

23 12:21 - Motion to Close the Meeting
Chair
Item 23 Placeholder Motion to Close the Meeting

24 12:24 - 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 12:29 - Next Meeting in Public: Thursday, 09 January 2025

TRUST BOARD MEETING IN PUBLIC

Thursday 14 November 2024, 10:00 -12:30 hours
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 05 September 2024	Approve	Chair	Attached
5		Matters Arising and Action Log	Note	Chair	Attached
Chair and Chief Executive Updates					
6	10:30	Chair's Report	Note	Chair	Verbal
7	10:40	Chief Executive's Report • BLMK ICB Update November 2024	Discuss Note	Chief Executive	Verbal Attached
Patient Safety					
8	10:45	Patient Safety Update	Discuss	Chief Medical Officer/Chief Corporate Services Officer	Attached
9	10:50	Mortality Update	Discuss	Chief Medical Officer	Attached
Patient Experience					
10	11:00	Maternity Assurance Group Update	Discuss Note	Chief Nursing Officer	Verbal Attached

Item No.	Timing	Title	Purpose	Lead	Paper
		• Midwifery Workforce Update			
11	11:10	Annual Patient Experience Report	Discuss	Chief Corporate Services Officer	To Follow
Performance					
12	11:15	Performance Report	Discuss	Chief Operating Officer – Planned Care	Attached
Break 11:20 (10 mins)					
Finance					
13	11:30	Finance Report	Discuss	Chief Finance Officer	Attached
Workforce					
14	11:40	Workforce Report	Discuss	Chief People Officer	Attached
Assurance and Statutory Items					
15	11:45	Antimicrobial Stewardship – Annual Report	Note	Chief Medical Officer	Attached
16	11:50	Infection Prevention and Control Annual Report	Discuss	Chief Medical Officer	Attached
17	11:55	Risk Management Report • Corporate Risk Register • Significant Risk Register	Note	Chief Corporate Services Officer	Attached Supplementary Shelf
18	12:00	Board Assurance Framework (BAF)	Note	Chief Corporate Services Officer	Attached
19	12:05	• Annual Review of Trust Board and Committees' Terms of Reference	Approve	Chief Corporate Services Officer	Attached
20	12:10	Use of Corporate Seal	Note	Chief Corporate Services Officer	Attached
Administration and Closing					
21	12:20	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		Resolution to Exclude the Press and Public The Chair to request the Board pass the	Approve	Chair	

Item No.	Timing	Title	Purpose	Lead	Paper
		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."			
12:30		Close			
Next Meeting in Public: Thursday, 09 January 2025					

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	Precious Zumbika	Non-Executive Director
9	Ganesh Baliah	Non-Executive Director
10	John Blakesley	Executive Director - Deputy Chief Executive
11	Ian Reckless	Executive Director - Deputy Chief Executive
12	Fay Gordon	Executive Director
13	Helen Beck	Executive Director
14	Catherine Wills	Executive Director
15	Fiona Hoskins	Executive Director
16	Kate Jarman	Executive Director
17	Jonathan Dunk	Executive Director

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TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 14 November 2024

Apologies

Heidi Travis
Chair

Verbal/ Note

TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 14 November 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/Note

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TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 05 September 2024

Patient Story

Fiona Hoskins
Chief Nursing Officer

Presentation/Discuss

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BOARD OF DIRECTORS MEETING

Minutes of the Trust Board of Directors Meeting in Public held on Thursday, 05 September 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)
Dr Dev Ahuja	Non-Executive Director	(DA)
Mark Versallion	Non-Executive Director	(MV)
John Blakesley	Deputy Chief Executive	(JB)
Dr Ian Reckless	Chief Medical Officer	(IR)
Fiona Hoskins	Chief Nursing Officer	(FH)
Louise Clayton	Acting Chief People Officer	(LC)
Helen Beck	Chief Operating Officer – Planned Care	(HB)
Jonathan Dunk	Chief Finance Officer	(JD)

In Attendance:

Tom Daffurn	Public Governor	(TD)
Babs Lisgarten	Lead Governor	(BL)
William Butler	Public Governor	(WB)
Stevie Jones	Staff Governor	(SJ)
Nicholas Mann	Business Leaders Representative	(NM)
Kate Jarman	Chief Corporate Services Officer	(KJ)
Jacob Pritchard	Head of Communications and Engagement	(JP)
Zara and Cameron Shafiq (For item 3)	Parents	(Z&CS)
Ganesh Baliah	Associate Non-Executive Director	(GB)
Precious Zumbika-Lwanga	Associate Non-Executive Director	(PZL)
Oluwakemi Olayiwola	Trust Secretary	(OO)
Timi Achom	Assistant Trust Secretary	(TA)

1 Welcome and Apologies

1.1 The Chair welcomed all Board members in attendance and recognised those attending virtually. The Chair also recognised the Governors who were in attendance over Teams.

There were apologies from Gary Marven, Non-Executive Director; Haider Husain, Non-Executive Director; Sarah Whiteman, Non-Executive Director and Emma Livesley, Chief Operating Officer – Planned Care.

2 Declarations of interest

2.1 IR declared his part-time secondment to BLMK ICB as Chief Medical Officer until 31 December 2024.

The Chair highlighted that declaration of interest was a continuous exercise and urged members to update their interests as soon as such interest arise.

3 Patient Story

3.1 FH stated that this patient story focus was on patient choice and the significant impact of listening and providing quality care, particularly during challenging situations.

3.2 The story was presented by Zara Shafiq, a recently bereaved mother, regarding her pregnancy and the birth, life, and death of her son, Abdul, who passed away at four days old due to a congenital condition. Zara recounted the compassionate support provided by Keech Hospice and Milton Keynes

Hospital staff. Keech nurses were in constant contact with the family and provided comfort throughout Abdul's short life.

3.3 Zara expressed gratitude for the ability to keep Abdul at home after his passing, which provided them with comfort and allowed the family to spend time with him. She discussed her experience during pregnancy, noting that around 17 weeks, she experienced pain that was initially thought not to be pregnancy related. During her visit to the hospital, she encountered a doctor who discussed her options regarding continuing the pregnancy, which left her feeling unsupported. She eventually met with a research midwife, who informed her that her baby was unlikely to survive. Zara shared how emotional this moment was for her, and how, she was comforted by the hospital staff.

3.3 Zara emphasised her choice to carry on with the pregnancy, which was not an easy decision but was important to her as a mother. The family's priority was for Abdul to be born alive so they could have precious moments with him. The hospital facilitated this, and Abdul lived longer than anticipated, allowing the family to take him home, where they were surrounded by love and support.

3.4 Zara and Cameron shared feedback on the facilities at the hospital, praising the labour ward staff but highlighting the need for more family space. They noted the impact of the room's placement in the ward, as it was located near emergency walkways, which caused some emotional distress to other patients. They also commented on the positive, sensitive treatment they received from the staff, despite the knowledge of Abdul's condition. The Board acknowledged the feedback and the need to consider these aspects in future facility planning.

3.5 The Board members expressed their gratitude to Zara and Cameron for their bravery in sharing such a personal and emotional story. They acknowledged the importance of learning from their experience to improve care for future patients. A few questions were posed regarding the family's interactions with staff and any challenges they faced. Zara shared that, aside from a few isolated incidents, the staff treated Abdul with care and respect. The Board recognised the significance of the feedback in relation to supporting families through bereavement and ensuring that staff are sensitive to patients' religious and personal needs. The Board assured that lessons from Zara's story would contribute to the ongoing development of patient-centred care practices.

3.6 On behalf of the Board, HT expressed heartfelt thanks to Zara and Cameron, emphasising the importance of hearing patient stories to improve care and ensure cultural and emotional sensitivity in future cases.

4 Minutes of the Trust Board Meeting in Public held on 04 July 2024

4.1 The minutes of meeting held on 2 May 2024 were **reviewed** and **approved** by the Board.

5 Matters Arising and action log

5.1 Action 37
The annual EDI report is on the agenda. EDI sessions with Yvonne Coghill were planned in smaller steps, starting with a seminar in October 2024 and continuing in November 2024 after the Board meeting. Future actions will be coordinated following these sessions. Closed

Action 38
The standard questions in the annual staff survey were shared. Closed

Action 40
A meeting had been held between Emma Livesly, Chief Operating Officer (Planned Care) and Paul Ewers, Risk Manager. The BAF risks were all up to date. Closed

There were no matters arising.

6 Chair's Report

6.1 HT provided a verbal update mentioning a productive meeting with Paul Ewers, the Trust's Risk Manager on hospital-wide risk management. She noted that two public Governors, Rachel Medill and Kat Jaitly had stepped down and efforts were underway to elect replacements. She also acknowledged the work of OO and TA in improving Governor engagement and induction, which should aid in smoothly integrating new Governors. The longlisting for the qualified Finance Non-Executive Directors (NED) was in progress, and a visit to midwifery teams, including a walkaround with midwife Caroline Kintu, was highlighted as a positive experience.

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

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

7.1 JH highlighted continued efforts to reduce waiting times, with initiatives involving the private sector and internal clinicians showing progress. By the end of September 2024, the goal was to stabilise the backlog of over 65-week waiters. Meetings with local MPs had been productive, with strong support for hospital development in alignment with Milton Keynes' growth.

7.2 KJ reported an internal communications audit aimed at improving engagement across the growing organisation, focusing on underrepresented voices.

7.3 JB provided an update on site developments, noting construction projects and the associated disruptions, including parking limitations and noise. Mitigation efforts such as additional parking spaces and communication with patients regarding parking challenges were in place. HB added that patient appointment letters would include guidance on parking to reduce issues. Further updates included positive results from the recent inpatient survey, noting room for improvement.

7.4 Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB) update

7.4.1 The Board noted the BLMK ICB report which provided a summary of the items discussed at the ICB Board meeting on 19 July 2024.

7.4.2 Key topics included: questions from residents regarding cardiac rehabilitation and engagement with NHS Trust Governors; the impact of apprenticeships on local healthcare workers; progress on the "Start Well" priority for children and young people; challenges of balancing the 2024/25 Operational Plan amid £55m financial risk; updates to the Working with People and Communities Strategy; an increase in hospital emergency activity; and positive results from the BLMK ICS staff survey. The ICB also discussed ongoing collaboration with partners on strategic initiatives and financial planning, approved the Mental Health and Learning Disability Committee's revised terms, and confirmed the next ICB meeting for 27 September 2024.

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

8 Patient Safety Update

8.1 IR provided a comprehensive overview of patient safety activities since the Trust-wide launch of the Patient Safety Incident Response Framework (PSIRF) on May 1, 2024.

8.2 The discussion emphasised the need to identify recurring issues, such as delayed diagnoses, pressure ulcers, and medication errors, from reported incidents. It was acknowledged that integrating these themes into a cohesive work program for continuous improvement remains a challenge. The approach to learning has evolved, focusing more on thematic reviews rather than the previous system of action plans.

8.3 Concerns were raised about the backlog of low-level incidents requiring further investigation. IR reported that the team was actively managing this backlog and exploring ways to formalise the reporting and categorisation processes to ensure no incidents are missed. While Radar, the Trust's incident reporting system, assists with incident classification, improvements were needed to enhance the capture of learning. There was a discussion about the necessity of tracking whether the learning

from incidents is being effectively incorporated into daily practices. Current quality improvement programs addressed numerous patient safety issues, but a more structured approach is needed to evaluate and report on the outcomes of these learnings.

8.4 The Board recognised the need for better alignment between incident reporting and the Trust's annual safety priorities, such as sepsis and medication errors and acknowledge that a more transparent connection between ongoing incidents and their impact on improvement programs is required.

8.5 The Board **noted** the Patient Safety Update

9 Maternity Assurance Group (MAG) Update

9.1 FH provided a verbal update on the recent unannounced CQC inspection, which commended staff engagement and interdepartmental relationships. However, the inspection highlighted concerns about managing short-term absences and the adequacy of the physical environment, particularly regarding equipment. Infrastructure challenges within maternity services were also noted as requiring attention.

9.2 The discussion included the governance of patient safety at the board level, with the potential merging of MAG with the Quality Committee being considered. Further deliberation is needed to determine the best approach for ensuring comprehensive Board assurance on safety matters. The focus would be on addressing outstanding actions from recent reviews, collaborating with external bodies such as the ICB and Local Maternity and Neonatal System (LMNS), and continuing to monitor ongoing issues, including the perinatal mortality surveillance report.

9.3 The Board **noted** the Maternity Assurance Group Update

10 Performance Report Month 4

10.1 HB provided an overview of the Month 4 Performance Report, highlighting key operational challenges faced by the Trust, including ambulance handover times and Referral to Treatment (RTT performance. She discussed a new initiative from the ambulance service proposing a "drop and go" policy, where patients would be left in the emergency department after 45 minutes if handover had not occurred, allowing ambulance crews to attend other urgent cases in the community. The Trust, along with other acute Trusts, is working to manage the risks associated with this policy.

10.2 Regarding RTT, there had been slight progress, but the Trust remained near the bottom nationally, only ahead of two community Trusts. Plans were in development to address backlogs, particularly the 65-week clearance trajectory, with updates expected next month. Nationally, 20,000 patients were projected to miss the September clearance target, with the Trust contributing to a portion of this figure.

10.3 Efforts were underway to improve diagnostic wait times and meet constitutional targets, aiming for an 18-week pathway as set by the government. While performance metrics showed challenges, the focus remained on reducing waiting times and providing better care, especially for long-wait cancer patients. A detailed plan on cancer services and backlog reduction would be shared with the Board in upcoming meetings.

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

11 Finance Report Month 4

11.1 JD reported a deficit of £4.3m by the end of July, which was £0.4m adverse to plan, though Month 4 saw a favourable in-month variance of £0.2m. Elective Recovery Fund (ERF) performance was above the 106% target, with income exceeding the national target by £5.6m as of Month 4, resulting in a favourable income variance of £1.9m. However, significant risks, including delivery of the efficiency plan, ongoing escalation capacity, and premium costs for RTT recovery, persist. Uncertainty around payments for some activities and the potential system-wide impact of the "triple lock" regulation further complicates the Trust's financial outlook. Nonetheless, a break-even position was still forecasted by year-end.

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

12 Workforce Report

12.1 LC presented the Workforce Report, highlighting key KPIs, including a reduction in vacancy rates to 6% and turnover down to 12.5%, reflecting significant progress over the past 18 months. The report focused on managing temporary staffing, ensuring bank staff usage is optimised, and addressing long-term sickness through enhanced support and training. Improvements in induction and onboarding processes had been implemented to boost staff retention. Recruitment challenges continue, particularly with healthcare workers, but efforts were being made to improve role clarity and provide tailored education programs. A new round of the Staff Survey was also in progress to gather additional workforce insights.

12.2 The Board **noted** the Workforce Report

13 New Hospital Project Update

13.1 JB provided a verbal update on the New Hospital project indicating that the project was progressing well, with continued positive indications from key stakeholders. Initial funding of £1.7 million had been received to support the enabling business case, and the total cost for the Outline Business Case (OBC) was expected to be around £10 million. Further funding was anticipated by the end of the September 2024. Several specialist consultants, including architecture, planning, and transport advisors, have been engaged to assist with the project.

13.2 A brief discussion took place regarding potential risks from recent government changes and the suspension of certain infrastructure projects. However, JH noted that the Secretary of State reaffirmed the importance of continuing to build new hospitals, with an emphasis on critical infrastructure.

13.3 The hospital project remains part of the national programme, and while there may be some adjustments to timelines due to contractor availability and project scale, there was no indication that the project is at risk of cancellation. The Board emphasised the positive steps taken so far, noting the importance of having a strong track record, as demonstrated by previous successful projects.

13.4 The Board **noted** the New Hospital Project Update

14 Equality, Diversity & inclusion (ED&I) Annual Report

14.1 LC presented the annual Equality, Diversity, and Inclusion (EDI) report, outlining activities, performance, compliance, and the Trust's action plans for 2023 - 2024. She confirmed that the report, along with the action plans, would be published on the Trust's website by 31 October 2024, in accordance with the Public Sector Equality Duty.

14.2 The Trust now operates eight networks, including the newly established Neurodiversity network. A cultural review on talent management and recruitment, led by Roger Kline, is currently in progress. During the discussion, it was highlighted that the Trust’s initiatives should have a meaningful impact across all divisions. While positive progress had been made, there is still work to be done to enhance individual staff experiences.

14.3 The Workforce Race Equality Standards (WRES) consist of nine metrics designed to highlight disparities in the treatment and experiences of white and BME staff within the NHS. NHS Trusts are required to demonstrate progress in areas such as recruitment, disciplinary actions, and access to non-mandatory training to foster workforce equality and create a more inclusive environment.

14.4 PZL proposed shifting the terminology from "equality" to "equity" to better align with the Trust’s efforts to provide reasonable adjustments and foster an equitable environment for both staff and patients.

JH noted that while "equality" remains the preferred term within NHS guidelines, the Trust could explore how to incorporate "equity" and revisit the discussion in the future.

14.5 The Board **noted** the Equality, Diversity & inclusion (ED&I) Annual Report

15 Complaints and PALS Annual Report 2023/24

15.1 The Complaints and PALS Annual Report for 2023/24 was presented by LC, noting that while quarterly reports track complaint numbers throughout the year, this is the formal annual submission required by the Trust. Complaint numbers have remained fairly static, but the complexity of complaints had increased, often involving numerous questions and multiple themes. This has impacted response times, as resolving such complaints required input from various teams.

15.2 To improve efficiency, the department is trailing a new approach by coordinating teams in real-time to address complaints rather than relying on lengthy email exchanges. This pilot aims to provide faster, more effective responses, particularly when a meeting with the patient or family may be a better solution than prolonged written communication.

15.3 LC highlighted that communication issues remained a significant category of complaints. While PALS effectively resolves many issues, the rise in complex, multi-department complaints make it challenging to assign a single point of contact for patients. Though resources for a dedicated liaison model was limited, this remains an area under review for improvement.

15.4 The Board **noted** the Complaints and PALS Annual Report 2023/24

16 Risk Register Report

16.1 KJ presented the Risk Management Report, providing a high-level overview of the Trust's risk register and supplementary documentation.

She highlighted areas where further work is required on risk controls. Key themes included ongoing efforts to address and mitigate identified risks, with a particular focus on managing external risks, including finance, which may exceed thresholds in the coming years. Discussion touched on the importance of ensuring the Trust takes control of these risks and better defines its risk management objectives.

16.2 The report also noted the work being done with the Integrated Care Board (ICB) to develop a system-wide risk profiling approach, aiming to identify which partners hold the greatest risks, particularly in finance and emergency care. This collaborative system-based risk assessment was seen as a valuable new approach.

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

17 Board Assurance Framework (BAF)

17.1 KJ presented the Board Assurance Framework (BAF) which provided assurance that the BAF is being effectively managed. HT highlighted the Trust Board October seminar as an opportunity to further refine risk management strategies and objectives. The Board expressed appreciation for the comprehensive nature of the report and acknowledged the value of engaging in system-level risk discussions moving forward.

17.2 The Board **noted** the Board Assurance Framework.

18 (Summary Reports) Board Committees

18.1 The Board noted the Finance & Investment Committee Assurance report which provided an overview of the activities of the Committee since the last Board held in public.

18.2 MV (Audit Committee Chair), highlighted a few key points from the report. He reported a reduction in waivers and a more robust recovery process. He emphasised the importance of continuing discussions around risk management and noted that while there may not yet be a clear solution, it was crucial to demonstrate that the Trust is actively addressing risk-related issues.

The report also covered workforce development, acknowledging a comprehensive plan to tackle workforce challenges. MV underscored the need for ongoing improvements throughout the year, particularly in enhancing both staff and patient experiences.

19 Forward Agenda Planner

19.1 The Board reviewed the Forward Plan and noted that there were no items captured for discussion at the November Board.

HT noted recent discussions about refining the Board's structure and governance. It was agreed that a small group, including OO, KJ and two or three other Non-Executives, would review the Board's preferences and gather feedback from both Executives and Non-Executives. The goal is to streamline the process, delegating more actions to committees for in-depth discussions and providing assurance to the Board. This would allow the Board to focus on more strategic conversations in both public and private sessions.

20 Questions from Members of the Public

20.1 The below questions were received from governors and members of the public:

1. *"Sepsis reduction is a NED priority"*. Are the Board assured that the sepsis protocols are known and understood across the hospital estate and being put into practice.

Dr Hamid Manji's response:
The mainstay of our approach to sepsis is timely triage in Emergency Department (ED) and early recognition of the deteriorating patient through the NEWS2 scoring. The ED team also discuss all acutely unwell patients, including any at risk of sepsis at their 4pm hand over meeting each day. Additionally, sepsis is on the agenda of the monthly ED senior staff meeting and sepsis related patient stories and learning is to be incorporated at the monthly clinical governance meetings. On the wards there is access to a sepsis dashboard and intranet access to the sepsis policy. There is ongoing comms to educate and signpost medical and nursing teams to these resources. We have regular audits against the sepsis guidelines; Tenable audits on the wards and specific ED audits looking at time to antibiotic administration against time of prescription to look for any delays in administration. There is an established, well attended, monthly Trust wide Sepsis meeting which reports into the bi-monthly Care of the Critically Ill meeting. Currently the Sepsis and Care of the Critically Ill meetings are chaired by the Medical Director for Planned Care.

2. What is the strategy for local recruitment, as the Staffing report only mentions international recruitment?

   Can you clarify who is employed, including details on consultants, doctors (grades), nurses (grades), Physician Associates, etc?

   Do the statistics cover just clinical staff or also include ancillary staff like managers, clerks, cleaners, etc?

Acting CPO (LH) and CNO (FH) Response:
Domestic recruitment continues and is detailed in the Workforce Strategy with a mix of department open days, local and national recruitment and careers fairs, national advertising, school and community engagement work etc.

The safe staffing paper is written for nursing and midwifery staffing to meet the National Quality Board Requirement to report safe ward staffing levels at Board. This was a direct action from the Frances Report. There is no requirement for other staff groups vacancies to be reported to Board however, the staffing levels for other workforces are reported to the Workforce Development and Assurance Committee and also to Board in the Workforce Report.

This paper is specifically for Nursing, Midwifery and AHPs – it does not include ancillary staff. The Safe Staffing report only covers staff on the ward template delivering direct patient care.

3. "*The HCA role contributes significantly to patient care and safety, is cost effective and releases qualified staff to undertake more complex care and treatments*". What specific plans are there to fill the large number of HCA vacancies?"

CNO (FH) Response:
We have a working group set up that leads on HCA retention work as well as supports the domestic recruitment campaigns. Part of the remit of the group is to explore the challenges of the role how we can develop and support our HCA workforce. This has resulted in a review of the Fundamentals of Care programme and a change to onboarding. The Trust has also engaged with system-wide recruitment for our HCSW gaps.

21 Any Other Business

None

The meeting closed at 12:33PM

Updated:05.09.24

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	01-Feb-25	Moved to February 2025 Seminar due to Yvonne Coghill Session in October	**Open**
39	04-Jul-24	12	Finance Report Month	Provide a Provider Selection Regime and the potential implications of this for the Trust/ICS Report at the Trust Board Seminar in October	JD	01-Dec-25	Moved to December 2024 Seminar	**Open**

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TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 14 November 2024

Chair's Report

Heidi Travis
Chair

Verbal/Note

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TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 14 November 2024

Chief Executive's Report

Joe Harrison
Chief Executive

Verbal/Discuss

Meeting Title	Trust Board	**Date:** 14 November 2024
Report Title	Patient Safety Update	**Agenda Item Number: 8**
Lead Director	Dr Ian Reckless, Chief Medical Officer	
Report Author	Anna O'Neill, Patient Safety Specialist, Head of Patient Safety and Learning Specialist Dr Anna Costello, Patient Safety Specialist and Patient Safety Doctor	

Introduction	This paper provides Board with an overview of patient safety activity between 01 September 2024 and 31 October 2024. The paper seeks to familiarise Board members with the new systems in place whilst also providing oversight to the number and nature of the safety incidents reports, and the responses to them.		
Key Messages to Note	1. PSIRF was launched Trustwide on 01 May 2024: a variety of new systems and processes are now in place and embedding. 2. We remain in transition from the previous system – with root cause analysis of serious incidents, and the actions resulting, having a 'long tail' in terms of timescale for formal closure. 3. The incident reporting rate is stable / increasing (an increase being a positive finding). 4. In PSIRF, the role of Trustwide triage (daily) and local patient safety huddles (typically at directorate level, weekly) is pivotal. 5. New significant emerging patient safety themes are described within this paper. 6. An annual report will be produced by the patient safety team detailing patient safety themes, trends and successes from the previous year. It will also identify areas requiring additional focus (future patient safety priorities) and improvement.		
Recommendation	[x] 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
Report History	Last report shared September 2024.

Executive Summary

The Patient Safety Incident Response Framework (PSIRF) was launched across Milton Keynes University Hospital (MKUH) on 01 May 2024, following a period of limited piloting. This paper aims to give a brief overview of the purpose of PSIRF, how this is being implemented at MKUH and recent data: data within the paper covers the period 01 September 2024 to 31 October 2024. Much of this information has been shared in other forums within the Trust and is shared today for information and feedback from the Board.

Key points:

1. Radar dashboards were launched on 04 November. This offers the long-awaited ability to review incidents and responses to them, drilling into the data by division and department. Initial responses have been very positive.
2. Approximately 500 incidents reported over the last six months (since PSIRF launch) have ‘overdue workflows’ associated with them. Whilst recognising that timelines for these workflows are internally set, the nature and distribution of these delays is described. The Radar dashboards described above will enhance visibility of delays and drive completion.
3. Two incidents reported were reported in the time frame which led to a Level 1 Patient Safety Incident Investigation (PSII). These both related to delayed diagnosis and are being investigated together.
4. A stocktake of ‘PSIRF at six months’ is planned for November 2024 such that processes can improve iteratively as a result of our experience and learning.

Main Report

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 the triage and response 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 include:

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

Patient safety incidents reported at MKUH (through our RADAR software system) are reviewed in a **2-stage process**; a daily Trust wide triage panel and weekly locally led patient safety huddles. The two stages allow for both Trust wide and local oversight and learning.

Trust wide triage includes a broad membership with representation from all key clinical areas (including patient safety, corporate nursing, medical, pharmacy, maternity, paediatrics, radiology, pathology, safeguarding). Trust wide triage occurs every working morning such that all incidents should be considered by triage within 72 hours of being reported – usually within 24 hours. Of note, relevant leaders are informed of the incident at the time of reporting through an email cascade appropriate to the geographical area / category of incident. The **local patient safety huddles** (sometimes described as 'local triage') are smaller groups and include representation from patient safety, operations, medical and nursing at either divisional or clinical directorate / clinical service unit (CSU) level. Both panels are responsible for appropriately grading all patient safety incidents using the 4 MKUH response levels (***Appendix 2***). A key role of a local patient safety huddle is to review any level 4 incidents (which require further information over and above that included in the original incident report) and determine an appropriate learning response. In such cases, a rapid review form is completed by the ward/department - this ideally occurs within 7 days of the incident being discussed at daily Trust wide triage. The questions in the form are based on the following national criteria:

i. potential for learning in terms of:
   - enhanced knowledge and understanding
   - improved efficiency and effectiveness
   - opportunity for influence on wider systems improvement

ii. actual and potential impact of outcome of the incident (harm to people, service quality, public confidence, products, funds, etc)

iii. likelihood of recurrence (including scale, scope and spread)

Based on the rapid review findings, the members of the local patient safety huddle agree to either close the incident on Radar or assign a level 1 or 2 response. For level 1 and 2 responses a learning event will be suggested. The details of the different types of learning

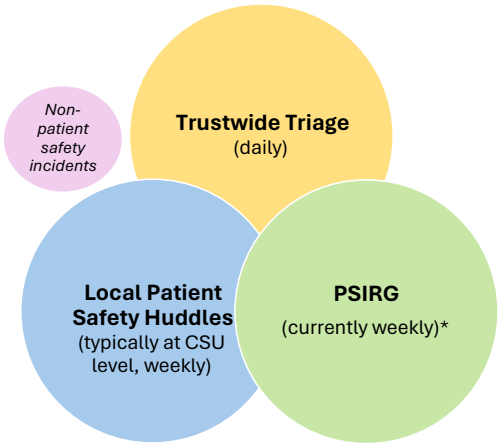
[1] B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL.pdf (england.nhs.uk)

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 members of the executive group for their information.

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

Key groups driving triage, understanding and management of reported patient safety incidents



* The frequency and format of PSIRG (patient safety incident response group) will be kept under review as the transition away from historic processes completes and as we optimise our focus on learning.

Outcomes (learning and actions) from learning events are shared in several different forums including local safety huddles, team newsletters, 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 Round [2] style meetings, *lunch and learn* sessions and simulation are being developed and trialed.

Reporting Period (01 September – 31 October 2024)

Radar Dashboards

Launched on 04 November 2024, the newly developed Radar dashboards offer teams and individuals the opportunity to review and interact with patient safety data. There are 2 dashboards available:

1. *Divisional Dashboards* - provide an overview of all incidents and the ability to filter and interrogate the data by drilling down into PSIRF incidents by division, CSU and department as well as adjusting date periods (see ***Appendix 5*** for snapshots of the Trustwide view of the divisional dashboard). These dashboards will be widely used at Trustwide and CSU meetings.

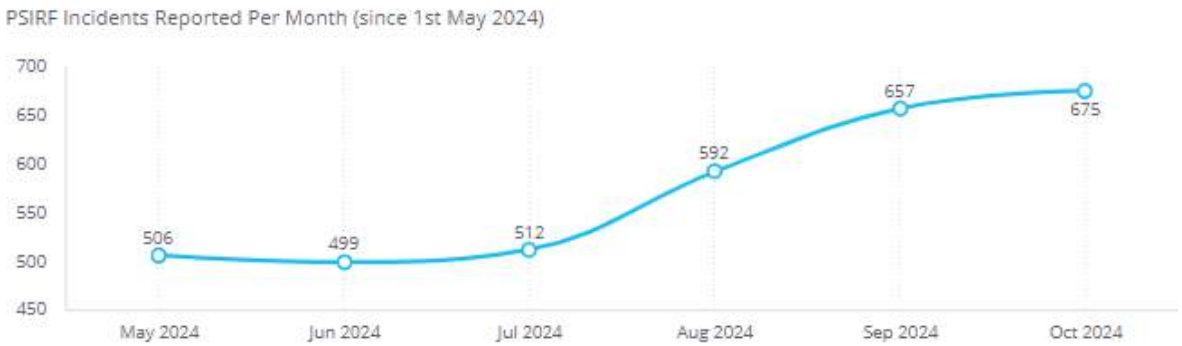
[2] Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. For further information Schwartz Rounds - Point of Care Foundation

2. *PSIRF Dashboard* – provides a more detailed overview of the PSIRF incidents, individual workflows, learning outcomes and actions (see ***Appendix 6*** for snapshots of the PSIRF dashboard). This will be predominantly used by the patient safety team.

These interactive dashboards enable teams to discuss their current patient safety data and make any changes or updates live on the system during meetings, whilst also saving time on report writing. Please note the dashboard data is not 'live' but updates every 24 hours.

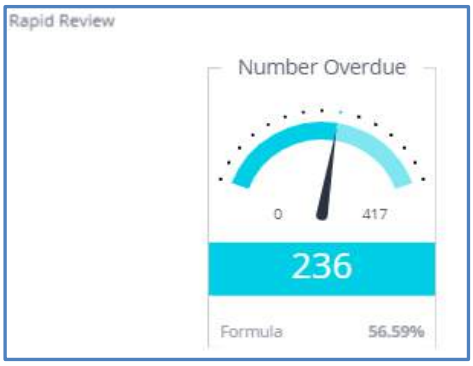
Key Data

The total number of incidents reported monthly continues to rise, partly due to a surge in incidents relating to violence and aggression towards staff reported during October. However, the increased reporting is also reflected in the patient safety incident data (see graph below) which remains on an upward trajectory, suggesting a positive reporting culture ('PSIRF incidents' versus 'all incidents').



The number of incidents with overdue workflows is currently 574. Agreed KPIs for timelines relating to the various workflows were approved at Patient Safety Board in October and these will be added to Radar in due course. **It is important to note that there are no national KPIs for PSIRF other than guidance that PSIIs should be completed within 3-6 months.** The KPIs agreed are to provide assurance that progress is being made and learning and action occurs within a timely manner. In the meantime, the patient safety team are supporting divisions to clear their backlogs. Women's Health currently has the largest number of overdue incidents but are working as an MDT to overcome this. The planned appointment of a dedicated patient safety and learning lead in women's health will support the PSIRF processes as evidenced in the other three divisions.

The two Radar workflows contributing to the largest number of overdue incidents are the rapid reviews and the local safety huddles (described here as 'local triage').



1. Rapid reviews are required for incidents allocated as 'Level 4 – more information needed'. The process for level 4 more information includes:

   i. Identified at initial Trustwide triage that further information is required in order for an informed decision to be made regarding learning response level.
   ii. Local teams (division or CSU) are asked to clarify details and gather further information about the event (as supported by the rapid review form). The expectation is that this is completed ahead of the next weekly local safety huddle.
   iii. If more work or time is required to gather the necessary information, it remains on their local task list and therefore will appear as overdue when it exceeds the agreed KPI of 15 working days (currently 236 are overdue and awaiting completion).
   iv. Once more information is gathered and the rapid review form complete, the local team will either close the incident, convert it to a level 2 or 3, or ask for consideration of a Level 1 investigation (PSII). All potential PSIIs are discussed at PSIRG on a weekly basis.

2. As described above, the rapid review form needs to be completed ahead of the local safety huddle and therefore is having a knock effect on the number of overdue local safety huddles (currently described as local triage). All CSUs now have established weekly MDT meetings to review their incidents and rapid reviews. This will reduce the current backlog of 326.

Level 1 Patient Safety Incident Investigations (including local PSIIs)

Since the PSIRF launch in May, there have been 13 level 1 investigations identified – 10 local PSIIs and 3 'other' level 1 investigations. One PSII has been completed and quality assured by one of our patient safety partners and approved at PSIRG.

INC No.	Date declared at PSIRG	Level 1 investigation type	Safety Priority (National & Local)	Description	Progress update
24255	13-Jun-24	PSII	None	Inaccurate readings of HbA1c in the paediatric diabetes clinic resulting in a number of children receiving incorrect HbA1c results for some months. Lack of oversight of point of care machines.	Completed – Quality Assurance tool completed by patient safety partner and approved at PSIRG
24659	18-Jun-24	PSII	None	30+5 neonatal death. Intrauterine rupture. Miscommunication around blood transfusion resulting in potential delay.	Overdue – referred to Coroner
25330 25342	05-Aug-24	PSII	Local Priority: Deteriorating Surgical Patient	Delay in escalation of deteriorating patient on Ward 20.	On track – Surgical MDT planned

INC No.	Date declared at PSIRG	Level 1 investigation type	Safety Priority (National & Local)	Description	Progress update
25503	05-Aug-24	PSII	Local Priority: Delayed Diagnosis	13 month delay in listing patient for urgent exploratory surgery. On procedure being undertaken histology confirmed cancer.	On track - Thematic PSII being undertaken with INC 28226 & 27576. Joint MDT planned with operations & patient access team.
26540	05-Aug-24	PSII	Local Priority: Delayed Diagnosis	Management of a gynaecological malignancy was neither timely nor appropriate. Typographical error relating to diagnostics contributory.	On track – Learning identified by radiology. Further learning with gynae team needed.
26781	22-Aug-24	PSII	National Priority: Never Event	Bone marrow biopsy completed on the wrong patient. Similar features to a previous event involving failures in positive patient identification and consent.	On track – report writing in progress.
24787	22-Aug-24	PSII	None	Fall during seizure and head injury - Coronial case.	On track - report writing in progress.
26824	22-Aug-24	PSII	None	Aspiration Pneumonia - Coronial case.	On track - report writing in progress.
27576	19-Sept-24	PSII	Local priority: Delayed Diagnosis	Delay in clinic booking for endocrine clinic causing progress in symptoms.	Thematic PSII being undertaken with INC 28226 & 25503. Joint MDT planned with operations and patient access team.
28226	24-Oct-24	PSII	Local priority: Delayed Diagnosis	Delay in outpatient appointment for head and neck cancer.	Thematic PSII being undertaken with INC 27576 & 25503. Joint MDT planned with operations and patient access team.
26809 26883	12-Sept-24	PMRT	National Priority: Neonatal Death	Neonatal death.	On Track – awaiting presentation at PSIRG
27349	12-Sept-24	PMRT	National Priority: Child Death	Death of a baby in the community (pre-alerted to the ED).	On Track - awaiting presentation at PSIRG
27783 27656 27750	19-Sept-24	MNSI	National Priority: Maternal Death	Death of pregnant patient from metastatic cancer. Some learning (which would not have materially changed the outcome).	On Track – review completed by AMD, safeguarding input.

Themes from reported incidents

Potential themes identified from reported patient safety incidents are actively tracked by the team. An identified theme may lead to specific actions (for example, co-ordination of an MDT meeting to discuss and improve understanding) which may not have been warranted based on a single incident. Identified themes may also assist in the identification of training needs and patient safety priorities for future years (as identified in the annual Quality Account). The table below describes themes which are continuing or newly emerging since 01 September 2024.

Category	Source	Plan / next steps
Discharge summaries – quality of / not being sent / not received by GPs	Incidents	Previous QIP in 2023 being reviewed to assess sustainability of actions.
Outpatient appointments – missed / unfilled slots / incorrect patient details	Incidents	Transformation project ongoing. Patient safety team representative attending Transformation Board to share incident data and themes. Collaborative work with patient access team & PA Consulting representative, including a planned workshop.
Patients absconding from wards	Incidents	Being managed under Health & Safety.
Copying and pasting information from patient care records onto external documents	Incidents, M&M meetings	Learning has been shared via the M&M outcome summary and SOS message.
Violence and aggression towards staff	Incidents	Being managed under Health & Safety.
Patient discharges from the ED (medication errors, transport issues)	Incidents	Level 2 learning event planned to include ED, acute medicine, frailty and discharge teams.

Collaborative working with the Quality Improvement Team

Patient safety workflows have many overlaps with the QI team and as such the teams have been working together closely to ensure gaps and duplication are avoided and learning and improvement optimised. Recent developments include:

- A QIP proposal form has been developed and a governance process agreed.
- The need for an obstetric ultrasound improvement project which was identified through the PSIRF process is now registered as a QIP and a QI coach and QI leads have been allocated.
- The teams are working together on larger improvement initiatives to ensure learning is maximised and safety actions are systems focussed and co-designed.

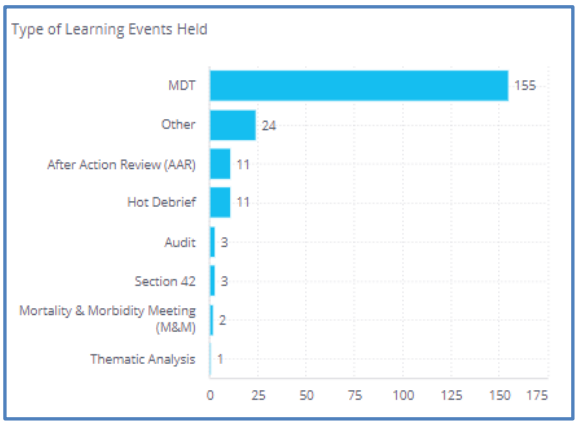
Learning from Patient Safety Incidents

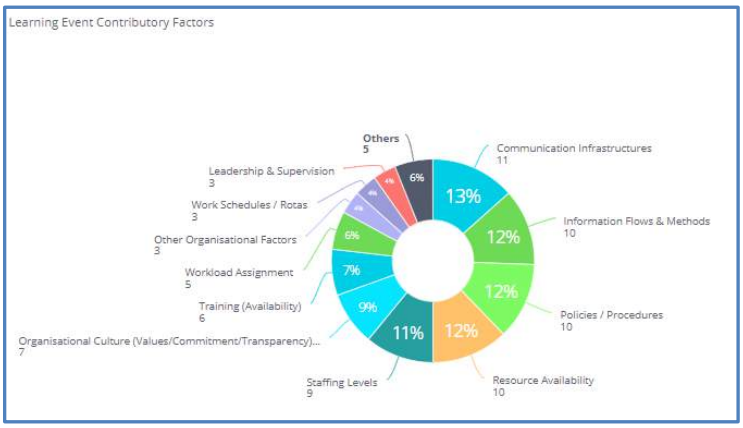
Learning is identified during the daily triage meeting when all patient safety incidents are discussed by experts representing each hospital department. Learning is also generated and shared during the weekly PSIRG meeting. This learning is shared via the SOS message of the week and in, the soon to be published, patient safety newsletters/case studies. Learning from level 2 learning events is captured and recorded on Radar and then shared at relevant groups / meetings using a variety of communication styles and tools. A plan is being developed to present case studies and learning during plenary sessions throughout the year. This is a collaborative approach with the QI team to triangulate safety, improvement and audit.

The patient safety team is capturing learning in a variety of ways including a new Mortality and Morbidity (M&M) meeting outcome form. This is a simple Microsoft form that encourages the M&M group to identify examples of care excellence, key learning and potential quality improvement and audit opportunities. The number of forms completed is steadily increasing with 11 forms completed during the past month by a variety of specialities. An outcome summary is developed monthly and shared across all CSUs for Trust wide learning. The current summary can be viewed in ***Appendix 7***.

Level 2 Learning Events

Since 01 May 2024, 210 level 2 learning events have been completed. The dashboard screenshots below illustrate the type of learning events being held and the key system factors contributing to our incidents and errors.





162 learning events are planned, of which 71 are currently overdue in accordance with the local KPI of ‘within 60 days’. 63 of these overdue learning events are sitting with maternity and an MDT meeting is planned to address this backlog.

It is important to recognise that learning events must be facilitated at a time and place that suits the people involved both logistically and emotionally. This requires detailed planning and scheduling to ensure that the right people are able to attend. PSIRF training is continuing to

up-skill the ward / department teams to facilitate timely learning events such as hot debriefs and after-action reviews. This should reduce the number of delayed learning events and hence the overdue incidents. MDTs are excellent for high quality thematic learning. Reviewing multiple incidents at one MDT learning event is beneficial in terms of time and expertise but can be more challenging to arrange which can impact the overdue incidents list.

A feedback form has been developed with a variety of feedback methods including satisfaction scales and open questions. Visual inquiry images (**Appendix 8**) are also provided as a well-established appreciative inquiry tool used at MKUH to help explore people's feelings and thoughts about a specific experience. So far staff completing the form have rated learning events as either 'good' or 'excellent' and images chosen to describe how the learning events felt for them include:

Below are some quotes from staff explaining why these images were chosen:

"Felt like everyone got an opportunity to share their views and finally we found that we all are on the same page that is to deliver quality patient care and to promote patient safety from learning from incidents. As health care professionals, running towards the same goal and supporting each other"

"Working towards progression"

Suggestions for improvement that have been identified through the feedback form include having more time for the learning events and having more MDT engagement – from medical staff in particular – so that learning from incidents feels less of a nurse-led activity.

PSIRF 6-month Review

PSIRF reached its six-month milestone on 1st November 2024, and whilst the plan and policy don't require a formal review until at least May 2025, it is felt that a stocktake of our collective early experience of PSIRF would be beneficial. On 21st November, the PSIRG meeting will be used to facilitate an after-action review style learning event where members of the Trustwide triage group and other key stakeholders will be invited to share their perspective of what is working well, any challenges and work together to support any change ideas and improvements in the current processes and workflows. Specific areas – clear from this report – which we will want to explore include:

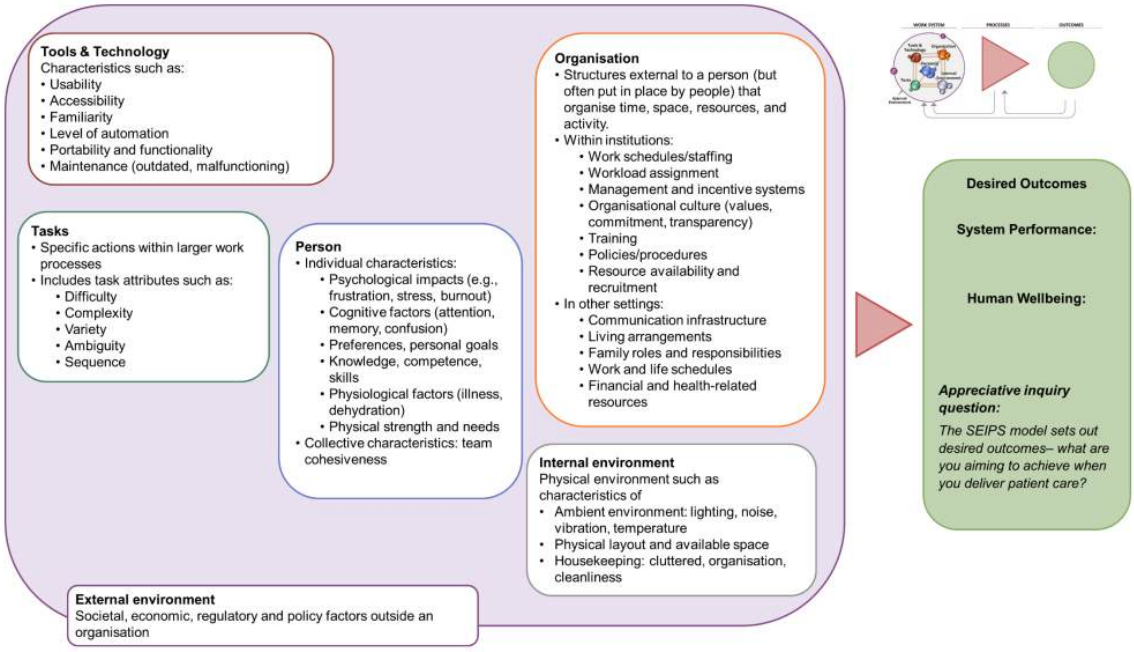
- triage arrangements for non-patient safety incidents

- triage process for ‘themed’ patient safety incidents where a clear programme for improvement is already in place (level 3 incidents)
- appropriate KPIs to ensure that processes occur in a timely fashion in order to support patients and staff whilst facilitating learning
- maintaining multi-professional engagement and involvement in PSIRF.

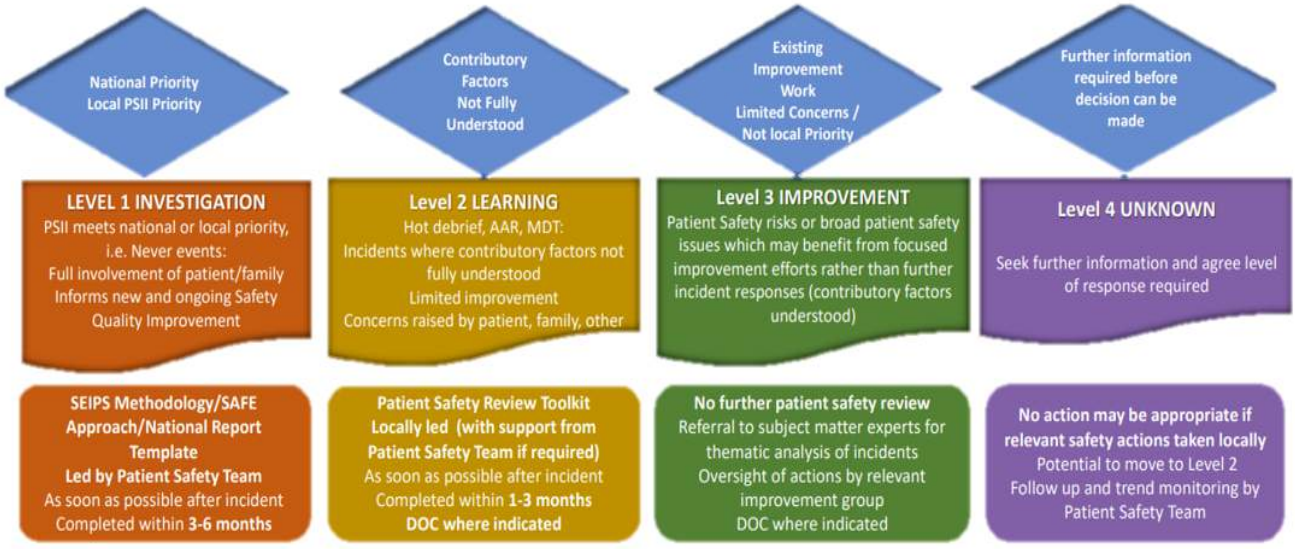
Appendices

Appendix 1 – The SEIPS model

B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL.pdf (england.nhs.uk)



Appendix 2 – Four response levels



Appendix 3: Types of Investigation and Learning Response Types

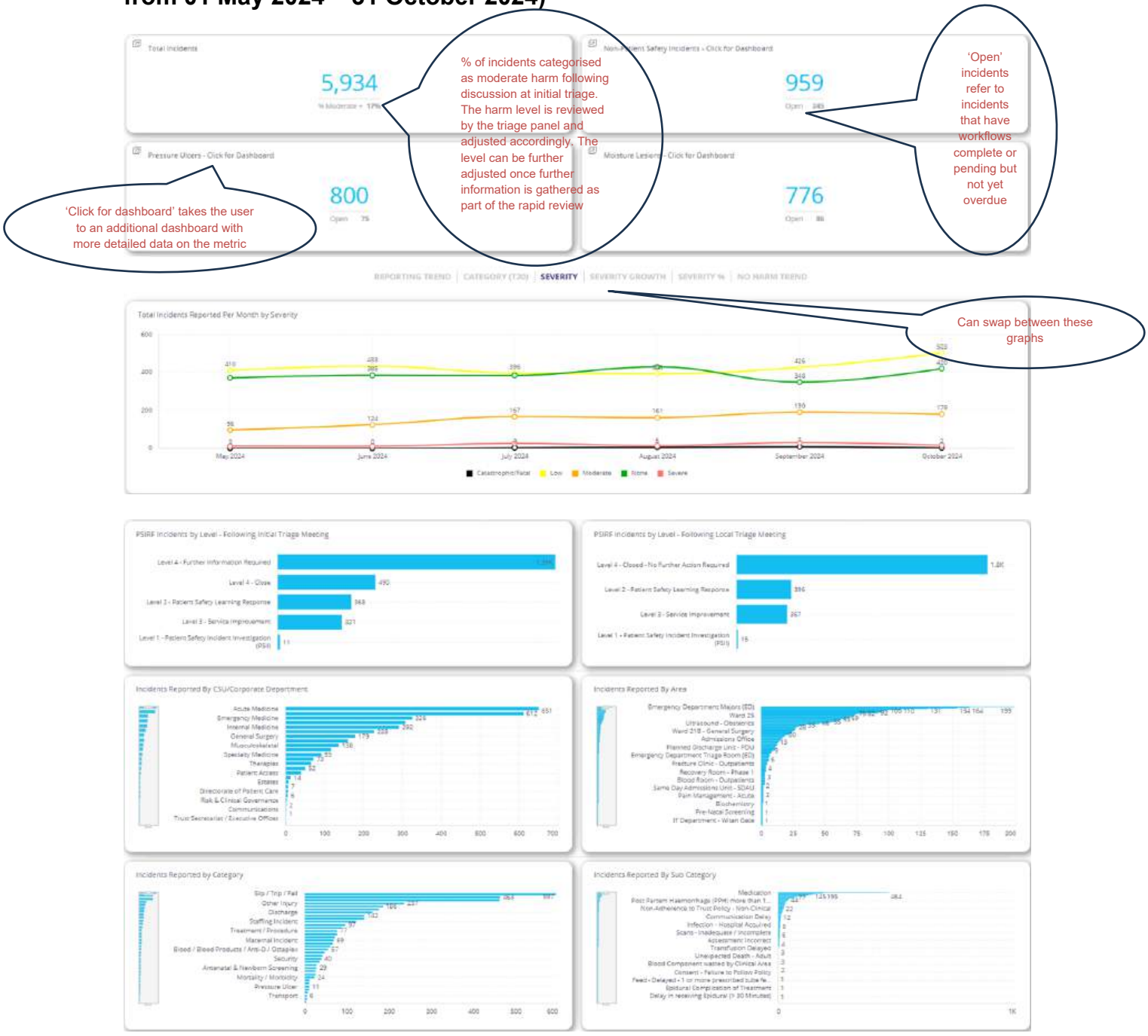
Response Type	Level	Description
Patient Safety Incident Investigation (PSII)	1	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how. These are led by the central patient safety team to ensure standardisation of high-quality system 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.

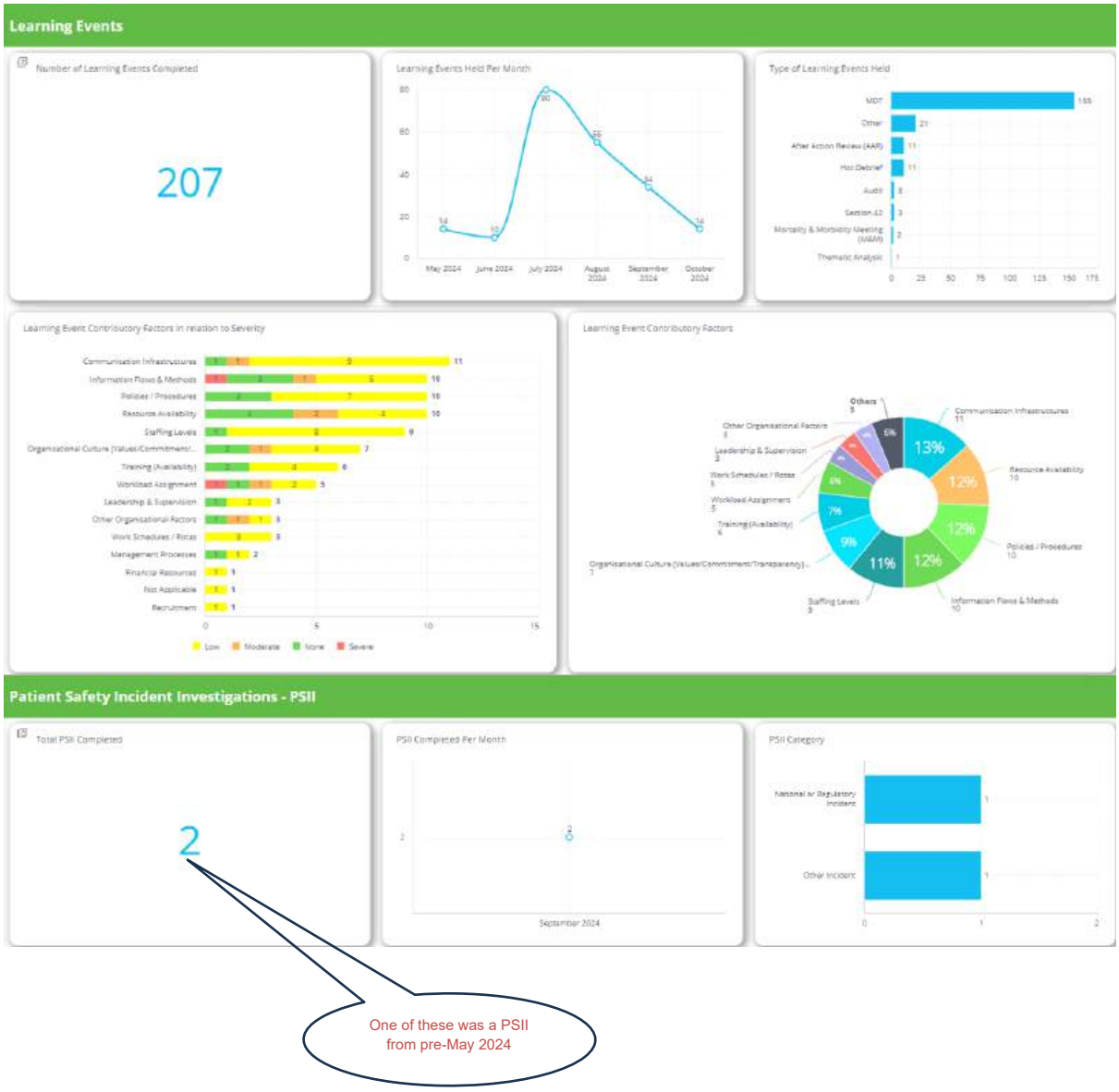
Other level 2 response types can be considered such as audit, tabletop exercises, observational studies, and local learning forums.

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)

Appendix 5 – Examples of Trustwide Overview of Divisional Dashboard (data from 01 May 2024 – 31 October 2024)





One of these was a PSII from pre-May 2024

Appendix 6 – Examples of PSIRF Dashboard (data from 01 May 2024 – 31 October 2024)

Appendix 7 – M&M Outcome Summary September – October 2024

KEY LEARNING

EFFECTIVE COMMUNICATION:

- IMPROVE DIALOGUE BETWEEN RESIDENT DOCTORS & SPECIALTY TEAMS, ESPECIALLY REGARDING PATIENT CONCERNS.
- ENSURE CLEAR HANDOVERS & THOROUGH DOCUMENTATION WHEN TRANSFERRING PATIENTS BETWEEN SPECIALTIES.

POST-OPERATIVE VIGILANCE:

- MONITOR THE TIMING OF RYLE'S TUBE REMOVAL & ENSURE PATIENTS WITH SWALLOWING DIFFICULTIES RECEIVE FOOD & MEDICATIONS UPRIGHT.

AUDITS AND GUIDELINES:

- CONDUCT REGULAR AUDITS ON STEROID USE IN SEPSIS & MANAGEMENT OF PERIANAL SEPSIS.
- FOLLOW ESTABLISHED GUIDELINES FOR DVT & VTE PROPHYLAXIS, SEDATION PRACTICES & ANTIBIOTIC PRESCRIBING.

ACCURATE DOCUMENTATION:

- DOCUMENT SEPSIS DIAGNOSES CLEARLY & MAINTAIN UP-TO-DATE PATIENT INFORMATION, INCLUDING NEXT OF KIN DETAILS.

MULTIDISCIPLINARY CARE:

- INVOLVE MULTIPLE SPECIALTIES IN ADVANCED CARE PLANNING FOR PATIENTS WITH COMPLEX CONDITIONS & ENSURE COORDINATED END-OF-LIFE CARE.

EDUCATION AND TRAINING:

- PROVIDE TRAINING ON PERIANAL ABSCESS MANAGEMENT, ANTICOAGULATION USE & DELIRIUM ASSESSMENT IN ELDERLY PATIENTS.

MEDICATION SAFETY:

- PRESCRIBE ANTIBIOTICS ACCORDING TO GUIDELINES & REVIEW MEDICATION RISKS, ESPECIALLY FOR PATIENTS WITH CHRONIC KIDNEY DISEASE.

PROACTIVE RISK MANAGEMENT:

- DISCUSS ABNORMAL IMAGING FINDINGS WITH RELEVANT SPECIALTY TEAMS WITHOUT DELAY & UTILISE EEGS (ELECTROENCEPHALOGRAM) FOR PROGNOSTIC GUIDANCE.

Appendix 8 – Visual Inquiry Images

6. Choose an image that best portrays how being part of the learning event/workshop/training made YOU feel? *

◯ Option 2

◯ Option 3

◯ Option 4

◯ Option 1

◯ Option 5

◯ Option 6

◯ Option 7

◯ Option 8

Meeting title	Trust Board in Public	Date: 14 November 2024
Report title:	Mortality Update	Agenda item: 9
Lead director Report author Sponsor(s)	Dr Ian Reckless Dr Nikolaos Makris	Medical Director Associate Medical Director
FoI status:	Publicly disclosable	

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

Report history	Periodic updates

Executive Summary

The Trust's mortality indices, including unadjusted mortality rate, HSMR, SHMI, and in-hospital SHMI remain in the mid-range compared to national peers.
There has been a fall in HSMR over the last year, which has converged on the national average value of 90.6. The picture with SHMI is more unstable, with a noticeable jump in SHMI value in the last quarter to 111.6, compared to a national average of 100. The overall value remains in the mid-range. This instability is due to changes in the way SDEC attendances have been recorded, discussed in more detail in the quantitative mortality review section.

The Medical Examiners' Office now scrutinises all Trust, hospice and community deaths in the Milton Keynes area. National changes to the process for certification and registration of deaths came into force on 9th September 2024. A weblink to the summary of changes is included in Appendix 4.
The increase in the number of Structured Judgement Reviews (SJRs) requested by the MEO in the last year has continued, reflecting a Trust wide decision to scrutinise all deaths where sepsis contributed to the death. There is no signal from either quantitative or qualitative data that the Trust is an outlier for sepsis care.
SJRs are now completed on a single Trust database, the Clinical Outcomes Review System (CORS), allowing audit of completion and outcomes and sharing of learning. A screenshot of the dashboard is included in appendix 3.

Main Report:

Quantitative data relating to mortality

Crude mortality data are shown in **Appendix 2a**.
HSMR data (supplied by CHKS) covering the 12-month period to July 2024 are shown in **Appendices 2a and 2b**.
SHMI data (supplied by NHS Digital / CHKS) covering the 12-month period to April 2024 are shown in **Appendices 2a and 2c**.

The Trust receives its Mortality data from CHKS in the form of crude (unadjusted) mortality rates and mortality indices such as HSMR, SHMI and in-hospital SHMI. Each uses their own methodology for adjusting raw outcome data to adjust for factors such as patient demographics and admission diagnosis. Mortality rates and indices are affected by several factors, some of which are given below:

- **Palliative care coding is in the mid-range** compared to the national peer position. 47.6% of all deaths included a palliative care code compared to the national average of 43.9%. Patients recorded as being managed under palliative care will have a higher expected mortality than those which are not. Palliative care coding is factored in when calculating HSMR but not SHMI.
- **Coding depth is in line with the peer position**, with an average of 7.1 diagnoses per Finished Consultant Episode (FCE) exactly matching the national average.
- **Sign or symptom' coding** (where signs or symptoms rather than an actual diagnosis are associated with the patient's episode of care) **is in the mid-range** compared to the peer position, with 9.9% of admissions having a sign or symptom as a primary diagnosis compared to the national average of 9.2%.
- The recording of **'zero-day length of stay admissions via the Emergency Department'** has seen more variability in its recording compared to the national average over the last 2 years than any other measure. While it is currently in the 'mid-range,' the Trust value has been both 'first-' and 'fourth quartile' in the last two years. This is due to changes in clinical practice, with more patients seen in the Maple Unit and changes in the method of recording attendances.

Lack of national guidance on the recording of these episodes resulted in local agreements between providers and commissioners as to how attendances at Same Day Emergency Care (SDEC) units were documented. This caused widespread variation in practice. At MKUH, SDEC attendances were initially recorded as hospital admissions for clinical coding purposes but were converted to outpatient appointments, where hospital admission did not follow the attendance, for financial accounting purposes.
This was changed in October 2023 when it became apparent that this practice was skewing admissions data due to inadvertent double-counting of some admissions. As a result, there was a significant fall in the number of apparent admissions, adversely affecting mortality indices, particularly SHMI.
A national mandate for recording of SDEC attendances according to a new methodology was issued by NHS England on 2nd September 2024. This results in SDEC admissions being coded as either ECDS type 5 or 6 activity (depending on attendance type) across the NHS. This standardises the coding methodology and should as a result, improve the validity of data for comparison of activity, including mortality analysis. These changes will not apply retrospectively, meaning it will take 12-18 months for the historical data to 'wash out' of the system.

Subset analysis of HSMR or SHMI (based on the '56 diagnostic baskets' making up HSMR, or 142 diagnostic groups making up SHMI) does intermittently flag outlier status. Any outlier flags are reviewed and discussed at the Mortality Review Group and SJRs are requested for deaths in that diagnostic category. There is currently only one 'high value' alert in the HSMR data, for the diagnostic category of 'chronic renal failure,' which saw 2 deaths in the last year compared to a statistically expected value of 1.39. No concerns were raised in the care of either of these patients.

Qualitative data relating to mortality

All deaths undergo review through the Medical Examiner system, which commenced operation on a statutory basis for all community and hospital deaths on 9th September 2024.
Key changes to practice include an updated Medical Certificate of Cause of Death (MCCD), the removal of the 28-day cut-off for practitioners to see the patient prior to death and the merging of death certification and cremation documentation.
Its introduction last month has influenced working in the Medical Examiners' Office, with an increase in workload relating to certification of community deaths and unfamiliarity of some attending practitioners with the new system. Data for the last 15 months are illustrated in **Appendix 3.**
The system offers a point of contact for bereaved families or clinical teams to raise concerns about care prior to the death. Concerns can also be raised by the Medical Examiner following review of the medical record. Deaths with concerns regarding avoidability then undergo a formal Structured Judgement Review (SJR).
SJRs are carried out by trained reviewers who look at the medical records in a critical manner and comment on specified phases of care. The output of the SJR is presented at Mortality and Morbidity (M&M) Meetings. If a death is deemed avoidable a second SJR is carried out at which point the case will be graded with an 'avoidability' score. The second SJR form concludes with key learning messages from the case and actions to be taken. In the last quarter, no SJR2s were requested and 8 SJRs revealed evidence of care that was 'adequate' rather than good or 'slight evidence of 'avoidability'.
Learning from cases discussed is summarised on an M&M outcomes form and collated by the Patient Safety Team for Trust wide dissemination. Examples of excellent practice, key learning and QI ideas are shared with other departments. An example of a recent M&M outcome form is shown in Appendix

Appendix 1

Definitions

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

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

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

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

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

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

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

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

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

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

Appendix 2a

Summary Mortality Data

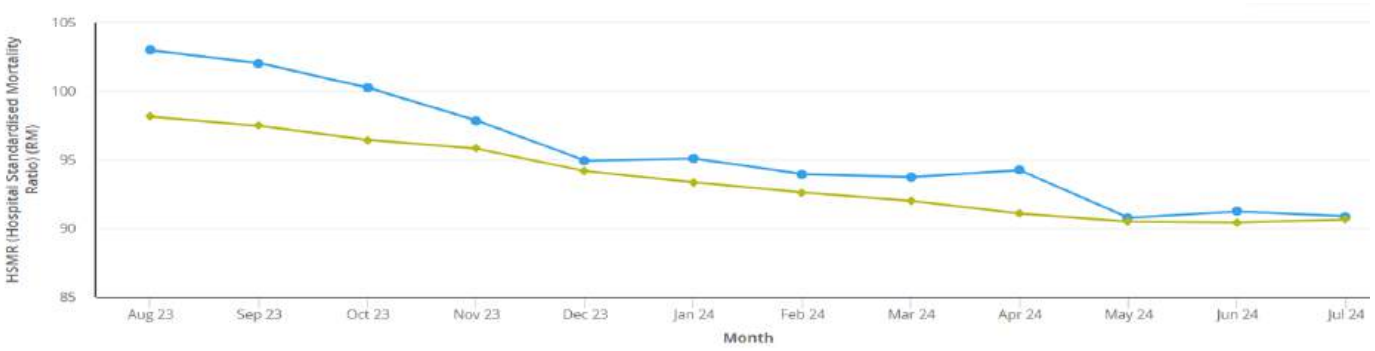
Metric	Period	Previous	Latest	National Peer	Variance	*Status*
HSMR	R12M to Jul-24	91.3	90.9	90.6	0.2	*'Mid-range'*
SHMI	R12M to Apr-24	110.3	111.6	100.0	11.6	*'As expected'*
SHMI - In Hospital	R12M to Jul-24	71.4	72.1	67.4	4.8	*'Mid-range'*
Mortality Rate %	R12M to Jul-24	1.22	1.23	1.16	0.07	*'Mid-range'*
Sepsis: In Hospital Mortality - primary diagnosis	R12M to Jul-24	16.5%	16.5%	17.9%	-1.5%	*'Mid-range'*
Sepsis: In Hospital Mortality - any diagnosis	R12M to Jul-24	23.4%	22.3%	20.6%	1.7%	*'Mid-range'*
FCEs with palliative care code Z515	R12M to Jul-24	1.7%	1.7%	1.4%	0.3%	*'Mid-range'*
Deaths with palliative care code Z515	R12M to Jul-24	46.6%	45.5%	44.2%	1.3%	*'Mid-range'*
Average Diagnoses per FCE	R12M to Jul-24	7.1	7.1	7.2	-0.09	*'Mid-range'*
Sign or symptom as a primary diagnosis	R12M to Jul-24	9.9%	9.8%	9.4%	0.4%	*'Mid-range'*
% 0 Length of Stay Admissions via A&E	R12M to Jul-24	28.3%	24.8%	32.5%	-7.7%	*'Mid-range'*
Readmissions within 30 days	R12M to Jul-24	10.2%	9.4%	8.4%	1.0%	*'Mid-range'*

Appendix 2b

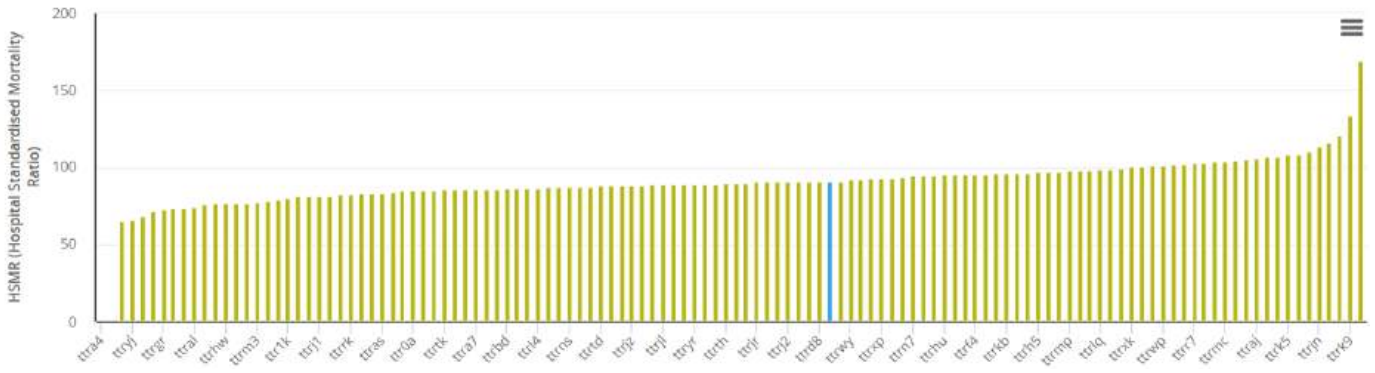
HSMR

HSMR	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Trust Monthly	88.8	97.9	87.6	82.7	91.7	92.7	87.6	92.6	97.5	79.4	108.4	86.5
Trust 12 month rolling	103.0	102.0	100.3	97.9	94.9	95.1	94.0	93.7	94.2	90.8	91.2	90.9
National Peer 12 month rolling	98.1	97.5	96.4	95.8	94.2	93.4	92.6	92.0	91.1	90.5	90.4	90.6
Variance from the national peer	4.8	4.6	3.8	2.1	0.8	1.7	1.3	1.7	3.2	0.3	0.8	0.2

HSMR, rolling 12 months



HSMR, national peer comparison



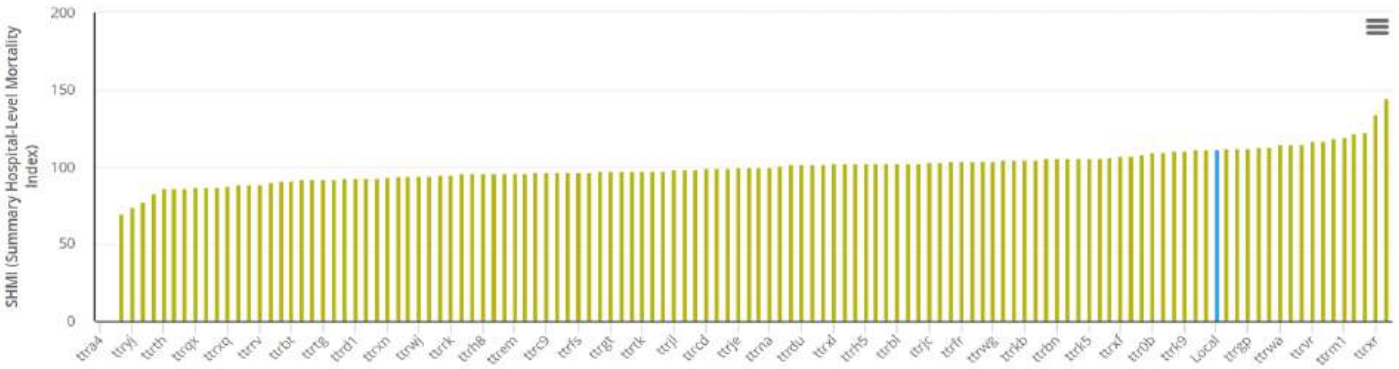
Appendix 2c

SHMI

SHMI	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Trust Monthly	121.1	118.2	121.7	119.2	102.2	98.7	104.3	103.5	109.5	114.4	115.3	117.8
Trust 12 month rolling	102.3	103.6	103.9	104.8	103.8	102.1	102.0	102.0	104.9	108.5	110.3	111.6
National Peer 12 month rolling	100.4	100.6	100.2	100.1	100.2	100.1	100.3	99.5	99.5	99.8	99.9	100.0
Variance from the national peer	0.5	0.4	-1.6	-1.1	-0.9	-1.3	-1.3	-3.7	-7.0	-8.8	-8.8	11.6

SHMI, monthly

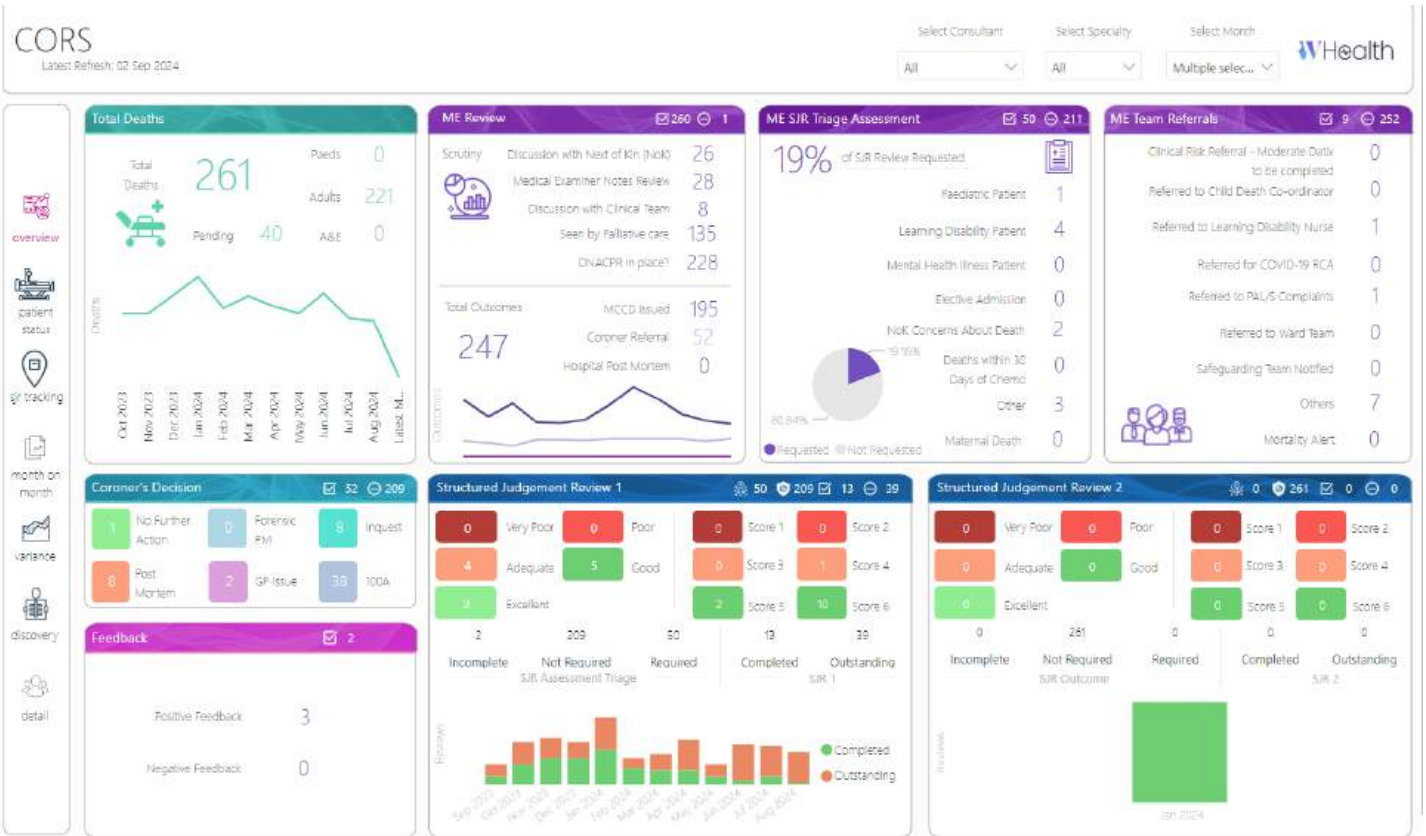
SHMI, National peer comparison



Appendix 3

Medical Examiners' Office Activity	Q1 Apr-Jun 2023	Q2 Jul-Sep 2023	Q3 Oct-Dec 2023	Q4 Jan-Mar 2024	Q1 Apr-Jun 2024
Number of deaths	230	222	252	294	261
Number of SJRs Requested by Medical Examiner	28	38	63	50	49
% Deaths in which SJR requested	12.2%	17.1%	25%	17.7%	21.4%
Cases taken for investigation by the coroner following referral (% of total deaths)	9.1%	13.9%	9.1%	9.5%	6.5%
Cases in which MCCD (Form A) completed after discussion with Coroner (% of total deaths)	12.6%	15.3%	16.1%	13.2%	15.7%
% (Number) of Urgent Release completed paperwork within 24hours †	100% (4/4)	100% (5/5)	100% (3/3)	80% (4/5)	100% (5/5)
MCCD completion within 3 days	91.3%	90.1%	79.5%	82.0%	83%
Number of Relatives directed to PALS	8	11	3	15	9
Number of MCCDs rejected after Medical Examiner scrutiny	4	3	6	3	4
Deaths of people with Mental Health or Learning Disability diagnoses	1	0	4	3	4

Clinical Outcomes Review System Dashboard

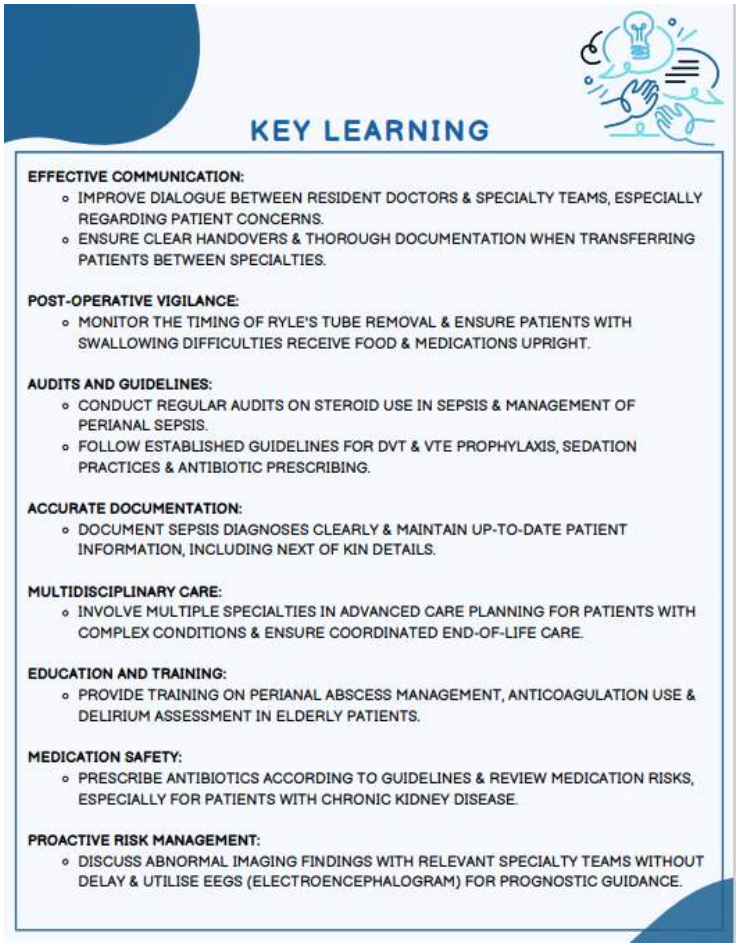


Appendix 4

Summary of changes in death certification

https://www.gov.uk/government/publications/changes-to-the-death-certification-process/an-overview-of-the-death-certification-reforms#:~:text=This%20page%20summarises%20the%20death%20certification%20reforms%20planned%20from%209#:~:text=This%20page%20summarises%20the%20death%20certification%20reforms%20planned%20from%209

Morbidity and Mortality Outcomes Summary Form



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TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 14 November 2024

Maternity Assurance Group Update

Fiona Hoskins
Chief Nursing Officer

Verbal/Discuss

Meeting Title	Trust Board in Public	**Date: 14 November 2024**
Report Title	Milton Keynes University Hospital Midwifery Workforce update 6 monthly report	**Agenda Item Number: 10**
Lead Director		
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. The data on the PWR has been improved but there are still data issues with midwives in trust to midwifery within the maternity services. A recruitment trajectory has been included in the paper which will reduce the vacancy by October 2024 to 0.45%. An increase of 0.20 from the predicated April midwifery staffing paper. 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 past 6 months supernumerary status of the Labour ward coordinator of 100%. The suggested level of compliance with BR+ is over 85% is majority achieved on the labour ward within this period but not currently achieved over this period in inpatient areas. A roster rebuild and establishment review has improved staffing numbers across the service, a budget alinement has been sent for review. Birth rate plus is currently underway to meet MIS requirements with a expected report in February 2025.		
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Review** [ ]

Strategic Objectives Links	1. *Keeping you safe in our hospital* 2. *Improving your experience of care*

(Please delete the objectives that are not relevant to the report)	*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	Executive Directors/Strategic Command
Next Steps	• The Trust will continue with current recruitment strategy, to improve the overall staffing position in line with BR+. • The division have submitted a proposed solution for consideration with trust executive boards for 2024/2025 FY. • Complete the BR+ assessment for 2024 in line with MIS requirements. • Other areas of focus need to be: Sustain data quality improvement 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 with key focus on Ward 9 and 10. Regular monitoring and review of fill rates as roster builds are now completed to be reported through CSU maternity and divisional forums. Regular monitoring and review identifying areas of improvement that impact fill rates such as sickness rates and non-compliance to meet KPI in relation to roster management. Monitor recruitment to ensure that it remains on Trajectory and employ strategy as detailed in the maternity service workforce plan relating to midwifery staffing.
Appendices/Attachments	

Milton Keynes University Hospital Midwifery Workforce update

1 Context

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

1.2 The data reported is partial based on the trust PWR data due to data errors that still require resolve and recruitment and staffing data that is held within the division. The report also provides the projection of recruitment in the next six months.

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

1.4 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.
- Next steps and actions relating to the midwifery workforce at MKUH

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 identified within the 23/24 PWR data set are resolved.

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. This has now been addressed with the band 8a and 8b being included in the PWR under midwifery.

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 was an increase in the midwifery establishment in line with the BR+ report. The funded establishment for 24/25 in table one includes all the 8a and 8b posts. It does not include the Divisional Chief Midwife
2.5 Roster builds have undergone a full review and are now aligned with allocation requirements within the clinical areas. Budget realignment to be completed paper submitted.

2.6 Rosters are built on the shift patterns worked within the clinical areas for example Long Days and Nights. If required, there is the ability to split demand incorporating flexible working agreements.

2.7 The rebuild of the roster has supported the increase of allocated midwifery hours for elective LSCS (lower segment caesarean section) activity to support theatre efficiency, as well as hours for the NIPE (Newborn Infant Physical Examination) screening programme to support the capacity and flow within the maternity service.

2.8 The data quality in relation to fill rates has improved, however the roster build has seen a decrease within the fill rate due to the increase in shift numbers per clinical area. Antenatal clinic and specialist roles such as diabetic midwives have been merged on to one roster.

2.9 Community roster still requires manual fill rate calculation.

3 Vacancy

3.1 In September 2024 the midwifery vacancy was 8.1% as tabled below:

Table 2

Band	Establishment	In post	Vacancy	Comments
8b / 8a	8	7.8	0.2	Failed recruitment x2 of 8b currently support interim 8a post within governance role – 8b back out to recruitment. 0.2 flexible working support for 1 year
7	40.28	38.04	2.24	2 vacant posts(PMA and Preceptorship Lead) current out for recruitment 3 Secondment positions s (Antenatal & Newborn Screening / Learning Environment and Audit & Guidelines Leas) to backfill for maternity leave
5/6	115.21	106.05	9.16	
Total	**163.49 (164.49 including fixed term)**	**151.89 (152.89 including fixed term)**	**11.60**	

3.2 The band 8a and 8b have now been correctly coded on the PWR.

4 Provider Workforce Return Review

4.1 The total number of midwives recorded within the Maternity Workforce Programme Trust View are not reflective of the current midwives in post at MKUH. This is under review with the regional team and the trust Finance Team to ensure consistent quality data relating to maternity PWR data. There is consistent error in the coding of registered midwives working outside of Maternity Services but with the trust.

5 Recruitment Trajectory

5.1 Recruitment is continuously underway, and it is forecast that at least 11.75WTE midwives will start in post before the end of January 2025 (See Table 3)

Table 3

Estimated timeline	Starters	Leavers	Vacancy 5-8b	Comments
August		1.0	11.60	Specialist Lead PMA role vacant – promotion within another NHS Trust.
September		0	12.60	
October	1.8	1.0	9.8	Preceptors due to commence in October. Specialist Retention Lead Midwife left October 2024.
November	7.35		2.45	Preceptors due to commence – start dates agreed. There is a reduction in expected WTE due to failure to qualify.
December		1.6	4.05	Not returning from maternity leave – moved to another NHS Trust due to relocation.
January	3.6		0.45	Preceptors to commence +0.20 above expected vacancy from April staffing trajectory.

5.2 The forecast leavers are 3.6 WTE (band 5-7) E before the end of January 2025.

5.3 Due to unsuccessful recruitment to the band 8b, there is currently an interim 8a in post to support governance.

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 4, for the past six months compliance has been achieved at 100% as defined in the guidance – MIS compliant – The midwifery coordinator in charge of labour

ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift).

Table 4

Month	% Supernumerary (Labour ward coordinator)
April	100
May	100
June	100
July	100
August	100
September	100

6.4 The RAG rating for acuity on the labour ward is detailed in Table 5. The RAG rating within BR+ is classified as: **Red** – 2 or more midwives short, **Amber –** up to 2 midwives short, **Green** – Meets acuity.

Table 5

Month	Red %	Amber %	Green %
April	2	32	66
May	3	15	83
June	2	31	68
July	0	27	73
August	3	33	64
September	6	32	62

6.5 The compliance with completing the BR+ acuity tool for Maternity Inpatient Services is detailed in table 6. Due to development work being undertaken by the BR+ team, historical reporting for the ward areas was limited to daily views.

Table 6

Month	Labour ward	Ward 9	Ward 10
April	87.22	20.83	[redacted]
May	83.87	24.19	
June	87.22	31.67	
July	86.56	29.03	
August	87.10	23.39	8.06
September	82.78	28.33	7.50

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 not achieved this threshold twice in the 6 months.

6.7 Compliance within the ward setting remains below the 85% requirement to ensure confidence in the data.

6.8 Compliance in the completion of the BR+ acuity tool is required within the inpatient settings now that the tool is now functional as this remains below 31.67%.

6.8 The three-year review of BR+ is due to be commenced in October 2024 to ensure that the maternity service has maintained full birthrate plus assessment.

7 Asks of the Board or of members present

The board is requested to take assurance

8 Next Steps

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

8.2 The division have submitted a proposed solution for consideration with trust executive boards for 2024/2025 FY.

8.3 Complete the BR+ assessment for 2024 in line with MIS requirements.

8.4 Other areas of focus need to be:

- Sustain data quality improvement 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 with key focus on Ward 9 and 10.
- Regular monitoring and review of fill rates as roster builds are now completed to be reported through CSU maternity and divisional forums. .
- Regular monitoring and review identifying areas of improvement that impact fill rates such as sickness rates and non-compliance to meet KPI in relation to roster management.
- Monitor recruitment to ensure that it remains on Trajectory and employ strategy as detailed in the maternity service workforce plan relating to midwifery staffing.

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TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 14 November 2024

Annual Patient Experience Report

Kate Jarman
Chief Corporate Services Officer

Discuss

Meeting Title	Trust Board Meeting in Public	Date: 14 November 2024
Report Title	2024-25 Executive Summary M5	Agenda Item Number: 12
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 8,710 ED attendances in September 2024, an increase of 435 attendances compared to August 2024.
	- The percentage of attendances admitted, transferred, or discharged within 4 hours was 73.0%, the best performance this financial year to date.
	- 77.1% of ambulance handovers took less than 30 minutes in September 2024 and 95.9% took less than 60 minutes.
	
	Outpatient Transformation:
	- There were 39,346 outpatient attendances in September 2024.
	- 12.6% of these appointments were attended virtually and 6.9% of patients did not attend.
	
	Elective Recovery:
	- There were 2,709 elective spells in September 2024.
	- At the end of September 2024, 37,198 patients were on an open RTT pathway:
	  ○ 688 patients were waiting more than 65 weeks.
	  ○ 113 patients were waiting over 78 weeks.
	- At the end of September 2024, 14,184 patients were waiting for a diagnostic test. Of these, 52.8% were waiting less than 6 weeks.
	
	Inpatients:
	- Overnight bed occupancy in adult G&A beds was 94.2% in September 2024.
	- A considerable proportion of beds were unavailable due to:
	  ○ 120 patients not meeting the criteria to reside.
	  ○ 122 super stranded patients (length of stay 21 days or more).
	
	Human Resources:
	- In September 2024:
	  ○ Substantive staff turnover was 13.1%.
	  ○ Agency expenditure remained well below the threshold of 5%, at 3.3%.
	  ○ Appraisals was 93% and mandatory training was 95%.
	
	Patient Safety:
	- In September 2024, the following infections were reported:
	  ○ E-Coli: 3
	  ○ C.Diff: 2
	  ○ MSSA: 2
	  ○ Klebsiella Spp bacteraemia: 1
	  ○ MRSA bacteraemia: 1

Recommendation *(Tick the relevant box(es))*	For Information	x	For Approval		For Assurance	

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

TheMKWay

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Trust Performance Summary: M06 (September 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)	70.5%	95%
RTT Incomplete Pathways <18 weeks	92%	92%
RTT Patients waiting over 65 weeks	600	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

September 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%	70.5%	73.9%	73.0%	✓	▼	×	
RTT Incomplete Pathways <18 weeks	92.0%	92.0%		48.8%	×	▲		
RTT Patients waiting over 65 weeks (Total)	0	600		688	×	▲		
Diagnostic Waits <6 weeks	95.0%	95.0%		52.8%	×	▲		
62 day standard (Quarterly)	70.3%	65.9%		54.5%	×	▼		

The percentage of ED attendances that were admitted, transferred, or discharged within four hours was 73.0%. This was below the national performance of 74.2% but above the majority of the MKUH peer group (see Appendix 1).

The volume of open RTT pathways was 37,198, an increase of 4,876 compared to August 2024. Of this total, 688 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 Q1 2024/25, the 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) was 54.5% against a national target of 85%, declining from 58.7% in the previous quarter. The percentage of patients to begin cancer treatment within 31 days of a decision to treat decreased from 95.1% to 94.5%, below the national target of 96%. The 28 Day Faster Diagnosis performance was 68.8%, down from 72.9% in the previous quarter.

3.0 Urgent and Emergency Care

During September 2024, three of these indicators saw a month-on-month improvement:

Indicator	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Cancelled Ops - On Day	1%	1%	0.49%	0.90%	✓	▼	✓	
Ward Discharges by Midday	25%	25%	17.4%	17.3%	×	▼	×	
Patients not meeting Criteria to Reside	50			120	×	▼		
Number of Super Stranded Patients (LOS>=21 Days)	50			122	×	▼		
Ambulance Handovers <60 mins (%)	100%	100%	96.5%	95.9%	×	▼	×	

Cancelled Operations on the Day

In September 2024, 27 operations were cancelled on the day for non-clinical reasons. The majority were due to insufficient time and staff availability.

Patients not Meeting Criteria to Reside

The number of inpatients not meeting the criteria to reside at the end of September 2024 was 120 against a threshold of 50. This was a notable increase compared to 87 reported last month.

Length of Stay (Stranded and Super Stranded Patients)

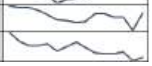
The number of super stranded patients (e.g. length of stay of 21 days or more) at the end of the month was 122, remaining consistent with August 2024.

Ambulance Handovers

In September 2024, the percentage of ambulance handovers to the Emergency Department taking less than 30 minutes was 77.1%. This was a reduction in performance compared to 81.4% in the previous month.

The percentage of ambulance handovers to the Emergency Department taking less than 60 minutes was 95.9%. This was a decline in performance compared to 96.9% 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%	95.4%	92.5%	94.2%	✓	▼	✓	
RTT Incomplete Pathways <18 weeks	92.0%	92.0%		43.8%	✗	▲		
RTT Total Open Pathways (inluding ASIs)	32,549	33,892		37,198	✗	▼		
Diagnostic Waits <6 weeks	95.0%	95.0%		52.8%	✗	▲		

Overnight Bed Occupancy

Overnight bed occupancy was 94.2% in September 2024, below the threshold of 95.4.

RTT Incomplete Pathways

The Trust's RTT 18 week performance at the end of September 2024 was 43.8% and the number of patients waiting over 65 weeks was 688. Total RTT open pathways was 37,198.

Diagnostic Waits <6 weeks

At the end of September 2024, performance was 52.8%, the second lowest month this financial year to date but an improvement from 50.5% from last month.

5.0 Patient Safety

Infection Control

In September 2024, the following infections were reported:

Infection	Number of Infections
E-Coli	3
C.Diff	2
MSSA	2
Klebsiella Spp bacteraemia	1
MRSA bacteraemia	1
P. aeruginosa 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:

July 2024 to September 2024 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	July-24	August-24	September-24
Homerton Healthcare NHS Foundation Trust	86.9%	87.1%	83.0%
Mersey and West Lancashire Teaching Hospital NHS Trust (Formerly Southport and Ormskirk)	74.5%	76.4%	74.3%
Oxford University Hospitals NHS Foundation Trust	78.7%	76.1%	73.1%
Milton Keynes University Hospital NHS Foundation Trust	75.1%	77.7%	73.0%
Northampton General Hospital NHS Trust	75.0%	73.0%	71.6%
Buckinghamshire Healthcare NHS Trust	72.6%	76.5%	70.7%
North Middlesex University Hospital NHS Trust	68.4%	69.4%	70.1%
The Hillingdon Hospitals NHS Foundation Trust	71.6%	71.9%	69.0%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	71.9%	70.6%	65.2%
Barnsley Hospital NHS Foundation Trust	71.4%	77.8%	64.1%
The Princess Alexandra Hospital NHS Trust	63.0%	63.1%	62.6%
Mid Cheshire Hospitals NHS Foundation Trust	63.4%	61.5%	60.4%

Board Performance Report 2024/25
September 2024 (M06)

Milton Keynes University Hospital NHS Foundation Trust

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) ★		90.6	90.6		90.9	✗	▲		
Mortality - (SHMI)		100.0	100.0		111.2	✗	▲		
Never Events		0	0	1	0	✓	▲	✗	
Clostridium Difficile		47	<24	16	2	✓	▬	✓	
MRSA bacteraemia (avoidable)		0	0	2	1	✗	▼	✗	
Falls with harm (per 1,000 bed days)		0.12	0.12	0.12	0.00	✓	▲	✓	
Incident Rate (per 1,000 bed days)		60	60	54.87	57.87	✗	▲	✗	
Duty of Candour Breaches (Quarterly)		0	0	1	1	✗	▼	✗	
E-Coli		57	<29	9	3	✓	▼	✓	
MSSA		17	<9	5	2	✗	▼	✓	
VTE Assessment		95%	95%	97.3%	97.5%	✓	▲	✓	
Klebsiella Spp bacteraemia		17	<9	10	1	✓	▬	✗	
P.aeruginosa bacteraemia		10	5	1	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%	58.8%	63.2%	✗	▼	✗	
Cancelled Ops - On Day		1%	1%	0.49%	0.90%	✓	▼	✓	
Over 75s Ward Moves at Night		1,500	750	809	123	✓	▲	✗	

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%	95.4%	92.5%	94.2%	✓	▼	✓	
Ward Discharges by Midday		25%	25%	17.4%	17.3%	✗	▼	✗	
Weekend Discharges		63%	63%	60.5%	59.2%	✗	▼	✗	
Patients not meeting Criteria to Reside		50			120	✗	▼		
Number of Stranded Patients (LOS>=7 Days)		184			258	✗	▲		
Number of Super Stranded Patients (LOS>=21 Days)		50			122	✗	▼		
Discharges from PDU (%)		12.5%	12.5%	10.5%	10.4%	✗	▲	✗	
Ambulance Handovers <30 mins (%)		95%	95%	78.8%	77.1%	✗	▼	✗	
Ambulance Handovers <60 mins (%)		100%	100%	96.5%	95.9%	✗	▼	✗	

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%	70.5%	73.9%	73.0%	✓	▼	✗	
Total time in ED no more than 12 hours		95%	95%	94.9%	94.9%	✗	▼	✗	
Triage within 15 Minutes		90%	90%	69.4%	66.3%	✗	▼	✗	
RTT Incomplete Pathways <18 weeks		92.0%	92.0%		43.8%	✗	▲		
RTT Total Open Pathways (inluding ASIs)		32,549	33,892		37,198	✗	▼		
Open AFBs					1,979		▲		
Referrals Waiting for Triage					3,204		▲		
RTT Patients waiting over 65 weeks (Total)		0	600		688	✗	▲		
RTT Patients waiting over 65 weeks - Non-Admitted					457		▲		
RTT Patients waiting over 65 weeks - Admitted					231		▲		
RTT Patients waiting over 78 weeks (Total)		0	0		113	✗	▼		
Diagnostic Waits <6 weeks		95.0%	95.0%		52.8%	✗	▲		
31 days Diagnosis to Treatment (Quarterly)		96.0%	96.0%		94.5%	✗	▼		
62 day standard (Quarterly)		70.3%	65.9%		54.5%	✗	▼		
28 Day Faster Diagnosis (Quarterly)		78.0%	75.8%		68.8%	✗	▼		

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		103,994	14,503	Not Available	▼	Not Available	
Total ASIs		0	0		518	✗	▼		
Total RTT Non-Admitted Open Pathways					31,903		▼		
Total RTT Admitted Open Pathways					5,295		▲		
A&E Attendances		101,918	50,475	52,345	8,689	✗	▼	✗	
Elective Spells		26,032	12,343	15,054	2,709	✓	▲	✓	
Non-Elective Spells		28,831	14,010	15,145	2,529	✗	▲	✗	
OP Attendances / Procs (Total)		443,414	214,898	231,289	39,346	✓	▲	✓	
Outpatient DNA Rate		5%	5%	7.3%	6.9%	✗	▲	✗	
Virtual Outpatient Activity		25%	25%	13.4%	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	193,834	198,890	34,072	✓	▲	✓	
Pay £'000		(246,892)	(123,820)	(127,259)	(20,760)	✗	▲	✗	
Non-pay £'000		(115,359)	(60,961)	(64,467)	(10,900)	✗	▲	✗	
Non-operating costs £'000		(30,997)	(13,140)	(11,800)	(1,981)	✓	▼	✓	
I&E Total £'000		0	(4,087)	(4,635)	431	✗	▲	✗	
Cash Balance £'000			18,089		15,252	✗	▲		
Savings Delivered £'000		23,822	11,910	9,769	2,813	✓	▼	✗	
Capital Expenditure £'000		(28,670)	(11,916)	(11,766)	(2,738)	✗	▲	✗	
Elective Spells (% of 2019/20 performance)		130%	130%	118.1%	125.4%	✗	▲	✗	
OP Attendances (% of 2019/20 performance)		130%	130%	116.1%	121.8%	✗	▲	✗	

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%		7.1%	✓	▼		
Agency Expenditure %		5.0%	5.0%	3.7%	3.3%	✓	▲	✓	
Staff Sickness % - Days Lost (Rolling 12 months)		5.0%	5.0%		4.9%	✓	▼		
Appraisals (excluding doctors)		90%	90%		93.0%	✓	▲		
Statutory Mandatory training		90%	90%		95.0%	✓	▬		
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		7	✓	▼		
Rebooked cancelled OPs - 28 day rule		90%	90%	87.7%	89.5%	✗	▲	✗	
Overdue Incidents >1 month		Not Available			83		▲		
Serious Incidents		40	<20	11	1	✓	▲	✓	

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.

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NHS
Milton Keynes University Hospital
NHS Foundation Trust

Meeting Title	**Public Board Meeting**	**Date: 14th November 2024**
Report Title	**Finance Paper Month 6 2024-25**	**Agenda Item Number: 13**
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 6 (Sep 2024).		
Key Messages to Note	The Trust is reporting a deficit position of £4.6m (on a Control Total basis) to the end of the September, adverse to plan by £0.6m. Positively the in-month position is a surplus of £0.4m (adverse to plan by £0.3m). Elective Recovery Fund (ERF) performance is 136% above pre-Covid levels which is above the 106% national target and our internal budget target of 124%, with income showing £8.8m above the national target as at M06 resulting in a favourable income variance to plan of £3.3m. The Trust has a challenging financial plan this year which includes a savings target of 6% (£23.8m). £9.8m has been achieved to date against a year-to-date plan of £11.9m.		
Recommendation *Tick the relevant box(es)*	**For Information** ☐	**For Approval** ☐	**For Assurance** [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 7-10

FINANCE REPORT FOR THE MONTH TO 30th SEPTEMBER 2024

TRUST BOAD MEETING

CONTENTS

EXECUTIVE SUMMARY

Measures

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	30,003	31,641	1,637	180,014	185,802	5,788	361,218	361,218	-	
2	Other Revenue	2,111	2,431	320	13,580	18,096	4,516	31,662	31,662	-	
3	Pay	(20,641)	(20,760)	(120)	(123,899)	(127,259)	(3,361)	(247,157)	(247,157)	-	
4	Non Pay	(8,728)	(10,900)	(2,172)	(60,882)	(64,466)	(3,585)	(115,206)	(115,206)	-	
5	Financing & Non-Ops	(2,068)	(2,032)	36	(12,343)	(12,105)	238	(24,931)	(24,931)	-	
6	Surplus/(Deficit)	678	380	(298)	(3,530)	67	3,597	5,586	5,586	-	
7	Control Total Surplus/(Deficit)	736	431	(305)	(4,087)	(4,637)	(550)	-	-	-	

Memos

8	IA Cost	-	-	-	-	(153)	(153)	-	(153)	(153)	
9	High Cost Drugs	(2,077)	(2,161)	(84)	(12,560)	(14,267)	(1,707)	(25,096)	(25,096)	-	
10	Financial Efficiency	1,985	2,813	828	11,911	9,769	(2,142)	23,822	23,822	-	
11	Cash	15,042	15,252	210	15,042	15,252	210	12,356	12,356	-	
12	Capital Plan - CDEL (excluding donated)	(3,177)	(2,738)	439	(7,688)	(6,758)	930	(35,287)	(43,773)	(8,486)	

Key messages

The Trust is reporting a deficit position of £4.6m (on a Control Total basis) to the end of September 2024. This is adverse to plan by £0.6m.

At month 6 the Trust is behind its savings plan by £2.1m which is reflected in the pressure on the expenditure budgets.

ERF performance is currently above the 106% target, with income showing £8.8m above the national target as at M06 and £3.3m favourable to Plan. There is a risk relating to mandated coding changes which could impact the ERF position in the second half of the financial year.

The capital expenditure programme is £0.9m below plan, no risk has been identified to scheme expenditure at year-end.

(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 reduced in September and is partly offset by substantive vacancies. Non-pay is overspent with an overspend on drugs offset by income for high-cost drugs.

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

(8.) Industrial Action costs – Industrial action took place in June and July and costs were reflected in the month 3 position.

(10.) Financial Efficiency – £9.8m delivered against an annual target of £23.8m. This increases the year to date position by £2.8m in month with a significant number of schemes having been approved from a quality perspective.

(11.) Cash – Cash balance is £15.2m, equivalent to 14 days cash to cover operating expenses.

(12.) Capital – Capital expenditure is slightly below YTD plan due to the timing of capital schemes however the Trust is now forecasting above its original plan due to the approval of additional funding for the NHP enabling scheme for Imaging which was received during August

FORECAST

2. Forecast

The annual plan for 2024/25 is for a breakeven position. The phasing of the final submitted 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.

The Trust continues to forecast a breakeven position in line with plan. However, there are very clear risks to delivery of this, including the need to recover the adverse year to date position, need to ensure payment of additional ERF income, costs of approved RTT recovery investments, additional cost pressures from utility costs and, more generically, the risk of full delivery of planned efficiency savings. As would be expected, the Trust is ensuring all possible options to mitigate against these risks, and ensure plan delivery, are explored.

3. Risks to Plan Achievement
Industrial action cost and lost income, ongoing cost of escalation capacity, cost pressures from RTT recovery, winter pressures, financial efficiency slippage, ERF baseline adjustments, the impact of Emergency Data Set reporting on ERF achievement.

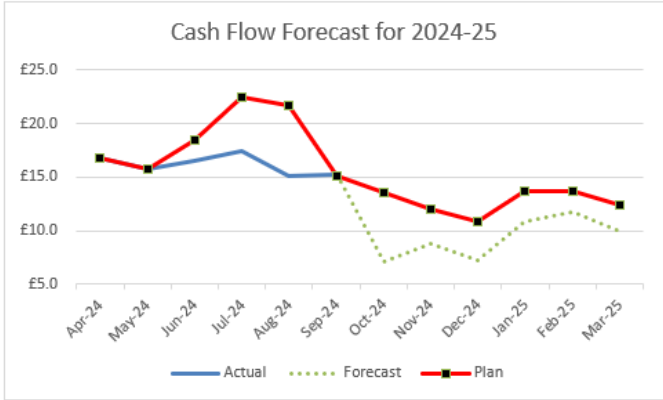
4. Opportunities to improve the Position
ERF income for additional elective work, funding for RTT plans, baseline adjustment for SDEC, recovery from community providers for delayed discharges and non-recurrent plan mitigation.

Key message
We have developed a mitigation plan to reach breakeven and this will continue to evolve. 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, as well as achieving additional ERF income to offset investment in RTT recovery.

CASH

5. Summary of Cash Flow

The cash balance at the end of September was £15.3m, £0.3m ahead of the planned figure of £15m, (due to the receipt of capital PDC offset by the delay in receipt of ERF income which was planned to have been received earlier in the year) and a £0.2m increase on last month's figure of £15.1m (see opposite). The increase in the month was caused by a £0.2m surplus in operating working capital



6. 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.

7. 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 M6 YTD Number	Actual M6 YTD £'000	Actual M5 YTD Number	Actual M5 YTD £'000
Non NHS				
Total bills paid in the year	31,499	112,116	26,651	93,375
Total bills paid within target	29,076	102,927	25,367	87,420
Percentage of bills paid within target	**92.3%**	**91.8%**	**95.2%**	**93.6%**
NHS				
Total bills paid in the year	1,141	5,305	996	4,318
Total bills paid within target	850	2,973	754	2,356
Percentage of bills paid within target	**74.5%**	**56.0%**	**75.7%**	**54.6%**
Total				
Total bills paid in the year	**32,640**	**117,421**	**27,647**	**97,693**
Total bills paid within target	**29,926**	**105,900**	**26,121**	**89,776**
Percentage of bills paid within target	**91.7%**	**90.2%**	**94.5%**	**91.9%**

Key message

Cash at the end of September was £0.3m ahead of plan, mostly due to the receipt of capital PDC offset by delayed receipt of ERF income. There was a month on month increase of 0.2m from August, due to an in-month working capital surplus.

BALANCE SHEET

8. 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 £3.1m; this is driven by a £5m increase in tangible assets, offset by a £1m decrease in the Right of Use assets, a £1m decrease in Intangible assets and a £0.1m decrease in other assets.
- Current assets have increased by £8m; this includes increases in other receivables of £13.3m (£11.2m increase in prepayments, offset by a £2.1 decrease in non-NHS debtors) and in NHS receivables of £6.6m, offset by a decrease in cash of £11.9m.
- Current liabilities have increased by £2.7m; this is due to the £3.1m increase in payables and £0.9m increase in deferred income, offset by the £0.7m decrease in Right of Use assets liability.
- Non-Current Liabilities have increased from March 24 by £0.4m; this is due to the Right of Use assets, related to IFRS 16.

9. Aged debt

- The debtors position as of September 24 is £4.5m, which is a decrease of £2.5m from the prior month. Of this total £1.1m is over 121 days old.

10. Creditors

- The creditors position as of September 24 is £12.8m, which is an increase of £1.2m from the prior month. £1.4m is over 30 days of ageing with £1.2m approved for payment.

Key message
Main movements in year on the statement of financial position are the reduction in cash of £11.9m, offset by increases in receivables of £19.9m and non-current assets £3.1m.

RECOMMENDATIONS TO BOARD OF DIRECTORS

11. The Board is asked to note the financial position of the Trust as of 30th September 2024 and the proposed actions and risks therein.

APPENDICIES

Appendix 1

Statement of Comprehensive Income
For the period ending 30th September 2024

	FY25	M6 CUMULATIVE			M6			PRIOR MONTH	
	Annual Budget £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	M5 Actual £'000	Change £'000
INCOME									
Outpatient First	33,734	16,217	16,621	404	2,574	2,487	(88)	(148) ▲	2,635
Outpatient Procedures	5,076	2,111	2,737	627	446	928	482	(150) ▲	1,078
Chemotherapy delivery	2,435	1,237	1,133	(104)	187	259	72	187 ▲	72
Day Case Admissions	21,187	10,081	12,326	2,245	1,763	2,170	408	1,652 ▲	519
Elecitve Admissions	16,653	7,698	7,962	264	1,369	1,530	160	1,093 ▲	437
High Cost Drugs & Devices	25,432	12,422	12,423	0	1,956	1,956	0	2,250 ▼	(294)
Total Variable Income	***104,518***	***49,765***	***53,202***	***3,437***	***8,296***	***9,330***	***1,034***	***4,884 ▲***	***4,447***
Outpatient Follow up	24,433	11,990	11,990	1	2,002	2,002	0	3,056 ▼	(1,054)
Emergency Admissions	92,550	45,518	45,532	14	7,559	7,569	11	7,096 ▲	473
A&E	20,484	10,145	10,145	0	1,708	1,708	(0)	1,639 ▲	70
Other Admissions	16,948	8,727	1,252	(7,476)	1,472	208	(1,263)	215 ▼	(6)
Maternity Other (Including Deliveries_	0	0	7,483	7,483	0	1,263	1,263	1,229 ▲	34
Maternity pahtway (ante/post natal)	9,026	4,654	4,658	4	753	753	0	739 ▲	14
Critical Care (adult)	4,164	1,933	1,931	(3)	359	359	(0)	445 ▼	(87)
Neonatal	3,728	1,793	1,793	(0)	315	315	(0)	291 ▲	24
Imaging	7,363	3,334	3,334	0	593	593	(0)	609 ▼	(16)
Direct Access Pathology	6,123	3,041	3,041	0	525	525	0	542 ▼	(17)
Best Practice Tariffs	627	305	305	(0)	53	53	(0)	50 ▲	3
Other block income	8,550	4,290	4,290	(0)	728	728	0	710 ▲	18
Total Block / Fixed Income	***193,996***	***95,730***	***95,754***	***23***	***16,067***	***16,077***	***10***	***16,621 ▼***	***(543)***
Non-recurent & additional income	0	2,131	4,460	2,329	247	840	593	5,073 ▼	(4,233)
National Block	62,704	32,387	32,387	(0)	5,393	5,393	(0)	5,399 ▼	(6)
Clinical Income	**361,218**	**180,014**	**185,802**	**5,788**	**30,003**	**31,641**	**1,637**	**31,976 ▼**	**(335)**
Non-Patient Income	25,256	12,674	13,087	413	2,111	2,431	320	2,031 ▲	400
Donations	6,293	905	5,008	4,103	0	0	0	0 ▲	0
Non-Patient Income	**31,550**	**13,580**	**18,096**	**4,516**	**2,111**	**2,431**	**320**	**2,031 ▲**	**400**
TOTAL INCOME	**392,768**	**193,593**	**203,898**	**10,304**	**32,115**	**34,072**	**1,957**	**34,008 ▲**	**64**
EXPENDITURE									
Pay - Substantive	(228,587)	(114,435)	(109,103)	5,332	(19,076)	(18,271)	806	(18,239) ▼	(32)
Pay - Bank	(10,361)	(5,157)	(9,902)	(4,745)	(859)	(1,641)	(781)	(1,718) ▲	77
Pay - Locum	(2,200)	(1,100)	(3,513)	(2,413)	(183)	(600)	(417)	(600) ▲	0
Pay - Agency	(5,045)	(2,779)	(4,761)	(1,982)	(450)	(691)	(241)	(880) ▲	189
Pay - Other	(942)	(471)	(508)	(37)	(78)	(86)	(7)	(83) ▼	(3)
Pay CIP	36	18	528	510	3	528	525	0 ▲	528
Vacancy Factor	50	25	0	(25)	4	0	(4)	0 ▲	0
Pay	**(247,049)**	**(123,899)**	**(127,259)**	**(3,361)**	**(20,641)**	**(20,760)**	**(120)**	**(21,519) ▲**	**759**
Non Pay	(90,106)	(48,322)	(50,199)	(1,878)	(8,651)	(8,739)	(2,088)	(8,851) ▲	112
Non Tariff Drugs (high cost/individual drugs)	(25,096)	(12,560)	(14,267)	(1,707)	(2,077)	(2,161)	(84)	(2,455) ▲	294
Non Pay	**(115,203)**	**(60,882)**	**(64,466)**	**(3,585)**	**(8,728)**	**(10,900)**	**(2,172)**	**(11,306) ▲**	**406**
TOTAL EXPENDITURE	**(362,251)**	**(184,780)**	**(191,726)**	**(6,946)**	**(29,368)**	**(31,660)**	**(2,292)**	**(32,825) ▲**	**1,165**
EARNINGS BEFORE INTEREST, TAXATION, DEPRECIATION AND AMORTISATION (EBITDA)	**30,517**	**8,813**	**12,172**	**3,359**	**2,746**	**2,412**	**(335)**	**1,182 ▲**	**1,229**
Interest Receivable	480	240	570	330	40	92	52	102 ▼	(10)
Interest Payable	(1,268)	(634)	(291)	343	(106)	(48)	57	(48) ▲	0
Depreciation, Impairments & Profit/Loss on Asset Disposal	(16,979)	(8,372)	(8,417)	(45)	(1,406)	(1,414)	(8)	(1,413) ▼	(1)
Donated Asset Depreciation	(707)	(348)	(304)	44	(58)	(51)	7	(51) ▼	(0)
Profit/Loss on Asset Disposal & Impairments	0	0	0	0	0	0	0	0 ▲	0
DEL Impairments	0	0	(348)	(348)	0	(58)	(58)	(58) ▲	0
AME Impairments	0	0	0	0	0	0	0	0 ▲	0
Unwinding of Discounts	0	0	0	0	0	0	0	0 ▲	0
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**12,044**	**(301)**	**3,382**	**3,683**	**1,216**	**933**	**(283)**	**(286) ▲**	**1,219**
Dividends Payable	(6,457)	(3,229)	(3,315)	(86)	(536)	(553)	(15)	(552) ▼	(1)
OPERATING SURPLUS/(DEFICIT) AFTER DIVIDENDS	**5,586**	**(3,530)**	**67**	**3,597**	**678**	**380**	**(298)**	**(838) ▲**	**1,218**

Statement of Cash Flow
As of 30th September 2024

	Mth12 2023-24 £000	Mth 6 £000	Mth 5 £000	In Month Movement £000
Cash flows from operating activities				
Operating (deficit)/surplus from continuing operations	13,970	3,451	2,503	(948)
Operating surplus/(deficit) of discontinued operations				
Operating (deficit)/surplus from continuing operations	**13,970**	**3,451**	**2,503**	**(948)**
Non-cash income and expense:				
Depreciation and amortisation	17,229	8,721	7,257	(1,464)
(Increase)/Decrease in Trade and Other Receivables	(3,720)	(20,009)	(12,143)	7,866
(Increase)/Decrease in Inventories	(127)	(1)	2	3
Increase/(Decrease) in Trade and Other Payables	544	5,124	(549)	(5,673)
Increase/(Decrease) in Other Liabilities	(6,967)	1,013	876	(137)
Increase/(Decrease) in Provisions	8,698	(661)	(118)	543
Income in respect of capital donations	(8,415)	(5,008)	0	5,008
Other movements in operating cash flows	891	(1)	0	1
NET CASH (USED IN) GENERATED FROM OPERATIONS	**22,103**	**(7,371)**	**(2,172)**	**5,199**
Cash flows from investing activities				
Interest received	1,399	570	478	(92)
Purchase of intangible assets	(425)	(66)	(66)	0
Purchase of Property, Plant and Equipment	(34,087)	(13,569)	(9,246)	4,323
Process from sale of Property, Plant and Equipment	252	0	0	0
Net cash (used in) investing activities	**(32,861)**	**(13,065)**	**(8,834)**	**4,231**
Cash flows from financing activities				
Public dividend capital received	11,039	7,918	0	(7,918)
Capital element of finance lease rental payments	(5,078)	(409)	(595)	(186)
Unwinding of discount	0	(348)	(290)	58
Interest element of finance lease	(680)	(291)	(242)	49
PDC Dividend paid	(5,725)	(3,398)	0	3398
Receipt of cash donations to purchase capital assets	8,415	5008	0	(5,008)
Cash flows from (used in) other financing activities	0	0	0	0
Net cash generated from/(used in) financing activities	**7,971**	**8,480**	**(1,127)**	**(9,607)**
(Decrease)/increase in cash and cash equivalents	**(2,787)**	**(11,956)**	**(12,133)**	**(177)**
Opening Cash and Cash equivalents	**27,208**	**27,208**	**27,208**	
Closing Cash and Cash equivalents	**27,208**	**15,252**	**15,075**	**(177)**

Appendix 3

Statement of Financial Position as of 30th September 2024

	Mar-24 Audited	Sep-24 YTD Actual	YTD Mvmt	% Variance
Assets Non-Current				
Tangible Assets	241.4	246.4	5.0	2.1%
Intangible Assets	16.6	15.6	(1.0)	(6.0%)
ROU Assets	18.6	17.6	(1.0)	(5.4%)
Other Assets	3.2	3.3	0.1	3.1%
Total Non Current Assets	**279.8**	**282.9**	**3.1**	**1.1%**
Assets Current				
Inventory	5.3	5.3	0.0	0.0%
NHS Receivables	12.0	18.6	6.6	55.0%
Other Receivables	7.5	20.8	13.3	177.3%
Cash	27.2	15.3	(11.9)	(43.8%)
Total Current Assets	**52.0**	**60.0**	**8.0**	**15.4%**
Liabilities Current				
Interest -bearing borrowings	(1.5)	(0.8)	0.7	(46.7%)
Deferred Income	(11.6)	(12.5)	(0.9)	7.8%
Provisions	(11.7)	(11.1)	0.6	(5.1%)
Trade & other Creditors (incl NHS)	(60.8)	(63.9)	(3.1)	5.1%
Total Current Liabilities	**(85.6)**	**(88.3)**	**(2.7)**	**3.2%**
Net current assets	**(33.6)**	**(28.3)**	**5.3**	**(15.8%)**
Liabilities Non-Current				
Long-term Interest bearing borrowings	(18.2)	(18.6)	(0.4)	2.2%
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)**	**(20.7)**	**(0.4)**	**2.0%**
Total Assets Employed	**225.9**	**233.9**	**8.0**	**3.5%**
Taxpayers Equity				
Public Dividend Capital (PDC)	294.2	302.1	7.9	2.7%
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)	(130.2)	0.1	(0.1%)
Total Taxpayers Equity	**225.9**	**233.9**	**8.0**	**3.5%**

GLOSSARY OF TERMS

Abbreviation	Full name	Explanation
A/L	Annual Leave	Impact of staff annual leave
BAU	Business as usual	In the context of capital expenditure, this is the replacement of existing capital assets on a like for like basis.
BPP	Better payment practice	This requires all NHS Organisations to achieve a public sector payment standard for valid invoices to be paid within 30 days of their receipt or the receipt of the goods or services – the target for this is 95%
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	**Trust Board in Public**	**Date: November 2024**
Report Title	Workforce Report M6 2024-25	**Agenda Item Number: 14**
Lead Director	Catherine Wills, Chief People Officer	
Report Author	Louise Clayton, Deputy Chief People Officer	

Introduction	This report provides a summary of workforce Key Performance Indicators for the previous 12 months up to 30 September 2024 (M6) and relevant Workforce and Organisational Development updates.		
Key Messages to Note	Temporary staffing usage remains high, which can be attributed to high levels of activity within the Trust. Turnover has reduced in month. Absence, vacancy rate, appraisal and training compliance remain below the KPI.		
Recommendation *(Tick the relevant box(es))*	**For Information** √	**For Approval** ☐	**For Assurance** ☐

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

Report History	Trust Executive Committee
Next Steps	
Appendices/Attachments	N/A

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators as at 30 September 2024 (Month 6), covering the preceding 13 months.

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

Indicator	Measure	Target	09/2023	10/2023	11/2023	12/2023	01/2024	02/2024	03/2024	04/2024	05/2024	06/2024	07/2024	08/2024	09/2024
Staff in post *(as at report date)*	Actual WTE		3758.3	3775.2	3820.9	3826.0	3834.9	3850.3	3869.1	3861.1	3880.6	3879.2	3913.0	3873.3	**3875.2**
	Headcount		4278	4296	4351	4352	4368	4381	4402	4392	4415	4412	4449	4408	**4406**
Establishment *(as per ESR)*	WTE		3962.0	3996.0	4005.3	4001.9	4012.1	4008.1	4018.1	4109.9	4144.0	4156.7	4162.7	4159.1	**4170.8**
	%, Vacancy Rate - Trust Total	**10.0%**	5.1%	5.5%	4.6%	4.4%	4.4%	3.9%	3.7%	6.1%	6.4%	6.7%	6.0%	6.9%	**7.1%**
	%, Vacancy Rate - Add Prof Scientific and Technical		20.6%	16.1%	15.7%	19.5%	18.6%	17.7%	16.1%	19.9%	21.4%	22.2%	23.0%	23.8%	**23.8%**
	%, Vacancy Rate - Additional Clinical Services *(Includes **HCA**s)*		3.4%	8.2%	9.5%	11.1%	16.0%	15.3%	15.3%	16.3%	15.5%	14.7%	14.4%	16.7%	**19.1%**
	%, Vacancy Rate - Administrative and Clerical		3.7%	3.6%	3.1%	2.1%	1.5%	1.6%	1.4%	2.9%	2.9%	3.1%	2.8%	4.5%	**3.9%**
	%, Vacancy Rate - Allied Health Professionals		16.9%	15.0%	16.0%	16.0%	15.3%	13.1%	12.1%	11.6%	17.0%	18.6%	18.0%	16.0%	**14.9%**
	%, Vacancy Rate - Estates and Ancillary		7.8%	8.0%	4.6%	4.9%	3.6%	3.8%	4.3%	9.2%	8.7%	8.2%	7.7%	6.6%	**7.0%**
	%, Vacancy Rate - Healthcare Scientists		6.0%	4.2%	0.0%	-1.7%	-0.5%	0.2%	-0.9%	4.1%	5.2%	5.0%	2.6%	1.9%	**1.6%**
	%, Vacancy Rate - Medical and Dental		0.4%	0.0%	0.0%	-2.3%	-1.8%	-1.0%	-1.3%	1.4%	2.1%	3.0%	-0.5%	1.2%	**1.6%**
	%, Vacancy Rate - Nursing and Midwifery Registered		4.3%	4.2%	2.5%	1.3%	-0.8%	-2.0%	-2.2%	0.9%	0.8%	1.5%	1.5%	2.0%	**1.7%**
Staff Costs (12 months) *(as per finance data)*	%, Temp Staff Cost (%, £)		14.0%	13.7%	13.4%	12.7%	12.4%	12.2%	12.2%	11.9%	11.7%	11.7%	11.7%	11.8%	**11.8%**
	%, Temp Staff Usage (%, WTE)		13.5%	13.3%	13.1%	12.8%	12.6%	12.4%	12.2%	12.2%	12.0%	11.9%	11.9%	11.8%	**11.8%**
Absence (12 months)	%, 12 month Absence Rate	**5.0%**	4.5%	4.5%	4.6%	4.6%	4.7%	4.7%	4.7%	4.8%	4.8%	4.8%	4.8%	**4.9%**	*4.9%*
	- %, 12 month Absence Rate - Long Term		*2.3%*	*2.4%*	*2.5%*	*2.5%*	*2.6%*	*2.5%*	*2.6%*	*2.6%*	*2.6%*	*2.6%*	*2.6%*	***2.6%***	*2.7%*
	- %, 12 month Absence Rate - Short Term		*2.2%*	*2.1%*	*2.1%*	*2.1%*	*2.2%*	*2.2%*	*2.1%*	*2.2%*	*2.2%*	*2.2%*	*2.3%*	***2.3%***	*2.2%*
	%,In month Absence Rate - Total		4.1%	5.1%	5.0%	5.6%	5.6%	5.0%	4.5%	4.8%	4.4%	4.3%	4.9%	**4.9%**	*4.8%*
	- %, In month Absence Rate - Long Term		*2.3%*	*3.0%*	*3.0%*	*3.1%*	*3.0%*	*2.8%*	*2.7%*	*2.4%*	*2.4%*	*2.4%*	*2.7%*	***2.8%***	*2.7%*
	- %, In month Absence Rate - Short Term		*1.8%*	*2.1%*	*2.0%*	*2.5%*	*2.6%*	*2.2%*	*1.8%*	*2.4%*	*2.0%*	*2.0%*	*2.2%*	***2.1%***	*2.1%*
Starters, Leavers and T/O rate (12 months)	WTE, Starters (In-month)		56.0	27.0	58.9	24.8	46.0	38.0	41.4	31.8	44.8	43.0	34.4	25.4	**25.9**
	Headcount, Starters (In-month)		62	30	68	28	51	42	48	36	52	49	43	28	**28**
	WTE, Leavers (In-month)		45.4	18.3	27.3	29.6	38.7	28.0	28.6	40.2	34.9	33.4	32.1	49.2	**35.5**
	Headcount, Leavers (In-month)		58	24	30	38	44	34	36	49	39	42	36	56	**45**
	%, Leaver Turnover Rate (12 months)	**12.5%**	14.1%	13.1%	13.0%	12.9%	12.8%	13.0%	12.6%	13.2%	13.1%	13.1%	12.5%	13.3%	**13.1%**
Statutory/Mandatory Training	%, Compliance	**90.0%**	95%	95%	96%	96%	95%	94%	94%	95%	96%	95%	94%	95%	**95%**
	Moving and Handling - Level 1 - 3 Years									94.0%	94.0%	94.0%	93.0%	93.0%	**93.0%**
	Moving and Handling - Level 2 - 3 Years									94.0%	94.0%	94.0%	94.0%	94.0%	**93.0%**
Appraisals	%, Compliance	**90%**	90%	89%	89%	90%	90%	91%	92%	92%	92%	91%	91%	90%	**93%**
Time to Hire (days)	General Recruitment	**35**	50	49	46	50	48	44	43	49	54	48	44	51	**51**
	Medical Recruitment (excl Deanery)	**35**	53	98	93	45	62	69	52	79	76	51	54	68	**86**
Employee relations	Number of open disciplinary cases		19	20	21	21	22	21	19	16	20	12	18	12	**17**
Number of payroll payments to all staff *(inc. Doctors in Training)* **for all payrolls processed**	*Number of Overpayments in monthly period*											10	19	27	**30**
	Number of Underpayments in monthly period											177	181	70	**81**

2.1. **Temporary staffing usage** has remained the same. Areas with high bank usage remain under review. A deep dive is currently being carried out into two ward areas with high bank usage and low vacancy rates to understand the skill mix, patient acuity and reason for bank use. Learning from this will be taken forwards through the Temporary Staffing Group for wider improvements and reductions. The team continue to review shift length times to ensure unpaid breaks are factored in and that TOIL is taken rather than paid through bank where appropriate.

2.2. The Trust's **headcount has decreased in month** and there are now 4406 employees in post, although budgeted wte has increased. The **vacancy rate** has increased (7.1%) with Additional Professional and Technical staying at its highest point in 12 months (23.8%). Work is ongoing to develop a robust workforce plan for recruiting into these vacancies, the majority of which are in Core Clinical.

2.3. **Staff absence remains at 4.9%** for the 12-month period and has reduced to 4.8% in month, which is still higher than previous trends. Managers continue to support staff back to work in line with the sickness absence and attendance policy. Bespoke work to identify pockets of high absence is being carried out by the HRBPs. Demand on Occupational Health is high and referrals are being triaged to ensure the most appropriate pathway is identified at an early point.

2.4. **Staff turnover has decreased 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 Assistants remain an area of focus for improved retention.

2.5. **Time to hire** remains at 51 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 17. A detailed Employee Relations case report is produced monthly to JCNC.

2.7. **Statutory and mandatory training** compliance is at 95% and **appraisal** compliance is at 93% (TEC member compliance is in Appendix A) (Manual Handling compliance is in Appendix B).

2.8. There are 16.2 wte nursing vacancies. There are 17 nurses in pre-employment and 13 with start date booked. Recruitment continues where posts are vacant, particularly in ED and Theatres.

2.9. There are 106 HCSW vacancies (B2 and B3 and including Maternity Support Workers) across the Trust with 21 ready to start/start date booked and 12 in pre-employment. Recruitment is ongoing in this area.

3. Continuous Improvement, Transformation and Innovation

3.1. The HR Services Team have been working to make **improvements on payroll processes** to reduce under and overpayments. Part of this is to increase visibility of errors and so a table is included on Board and TEC reports to highlight these and these errors are shared at divisional level in Performance Board. Department managers are also advised if their employee has been under or overpaid and their manager is cc'd into correspondence to ensure this is picked up through performance conversations as appropriate. There has already been some improvements in the quarter and these will be tracked against a KPI from April.

3.2. The **Fair and Just Culture Panels** are being piloted through M7 and M8. These panels run weekly to review cases and make a decision whether the case should be formally investigated or referred to an informal approach. This panel decision is based on 6 key questions which revolve around determining that any gaps in support, policy, and training/knowledge are taken into account prior to moving through to a formal disciplinary process. Each panel will be made up of a clinical or non-clinical manager, depending on the case, as well as an HR representative. Terms of Reference will also be set as soon as the decision is made, to reduce timelines for investigations further.

4. Culture and Staff Engagement

4.1. The **Protect and Reflect Event** comes to an end on 29th November. This is an opportunity for staff to attend an appointment to complete their staff survey and get their flu jab. A voucher for a bluelight card or the restaurant is available upon completion of the survey as well as prizes to be won. HRBPs will be taking uncompleted surveys round to departments in November for completion.

4.2. October saw celebrations of **Black History Month** and Jennifer Izekor, Founder of Above Difference, was invited to speak on a number of topics including leadership, diversity, equality, and being inclusive; feedback from the session was very positive. Yvonne Coghill also completed her feedback sessions with staff on culture and race equality and will be working with the Board in M8 to review this and next steps.

5. Current Affairs & Hot Topics

5.1. From 26 October a new preventative duty means that employers must take reasonable steps to prevent sexual harassment of employees in the course of their employment. This duty means that proactive prevention should take place through policy changes, promotion of values through leadership, and training in addition to the protection of any individuals making a complaint. The **Sexual Safety Steering Group** currently has representatives from across the Trust leading workstreams on preventative measures and policy development. Leaders role modelling professional behaviours and challenging behaviours that are against the Trust values are key to delivery against this agenda.

6. Recommendations

6.1. Members are asked to note the report.

Antimicrobial Stewardship Annual Report: 2023-24

Meeting title	Quality Board	**Date: June 2024**
Lead Director	**Ian Reckless**	
Author	**Prithwiraj Chakrabarti, Lauren Ramm**	

Report summary				
Purpose *(tick one box only)*	Y **Information**	☐ **Approval**	**To note**	**Decision**
Recommendation				
Strategic objectives links	1. Improve Patient Safety and clinical outcome 2. Deliver Key Targets			
Board Assurance Framework links	Antimicrobial Stewardship Group Infection Prevention & Control Committee			
CQC outcome/ regulation links	1. Outcome 4/regulation 9 2. Outcome 16/regulation 10 3. Outcome 13/regulation 9			
Identified risks and risk management actions	For information			
Resource implications	Nil			
Legal implications including equality and diversity assessment	Healthcare Act –code of practice criteria Criteria 3- Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance. Also includes, criteria 1,5,6,7,8,9,and 10.			

Executive summary

This report summarizes the key performance indicators and all the major activities performed by the antimicrobial stewardship (AMS) team between April 2023 and March 2024.

The year 2023-24 was a challenging year for AMS. The AMS team continued to provide support and strong vigilance on antimicrobial consumption at MKUH. The AMS ward rounds continued throughout the year, with a consistent focus on reducing consumption of broad-spectrum antibiotics and promoting IV to oral switch.

MKUH achieved the NHS England CQUIN target for IVOS (IV to oral switch) in 2023-24. The standard NHS contract challenged all trusts to reduce broad spectrum AM consumption (watch and reserve WHO AWARE category) by 10% from a 2017 baseline in 2023-24. Despite achieving the target in the first two quarters of the financial year, the overall target couldn't be achieved by the end of 2023-24. However, the consumption of antibiotics in the WHO watch & reserve category has increased significantly over the second half of the financial year, leading MKUH to benchmark in a poor light. The cause of this sudden shift is uncertain and was affected by a similar trend in all major disciplines including acute medicine, surgery, respiratory, haematology, elderly care and cardiology. In 2023-24, there was a change in reporting of admission data which may have contributed to the drastic change of data in Q3 and Q4. Despite this, the total consumption of antibiotics at MKUH remained lower than the national average and generally comparable to the neighboring trusts.

There have also been some other issues which may have an adverse impact on antibiotic use at MKUH: high NHS activity, acuity and complexity ; delay in key inpatient investigations (relating to overall elective and cancer pressures); and, delays in controlling the source of infections (interventional radiology, surgical, ERCP etc). These factors may explain a 30% upsurge in the use of meropenem in 2023-24. The increase/ aging population and complexity of individual patient factors including multiple comorbidities are also likely to have contributed to the rising number of multidrug resistant organisms in the hospital and the requirement for frequent use of broad-spectrum antibiotics. A rising trend of MDR organisms with a delay in clinical response is a genuine threat to AM stewardship for the years ahead.

In 2023-24, the AMS team updated the adult antimicrobial (AM) policy. This has been approved and is currently live on the microguide app. The team also supported the development of the cardiac intervention policy, nebulised gentamicin policy, ENT policy and orthopedic prophylaxis policy. As well as updating the vancomycin, gentamicin and amikacin prescribing and administration policies to promote safer practices in prescribing. An intervention strategy has also been rolled out to minimise the incidence of unsafe gentamicin prescribing. Actions to address the MHRA safety alert on fluoroquinolones have also been prioritised to reduce major adverse reactions of fluoroquinolones.

In 2023-34, the AMS team also participated in audit, research and teaching activities. The TIDE and GBS trials were completed in 2023. MKUH have created a partnership with University of Nigeria Teaching Hospital following a successful grant application from the commonwealth pharmacists antimicrobial stewardship scheme (CwPAMS) for collaborative AMS work. This partnership is working

on generating awareness and improved antimicrobial stewardship in Nigeria as part of the WHO global AMS program and it's associated goals.

Overall, there has been progress in the antimicrobial stewardship practices at MKUH, however there are challenges remaining which the AMS team will continue to work to combat.

Introduction

The Antimicrobial Stewardship (AMS) team drives, supports and monitors the AMS activity at MKUH. The AMS team consists of a consultant microbiologist and an antimicrobial pharmacist. The team reports to the Antimicrobial Stewardship Group (AMSG) members, which meet quarterly. Meetings are chaired by the Medical Director. AMSG consists of clinicians, nurses, pharmacists and managers from different disciplines. AMSG regularly discuss and review AMS activities along with national and local AMS targets. This involves review and approval of policies and proposals for change and setting out overall governance of AMS activity at MKUH. The main goal of AMS activity at MKUH is focussed on the reduction of unnecessary antimicrobial consumption. This is supported by a 24/7 clinical microbiology service and a twice weekly AMS ward round targeting general medical and surgical wards across the trust. Irresponsible antimicrobial prescribing is the main driver of antimicrobial resistance locally, nationally and globally. Institutional antimicrobial prescribing practice is largely dependent on individual clinician's knowledge, attitude and perception towards prescribing antimicrobial drugs. This is constantly changing due to a perpetual movement in staffing, demography and epidemiology. Therefore, continuous institutional governance on antimicrobial usage is required to monitor the antimicrobial prescribing practice among clinicians.

The key AMS activities during April 2023- March 2024 are summarised below.

1. **AMS ward round:**

AMS ward rounds (Consultant Microbiologist and lead antimicrobial pharmacist) were continued twice a week with the aim of providing regular antimicrobial governance, proactive decision making and improving antimicrobial prescribing behaviours. The AMS round focused on rationalising the duration of broad-spectrum antimicrobial agents (piperacillin-tazobactam, meropenem, quinolones and co-amoxiclav) along with promotion of early IV to oral switch. A range of staff also attended and shadowed antimicrobial stewardship ward rounds to gain experience and understanding of AMS with very positive feedback received. These included junior pharmacists, laboratory staff, and nurses.

2. **IV to oral switch: NHS England Regional AMS plan and CQUIN**

Reducing the use of IV antimicrobials was a CQUIN target for the financial year 2023-2024. The CQUIN target was for 40% (or fewer) patients audited to still be receiving IV antibiotics past the point at which they met the IV to PO switch criteria. Data submission for this CQUIN required 100 patients currently on IV antibiotics to be audited every quarter.

Data for Q1 and Q2 of 2023-2024 has been submitted and MKUH achieved the target with 21% of patients audited continuing IV antibiotics when they were eligible to be switched to PO antibiotics. In Q3 16% of patients were continued on IV antimicrobials when they were suitable for PO. Data for Q4 has been collected and showed an improvement with 13% of patients audited continuing on IV

antimicrobials when they were suitable for an oral switch. MKUH have therefore achieved the CQUIN target for all 4 quarters. Despite meeting the CQUIN targets we still have around 25% of antimicrobials prescribed via the IV route, therefore there is still room for an improvement in timely IV to PO switch of antimicrobials.

3. AMS policy update and Microguide

The Trust's antimicrobial policy must be continually reviewed and updated in response to local and national requirements. The current MKUH antimicrobial guideline is available via the Trust intranet and the Microguide app. The AMS team worked with respective clinical teams and divisions to upgrade local policies in 2023-24. The ENT policy has been updated and expanded to incorporate many common infections requiring antimicrobial treatment. The vancomycin policy has been updated with improved dosing to achieve appropriate therapeutic levels. In response to cases of post pacemaker related infections (including one case of MRSA bacteraemia), the pacemaker prophylaxis policy has been amended from flucloxacillin to now recommend teicoplanin to cover a wider spectrum of pathogens including MRSA.

Antibiotic policy updates	Update date	Comment
Review of MKUH AM policy		The whole policy has been reviewed and updated. Next review in 2026
Vancomycin Policy		Update completed in 2023
Prophylaxis for cardiac implant device		Update complete awaiting approval

4. Strategic planning to reduce the broad-spectrum antibiotics

The reduction of broad-spectrum antibiotics is one of the primary goals of AMS. The abrupt rise of carbapenem use since the beginning of the year was noted and discussed in several clinical forums and meetings. The trend was monitored closely and communicated widely to generate awareness of the issue. AMS ward rounds continued to focus on carbapenem prescriptions. Audits were conducted to focus on local prescribing issues in specific areas and the appropriateness of durations of meropenem prescriptions. The findings were communicated with the relevant clinical teams via the grand round but we aim to ensure regular feedback through local governance committees.

Other strategies we have implemented to reduce meropenem prescribing include

1. Introduction of nebulised antibiotic treatment for bronchiectatic patients requiring long term treatment and with frequent hospital admissions. This has been trialled and a patient information leaflet, formulary amendment application and shared care guideline to allow GPs to continue prescribing has been developed and is pending approval.
2. Introduction of temocillin onto the MKUH formulary for ESBL and other resistant gram-negative organisms for use as a meropenem sparing agent for suitable indications.

The AMS team have reviewed causes for the increase in antimicrobial consumption and our initial scrutiny suggests involvement of many systemic contributory factors other than local prescribing

issues. High NHS activity, increased complexity of cases, delay in investigations, source control issues (interventional radiology, surgical, ERCP etc.), ongoing COVID & norovirus activity, loss of key staff, and trust wide financial pressure may all have contributed to the overall clinical response and complex nature of antibiotic use throughout the year.

5. **Carbapenemase producing Enterobacterales (CPE) management plan**

An increasing number of cases of CPE have been noted since 2022 and this has been associated with increasing use of newer and more costly antibiotics including ceftazidime-avibactam (Zavicefta) and ceftolazane-tazobactam (Zerbaxa). The reporting and communication of CPE results have now been aligned with the national recommendations and include mandatory isolation of all CPE cases to reduce transmission. CPE screens are now undertaken for all ICU patients and the notification process has been updated by routine recording of CPE results with action plans in e-care.

6. Microbiology clinical service upgrades and UKAS preparation

2023-24 has been a challenging year for both the microbiology laboratory team and the infection prevention and control team, including significant staff turnover. The 24 x7 service has been reverted to core hours with on call-based service (between 9:30pm and 7am). The laboratory is currently operational from 8am to 9:30pm. To avoid delay in blood culture processing, the biomedical scientists working at night in Biochemistry were trained to upload blood culture bottles to bactec. A task and finish group has been formed to update SOPs in each section of the laboratory to ensure they are fit for purpose and to the standard expected by UKAS. A significant amount of laboratory time has been used to plan and discuss implementation of the LIMS project to harmonise microbiology work within the local lab network and is still ongoing awaiting implementation. The serology service has been evaluated for transfer to Oxford as the recognised hub laboratory. The UKAS accreditation process was delayed due to staff recruitment issues, LIMS harmonisation activity, and uncertainties around the future of the serology service.

The service has regained its strength with appropriate staff recruitment, focussed activities of the task and finish group including updating SOPs and the quality manual, resolving CAPAs, promoting lean processes and effective communication with an aim of UKAS application in 2025.

7. AMS audits/QI projects/ Research-

7A. AMS audit/QIP

7A.1 Nebulised gentamicin project

The introduction of nebulised antibiotic treatment for bronchiectatic patients requiring long term treatment and with frequent hospital admissions was started in 2023. This has been trialled on a small number of patients and a patient information leaflet, formulary amendment application and shared care guideline to allow GPs to continue prescribing has been developed and is pending approval. This will need support from the community team/ primary care to ensure patients are able to continue to access this service via their GPs. Benefits of nebulised antibiotics are anticipated to include a reduced use of IV broad-spectrum antibiotics, reduction of AM resistance and reduced risk of other adverse effects.

7A.2 Procalcitonin based individualised AMS QIP

The quality improvement project audit **'**Targeted antimicrobial review of inpatients based on procalcitonin (PCT) value' completed in 2022-23 was accepted for oral presentation at the British Infection Society 2023 Spring meeting. It was presented and was well acknowledged by the audience.

7A.3 British Infection Association (BIA) meeting poster presentation

A junior doctor from ward 18 presented a poster at the BIA meeting in Spring 2023. This was a case presentation of a rare nocardia infection admitted to W18.

7A.4 Neutropenic sepsis audit

An audit on antibiotic administration within an hour of diagnosis of sepsis among neutropenic sepsis was undertaken in the emergency department. As a result of this audit it was found that the average time to appropriate antibiotics (Tazocin/gent as per guideline) to the neutropenic patients was up to 106 mins on weekdays and 126 mins on weekends. The audit findings were discussed in the medicine audit meeting in Feb 2024 and further a poster to improve awareness has been proposed to improve practice in A&E.

7B Research

7B.1 TIDE trial (Trial for decolonization) is a multi-centre, randomised controlled, non-inferiority and cost effectiveness trial comparing Polyhexanide and Chlorhexidine with Neomycin to Mupirocin for nasal methicillin-resistant Staphylococcus aureus (MRSA) decolonisation amongst adult hospital in-patients. The trial has been completed and is now closed.

7B.2 GBS (Group B Streptococcus) 3 trial- The clinical and cost-effectiveness of testing for Group B Streptococcus: a cluster randomised trial with economic and acceptability evaluations. This is a national project which has been conducted at MKUH with relevant modification of the laboratory procedure for GBS detection. The trial looked at standardising the GBS screening advice to pregnant ladies with possible reduction in exposure to antibiotics during labour. The trial recruitment has been finished and closed.

7B.3 MSc project- The project focuses on the sensitivity of a new fluoroquinolone, Delafloxacin against local pseudomonas species. A laboratory biomedical scientist has compared the minimum inhibitory concentration of ciprofloxacin and delafloxacin against respiratory pseudomonas isolates. Delafloxacin has been reported to be effective against some ciprofloxacin resistant gram-negative organisms.

7B.4 Commonwealth Partnerships for Antimicrobial Stewardship (CwPAMS) Project

MKUH have created a partnership with University of Nigeria Teaching Hospital in Enugu, Nigeria following a successful grant application from the commonwealth pharmacists antimicrobial stewardship scheme (CwPAMS) which is a health partnership scheme funded by the Department of Health and Social Care's Fleming Fund for collaborative AMS work. This partnership is working on generating awareness on AMS as a part of the goal of WHO global AMS program to improve antimicrobial stewardship and detection of substandard and falsified antimicrobial medication.

During the partnership so far, we have been able to train three hundred and fourteen healthcare professionals across four institutions comprising pharmacists, health assistants/porters, nurses, medical laboratory scientists and physicians. The training included antimicrobial resistance, stewardship and consumption, detection and reporting of substandard and falsified medicines, infection prevention and control among other topics. Training sessions have been well received. The team have been able to purchase a digital autoclave, bench top pH meter, one analytical balance, two top loading balances and chemicals and other consumables for the quality analysis of antimicrobial medicines. A UV mass spectrophotometer has also been purchased to help with the identification of substandard and falsified medicines. Various physical, microbiological assays have been performed and the identification of some substandard metronidazole products which have been removed from the hospital has occurred due to the project. A community awareness radio program on AMR/AMS has also been initiated to improve local awareness.

8. Teaching:

The microbiology and AMS team participates in teaching regularly through grand rounds, departmental teaching, alongside junior doctor and nursing teaching programmes. In 2023-24, 5-6 sessions were delivered focusing on shared learning through interdisciplinary management of critical infections and AM stewardship focussing on the IV to oral switch project. The AMS team also offered work experience to 4 secondary school students aspiring to apply for medical and laboratory professions in the future. A number of staff also attended antimicrobial stewardship rounds to gain individual experience.

9. World Antimicrobial Awareness Week

The AMS team celebrated World Antimicrobial Awareness Week between 18-24th Nov 2023. Various activities were undertaken including educational ward rounds incorporating pharmacy students, promotional stands to raise awareness amongst patients and staff. Educational sessions were also undertaken with pharmacy and clinical staff and communications were circulated regarding the importance of AMS.

10. Local /regional networking

BLMK AMS Pharmacy Group

MKUH is actively engaged with the BLMK AMS network to work closely with our neighbouring trusts and ICB to ensure antimicrobial issues are addressed across BLMK.

TVIG (Thames Valley Infection Group)

The Thames Valley Infection Group is a network of local microbiologists and infection specialists (MKUH, Oxford, Swindon, Bucks and RBH). The group has been recently expanded to include laboratory specialists, infection control, pharmacists and the UKHSA. The group meets twice a year to share local audits, learning and implementation of local and national policies. MKUH have led the group since 2022 (Chair- Dr Prithwi Chakrabarti, Secretary- Dr Poonam Kapila). AMS is a focus of this group and several audits have been recently conducted and shared to improve antimicrobial prescribing. There were two meetings conducted in 2023-24 (May/Nov).

NHS England regional AMS focus group meetings:

The AMS team participated in the educational and regional meetings organised by NHS England throughout the year. The meetings mostly focused on the review of local AMS performance and support to roll out national strategies including the standard NHS contract, CQUIN and strategic response to the MHRA fluoroquinolone alert.

Action log 2023-24 and Progress report

	Action log 2023-24	Comment
1.	**IV to oral switch: Regional AMS plan/ CQUIN**	The IVOS policy has been approved. Pharmacists were trained and the policy has been rolled out across the trust Posters displayed in nursing IV cupboards to remind nurses to prompt for IV to PO switch. Ongoing training and education on wards with nurses, pharmacists and doctors.
2.	**Update of AM policy & microguide**	The microguide and the general antimicrobial policy were updated in 2023-24.
3.	**Safe gentamicin prescribing**	Gentamicin power plan in e-care to support gent prescribing. Alerts were generated for prescribers with a safety dose prompt and gentamicin level. The full actions have been attached to appendix 1.
4.	**Strategic planning to reduce the broad-spectrum antibiotics (Tazocin/Meropenem/fluoroquinolones)**	Concerns: Rise of resistance, complex clinical presentations, delays in investigations/ERCP/IR-surgical drainage, and high NHS activity with financial constrains Actions taken Targeted ward round continued Updated AM policy Meropenem audit- feedback and action plan General awareness-Grand round presentation on AM consumption

5.	**Network collaboration for Microbiology IT integration**	Ongoing. Microbiology LIMS harmonisation with 3 other network hospitals has been completed awaiting UAT and final implementation
6.	**Microbiology service improvement**	Service has been reverted back to core hours (8am-9:30 pm) and on call hours Task and finish group formed to review the whole service Serology restructure Preparation for UKAS following LIMS implementation
7.	**Safe use of Fluoroquinolones (FQs)**	The MHRA alert on FQs use came out in Jan 2024. Several meetings and discussions were conducted by the AMS team with respective stakeholders to outline an action plan. Progress has been made for implementation of all risk mitigating actions.
8.	**Nebulised gentamicin for selected respiratory ward patients**	Nebulised gentamicin could be used to reduce the use of broad-spectrum antimicrobials in patients with chronic respiratory diseases (e.g. bronchiectasis) who require frequent admissions for IV antibiotics. The project has been successfully launched. This project is expected to reduce the number of admissions and LOS among bronchiectatic patients. Gentamicin nebulisation has been used for a small number of patients with good clinical outcome. The ongoing project needs multi-disciplinary support for further expansion into out-patients and community. The policy for gentamicin nebulisation has been written and ratified among stakeholders awaiting approval.

9.	**Research projects:** -	TIDE study- A trial for new treatment regimen for MRSA decolonization started in February 2023- completed now. GBS 3 trail - completed Delafloxacin MSC project- completed CwPAMS Project- ongoing till Dec 2024

AMS performance data

The UKHSA regularly publishes data on the AMS performance of each NHS trust and the data is available in the public domain. The performance standards are comparable with the national average and other NHS trusts allowing MKUH to benchmark their performance. The UKHSA data related to AM performance focuses primarily on two parameters.

1. Total antimicrobial consumption (DDD-defined daily dose) per 1000 total admissions
2. Total Carbapenem consumption (DDD) per 1000 total admissions

The full performance report for MKUH can be found at https://fingertips.phe.org.uk/profile/amr-local-indicators

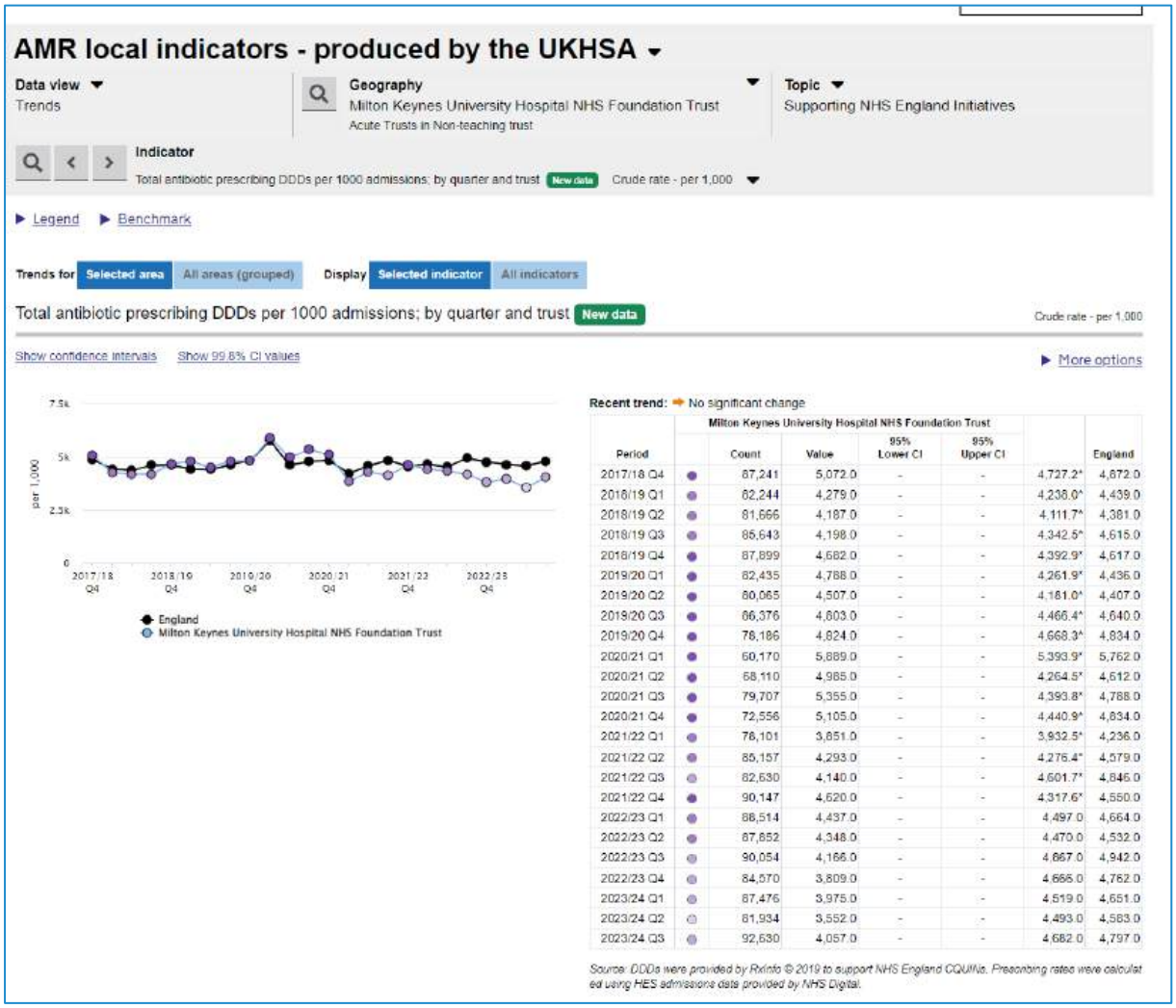


Fig1 UKHSA data showing AM consumption rate per 1000 admissions at MKUH in 2023-24 has been below the national average. Q4 data has yet to be published.

Standard Contract Previous Financial Year 2022-2023

Watch and reserve antibiotic data

The target for 2023-2024 was to reduce the amount of WHO watch & reserve category (broad-spectrum) antibiotics by 10% compared to a 2018 baseline. MKUH achieved the 4.5% reduction target in the previous financial year (2022-2023).

The absolute use of antimicrobials in DDDs has remained fairly stable between 2023 and 2024. Compared to other surrounding trusts we are low users of antimicrobials, as demonstrated on the graph below where MKUH are represented by the pink line.

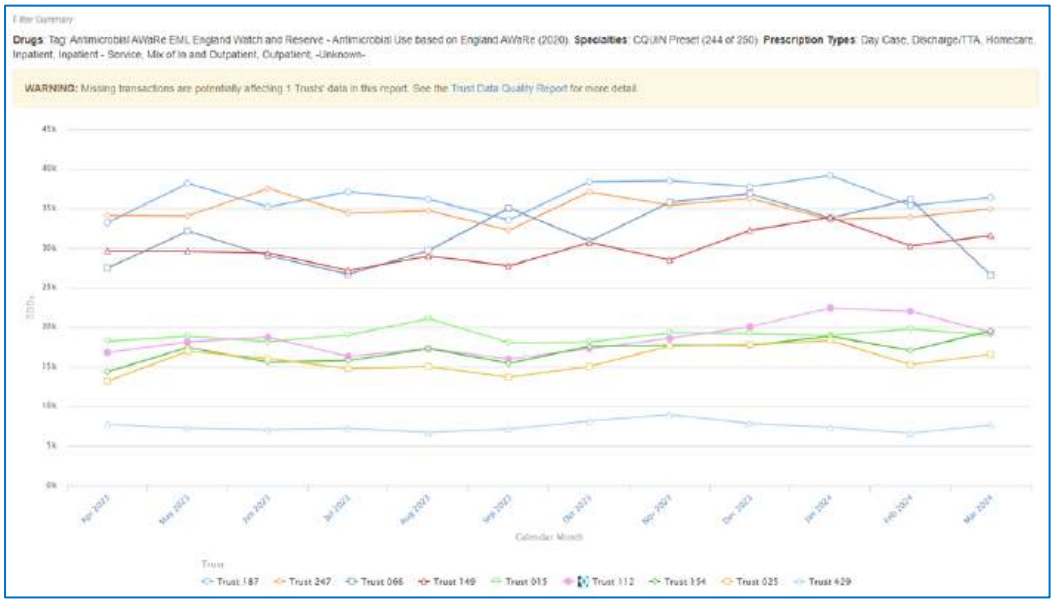


Fig:2 Comparative total WHO watch & reserve category antibiotic consumption of MKUH (pink line) with neighbouring trusts in 2023-24

When the data is weighted per 1000 admissions there has been a marked increase in use.

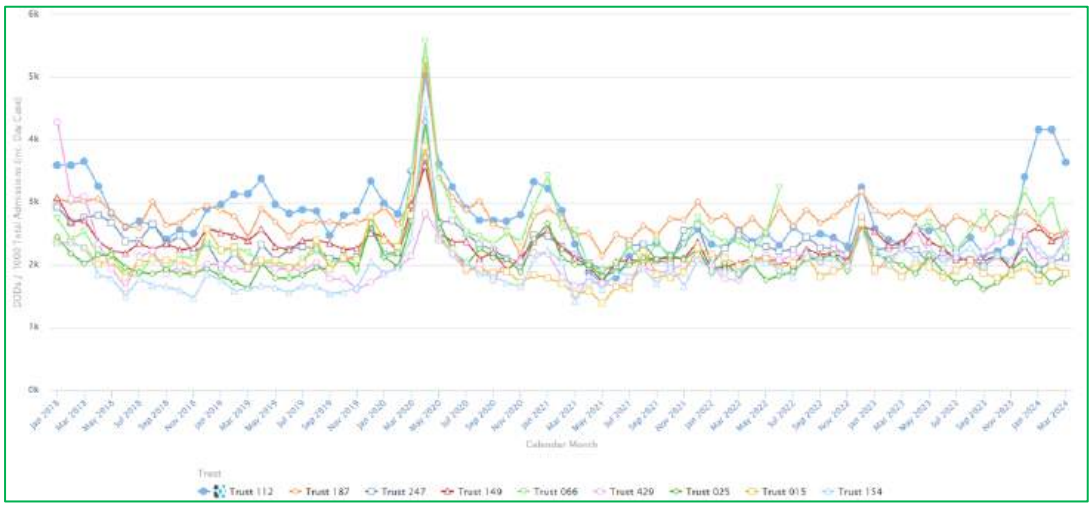
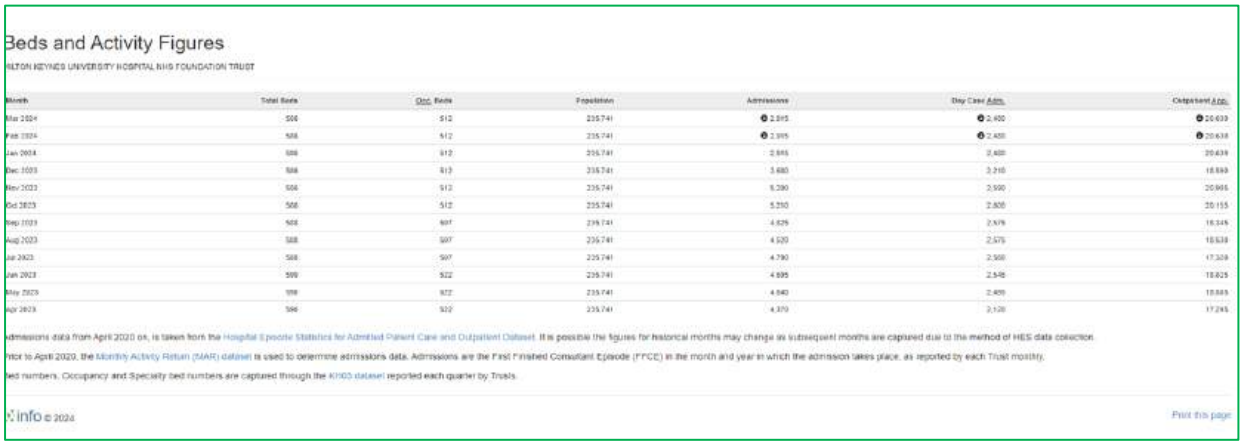


Fig 3 Comparative WHO watch & reserve category antibiotic consumption per 1000 admissions of MKUH (blue line) with neighbouring trusts in 2023-24

The consumption of antibiotics in the WHO watch & reserve category has increased significantly over the second half of the financial year, leading MKUH to benchmark in a poor light. The cause of this sudden shift is likely to relate wholly or in part to a change in the way in which admissions data for MKUH are reported. This in turn relates to the coding and reporting of attendances with the Same Day Emergency Centre (SDEC): if these are reported as outpatient appointments rather that day case admissions, the admissions denominator for antibiotic consumption changes markedly. There has been no major change in actual antibiotic use over that same period.



Beds and Activity Figures

MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

Month	Total Beds	Occ. Beds	Population	Admissions	Day Case Adm.	Outpatient Apc.
Mar 2024	506	512	235,741	2,595	2,400	20,633
Feb 2024	506	512	235,741	2,595	2,400	20,633
Jan 2024	506	512	235,741	2,595	2,400	20,633
Dec 2023	506	513	235,741	3,680	3,210	18,880
Nov 2023	506	512	235,741	5,290	3,900	20,905
Oct 2023	506	512	235,741	5,250	2,800	20,155
Sep 2023	506	507	235,741	4,625	2,575	18,345
Aug 2023	506	507	235,741	4,520	2,575	18,538
Jul 2023	506	507	235,741	4,790	2,900	17,309
Jun 2023	506	522	235,741	4,695	2,548	18,825
May 2023	506	522	235,741	4,640	2,400	18,845
Apr 2023	506	522	235,741	4,370	2,120	17,245

Admissions data from April 2020 on, is taken from the Hospital Episode Statistics for Admitted Patient Care and Outpatient Dataset. It is possible the figures for historical months may change as subsequent months are captured due to the method of HES data collection.
Prior to April 2020, the Monthly Activity Return (SMAR) dataset is used to determine admissions data. Admissions are the First Finished Consultant Episode (FFCE) in the month and year in which the admission takes place, as reported by each Trust monthly.
Bed numbers, Occupancy and Specialty bed numbers are captured through the KH03 dataset reported each quarter by Trusts.

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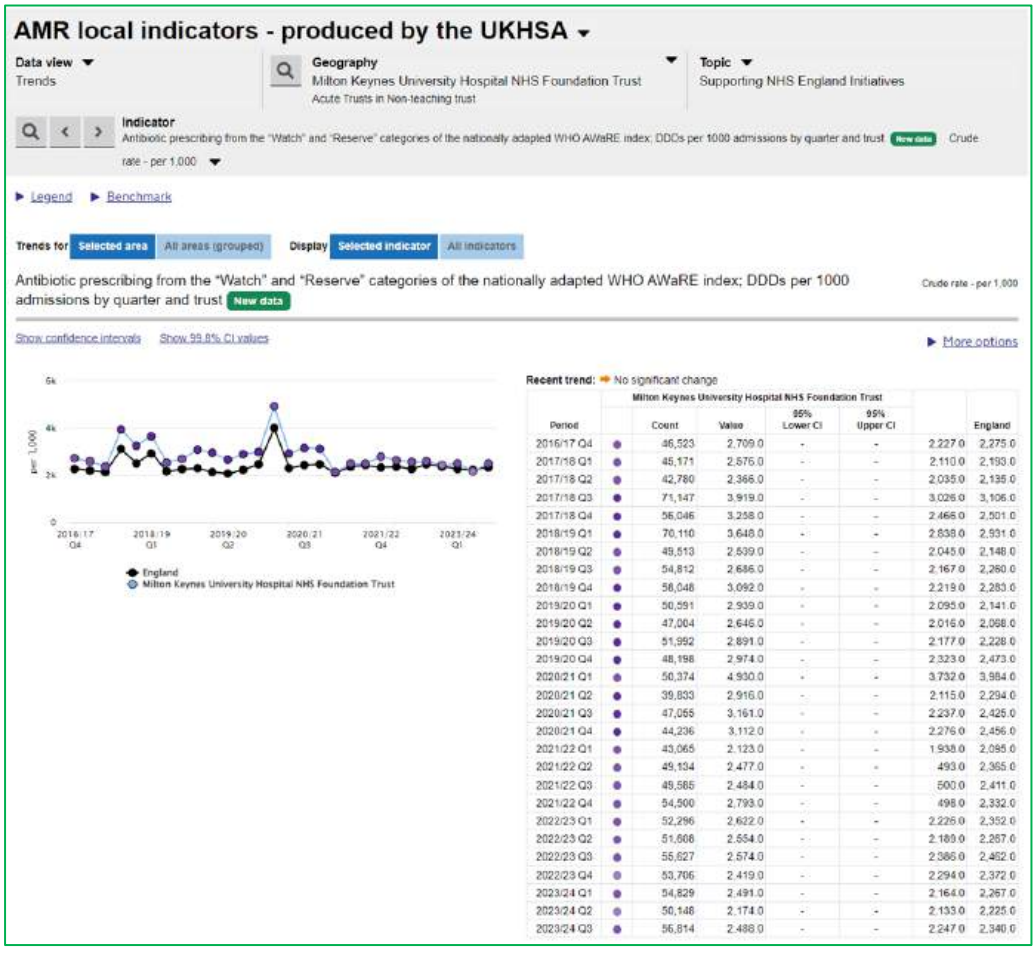
Fig 4: Admission data submitted in 2023-34 showing reduction of numbers in Dec 2023 and between Jan and March 2024.

Overall, MKUH has a relatively high consumption of WHO watch category of antibiotics due to high use of co-amoxiclav and levofloxacin. Nationally, UKHSA data suggests that the overall consumption of WHO watch & reserve category antibiotics use at MKUH is higher than national average, however the gap has been reduced significantly over the last few years as shown in Fig 5.



AMR local indicators - produced by the UKHSA

Data view: Trends
Geography: Milton Keynes University Hospital NHS Foundation Trust; Acute Trusts in Non-teaching trust
Topic: Supporting NHS England Initiatives

Indicator: Antibiotic prescribing from the "Watch" and "Reserve" categories of the nationally adapted WHO AWaRE index; DDDs per 1000 admissions by quarter and trust (New data) Crude rate - per 1,000

Legend | Benchmark

Trends for: Selected area | All areas (grouped) Display: Selected indicator | All indicators

Antibiotic prescribing from the "Watch" and "Reserve" categories of the nationally adapted WHO AWaRE index; DDDs per 1000 admissions by quarter and trust (New data)

Crude rate - per 1,000

Show confidence intervals | Show 99.8% CI values | More options

Recent trend: No significant change

Period		Milton Keynes University Hospital NHS Foundation Trust Count	Value	95% Lower CI	95% Upper CI		England
2016/17 Q4		46,523	2,709.0	-	-	2,227.0	2,275.0
2017/18 Q1		45,171	2,676.0	-	-	2,110.0	2,193.0
2017/18 Q2		42,780	2,366.0	-	-	2,035.0	2,135.0
2017/18 Q3		71,147	3,919.0	-	-	3,026.0	3,106.0
2017/18 Q4		56,046	3,258.0	-	-	2,466.0	2,501.0
2018/19 Q1		70,110	3,646.0	-	-	2,838.0	2,931.0
2018/19 Q2		49,513	2,639.0	-	-	2,045.0	2,148.0
2018/19 Q3		54,812	2,686.0	-	-	2,167.0	2,260.0
2018/19 Q4		56,048	3,092.0	-	-	2,219.0	2,283.0
2019/20 Q1		50,591	2,939.0	-	-	2,095.0	2,141.0
2019/20 Q2		47,004	2,646.0	-	-	2,016.0	2,068.0
2019/20 Q3		51,992	2,891.0	-	-	2,177.0	2,228.0
2019/20 Q4		48,198	2,974.0	-	-	2,323.0	2,473.0
2020/21 Q1		50,374	4,930.0	-	-	3,732.0	3,954.0
2020/21 Q2		39,833	2,916.0	-	-	2,115.0	2,294.0
2020/21 Q3		47,055	3,161.0	-	-	2,237.0	2,425.0
2020/21 Q4		44,236	3,112.0	-	-	2,276.0	2,456.0
2021/22 Q1		43,065	2,123.0	-	-	1,938.0	2,095.0
2021/22 Q2		49,134	2,477.0	-	-	493.0	2,365.0
2021/22 Q3		49,565	2,484.0	-	-	500.0	2,411.0
2021/22 Q4		54,500	2,793.0	-	-	498.0	2,332.0
2022/23 Q1		52,296	2,622.0	-	-	2,226.0	2,352.0
2022/23 Q2		51,606	2,554.0	-	-	2,189.0	2,267.0
2022/23 Q3		55,627	2,574.0	-	-	2,386.0	2,462.0
2022/23 Q4		53,706	2,419.0	-	-	2,294.0	2,372.0
2023/24 Q1		54,829	2,491.0	-	-	2,164.0	2,267.0
2023/24 Q2		50,148	2,174.0	-	-	2,133.0	2,225.0
2023/24 Q3		56,814	2,488.0	-	-	2,247.0	2,340.0

Fig 5 Comparative WHO watch & reserve category antibiotic consumption per 1000 admissions of MKUH and overall England national average in 2023-24. Q4 data has not been published yet.

IV/ PO Switch (IVOS) CQUIN

Reducing the use of IV antimicrobials is a CQUIN target for the financial year 2023-2024. The CQUIN target is for 40% (or fewer) patients audited to still be receiving IV antibiotics past the point at which they meet the IV to PO switch criteria. Data submission for this CQUIN requires 100 patients currently on IV antibiotics to be audited every quarter.

Data for Q1 and Q2 of 2023-2024 has been submitted and MKUH achieved the target with 21% of patients audited continuing IV antibiotics when they were eligible to be switched to PO antibiotics. In Q3 16% of patients were continued on IV antimicrobials when they were suitable for PO. Data for Q4 has been collected and showed an improvement with 13% of patients audited continuing on IV antimicrobials when they were suitable for an oral switch. MKUH have therefore achieved the CQUIN target for all 4 quarters. Despite meeting the CQUIN targets we still have around 25% of antimicrobials prescribed via the IV route, therefore there is still room for an improvement in timely IV to PO switch of antimicrobials.

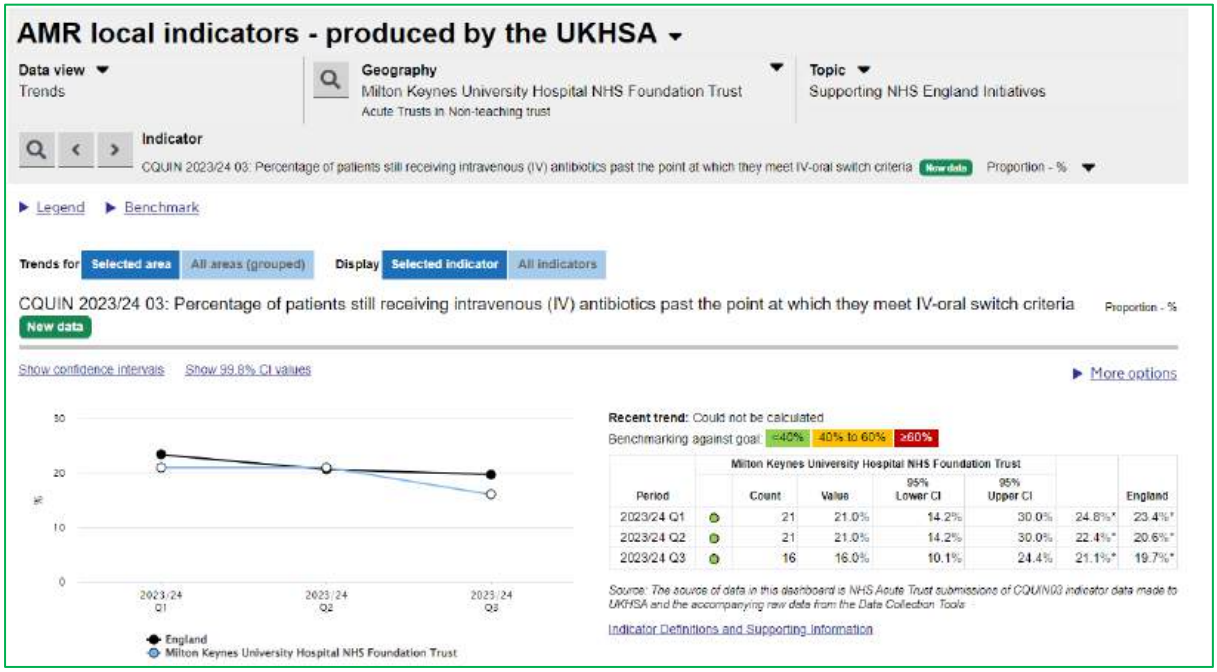


Fig: 6: UKHSA data showing MKUH performance on CQUIN target comparing national average.

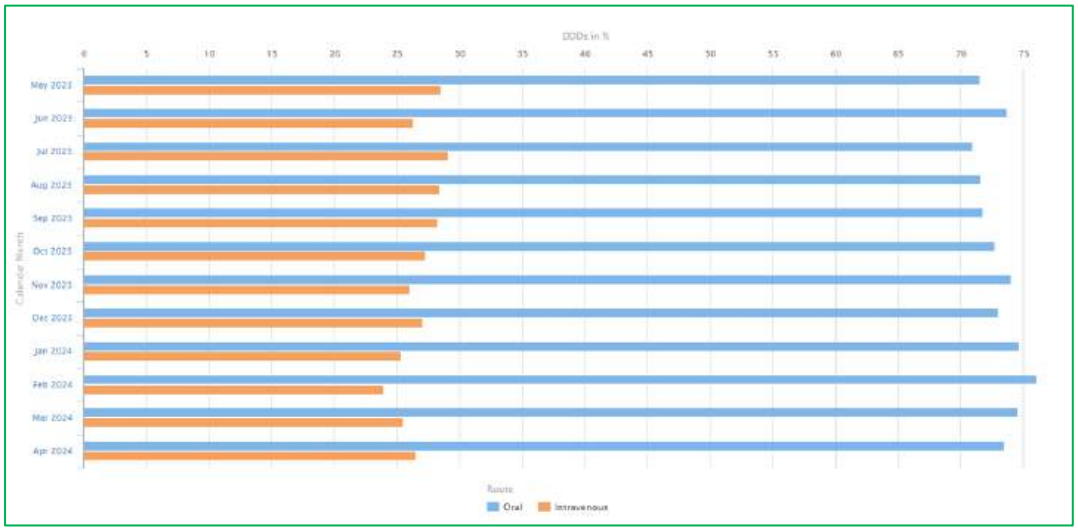


Fig 7: The ratio of IV and oral antibiotics data shows reduction of IV antibiotics throughout the year in 2023-24.

Local data on total consumption of AMs for 2023-24 has been collected from Refine shown below.

Total systemic antibiotic consumption at MKUH

Fig 8.1 (Total DDD of all antimicrobials) Historic data from Rx information showed that the total consumption of AMs has gone up in 2023-24 from the previous year and 13.2% rise from 2018. This is likely due to continuous increase in activity and the complexity of patient cases after the COVID pandemic.

Fig 8.2 (DDD/1000 admissions of all AMs) Comparative DDDs at MKUH showed a significant increase in AM consumption in 2023-24 from the previous year and 30% rise from 2018.

Carbapenem consumption at MKUH

Carbapenems are the broadest spectrum antibiotics. Our AMS activity is specially focused on appropriate prescription and duration of carbapenem antibiotics in the trust. Meropenem and ertapenem are the two carbapenems used at MKUH. Carbapenem resistance is rapidly rising nationally and internationally, and mostly due to increased use/duration of carbapenems for treating difficult infections. The following figures (fig 9.1, 9.2 and 9.3) showed the trend of carbapenem use in MKUH.

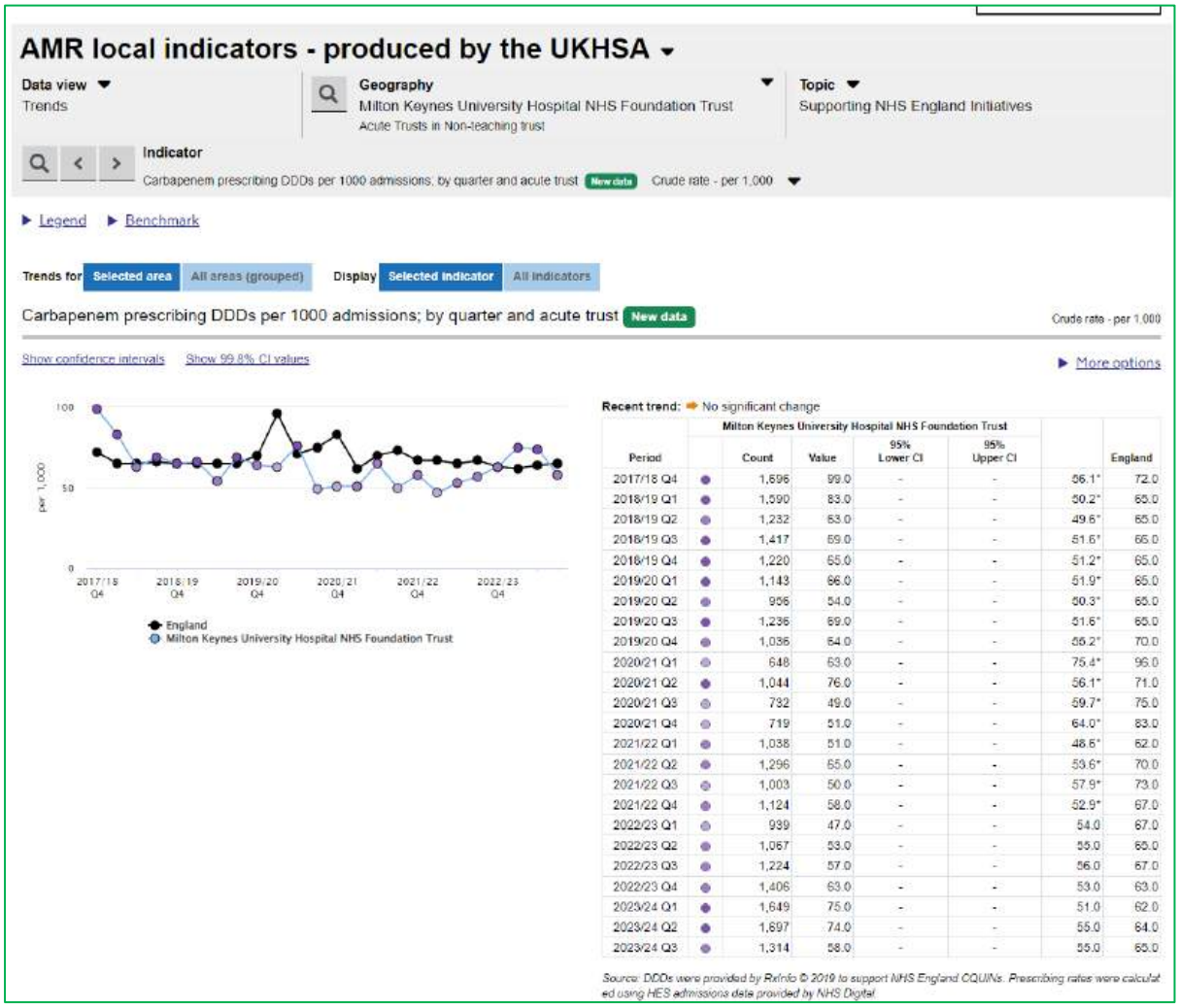


Fig 9.1. UKHSA data showed MKUH carbapenem use has generally gone up since the beginning of 2023 but reduced below the national average in Q3. Q4 data has yet to be published

Local data for carbapenem consumption 2016-24 has been collected from Refine shown below (Fig 10).

Carbapenem consumption at MKUH (Refine Data)

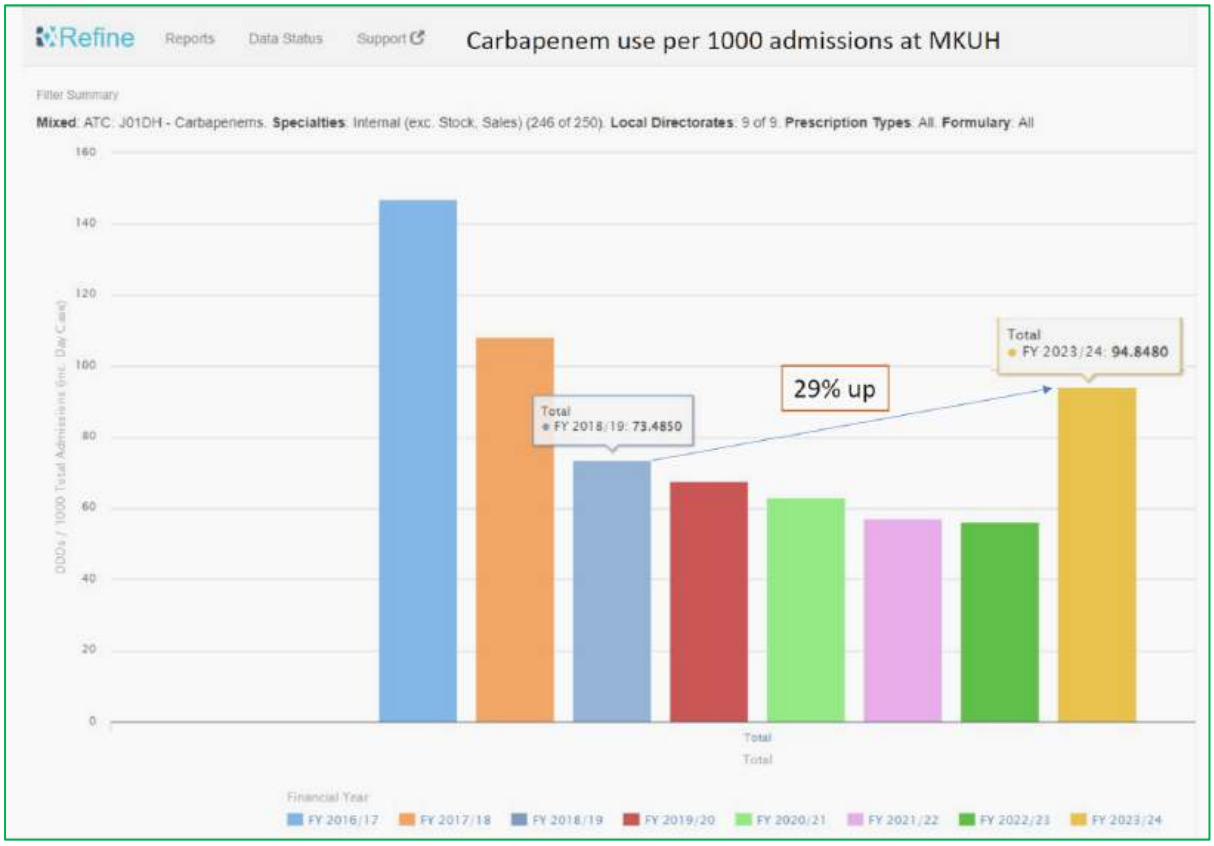


Fig 10 (Carbapenem DDD/1000 admissions) Data showed stepwise reduction of carbapenem consumption continued at MKUH until 2022-23 despite huge pressure on AM consumption in the last few years. However, in 2023-24, there is a significant rise (29%) of carbapenem use in the trust.

The AMS team have reviewed causes for the increase in antimicrobial consumption and our initial scrutiny suggests involvement of many systemic contributory factors other than local prescribing issues. High NHS activity, increased complexity of cases, delay in investigations, source control issues (interventional radiology, surgical, ERCP etc.), ongoing COVID & norovirus activity, loss of key staff, and trust wide financial pressure may all have contributed to the overall clinical response and complex nature of antibiotic use throughout the year. Despite the year wise sequential reduction of meropenem use in the trust since 2017-18, there was a sudden upsurge by approximately 30% in the use of meropenem in 2023-24. The increase/ aging population and complexity of individual patient factors including multiple comorbidities are likely to have contributed to the rising number of multidrug resistant organisms in the hospital and the requirement for frequent use of broad-spectrum antibiotics. A rising trend of MDR organisms with a delay in clinical response is a genuine threat to AM stewardship for the years ahead.

Fluoroquinolone consumption (per 1000 admissions)

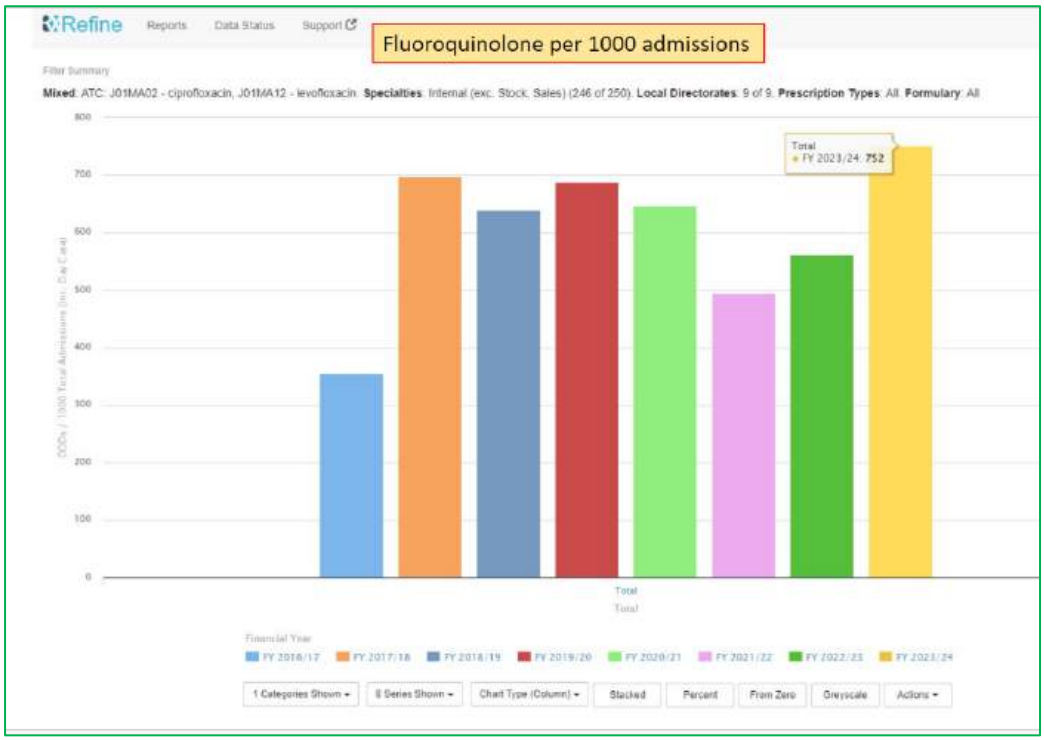


Fig 11. Data showed rise of FQ use from the previous year. An MHRA alert was issued in Jan 2024 advocating a reduction of FQ use due to increased incidence of unwanted adverse effects. MKUH has been in discussion with NHS England to implement plans for mitigating the risk to patients. A FQ action plan has been formulated and will be implemented in phases.

Piperacillin-Tazobactam (Tazocin) consumption at MKUH

Piperacillin-tazobactam (Tazocin) remains the most valuable 2nd line antibiotic for many infections. High use of Tazocin is the main driver of the spread of extended spectrum beta lactamase (ESBL) infections in many countries including the UK. Increasing use of Tazocin has been linked with concurrent increases in the use of carbapenems in many hospitals. The AMS round focuses on appropriate use and duration of Tazocin at MKUH but an abrupt rise in 2023-24 is concerning.

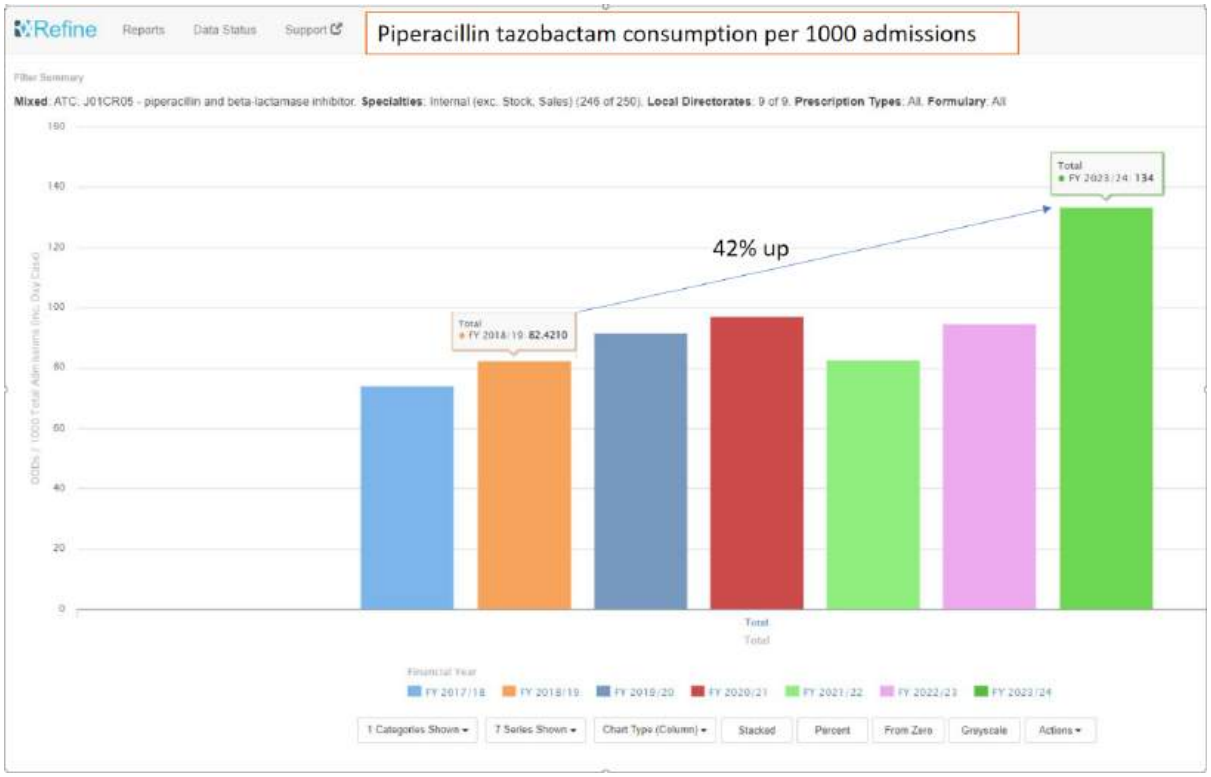


Fig 12 (Piperacillin- Tazobactam DDD/1000 admission) Comparative DDD/1000 admissions showed a steep rise of Tazocin use in 2023-24. Prescribers need to be aware of increasing Tazocin use and ensure that it is appropriate as it can contribute to ESBLs and other resistant gram-negative infections

Co-amoxiclav use at MKUH

MKUH uses co-amoxiclav as a primary antibiotic of choice for a significant number of infections. Despite rising gram-negative resistance to co-amoxiclav, when combined with gentamicin, co-amoxiclav provides good cover for the majority of infections in the local population. The AMS round focuses particularly on the regular review and duration of co-amoxiclav at MKUH.

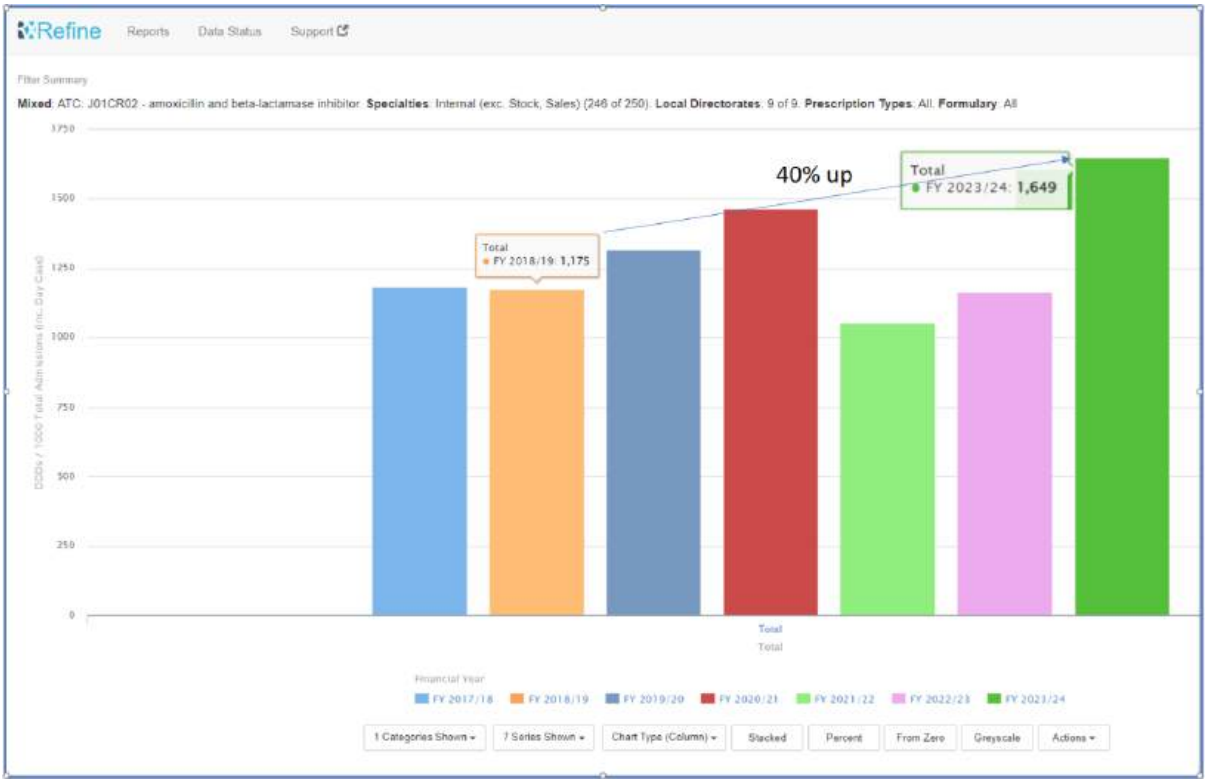
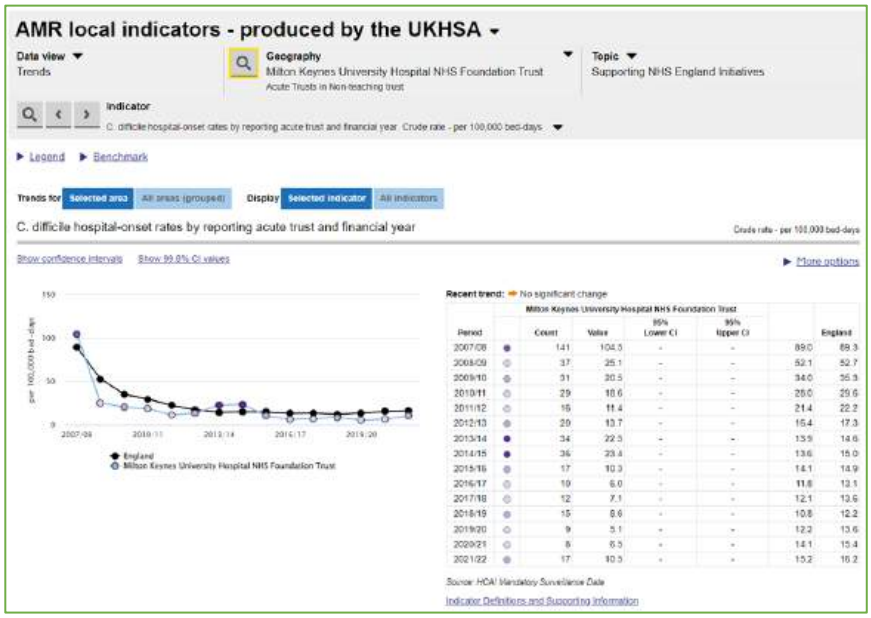


Fig13. (Co-amoxiclav DDD/1000 Admission) Comparative analysis showed co-amoxiclav DDD/1000admissions has gone up compared to the previous year. The AMS team is focused on reducing the duration of co-amoxiclav courses to 5 days where possible and switching away fromco-amoxiclav use where clinically possible and appropriate.

C. difficile infection

C. difficile infection numbers are associated with antibiotic use. MKUH reported 18 cases of health care associated CDI in 2022-23. Since 2015-16, MKUH CDI cases have remained lower than the national average (Fig 14) (data until 2022, 23-24 data yet to be published by UKHSA). However, the number of CDI cases has gone up since 2021-22 and a significantly higher number of community onset cases were also reported in 2022-23. This is likely related to higher antibiotic consumption in the community due to COVID, group A streptococcal infections and other complicated infections. The community and hospital cases of CDI continued to rise in 2023-24 at MKUH and total of 34 cases have been reported as healthcare associated. The national data showed there has been a country wide rise of CDI cases in 2023-24 in primary and secondary care.



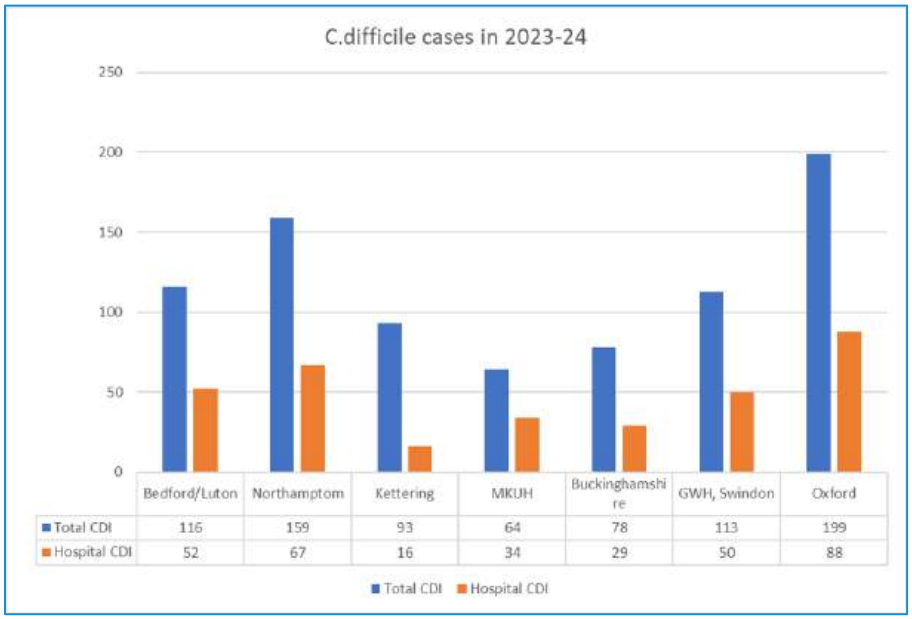


Fig 14-15: Number of *C. difficile* infections reported by MKUH between April 2023 and March 2024. The number of hospital cases has increased significantly (18 to 34) in 2023-24 from the previous year.

Areas of focus for 2023-24

The year 2023-24 was a challenging year for infection control and antimicrobial stewardship. COVID positive patients continued to be admitted in the trust throughout the year despite the severity of infection reducing. The overall total antimicrobial consumption increased compared to the previous year. Other healthcare associated infections like *C.difficile* infection and MSSA bacteremia remained higher than expected. Increasing incidence of multidrug resistant organisms and complex clinical cases were noted throughout the year. High bed occupancy, staff vacancies, delay in investigations/procedures and delayed discharge remained the major challenges for antimicrobial stewardship. Senior clinicians should continue supporting antimicrobial stewardship and take ownership of antimicrobial prescribing practice in their clinical areas. Regular feedback, audit,

research and AMS promotion are required to ensure this is achieved and maintained throughout the year.

1. **IV to oral switch: CQUIN & extension to paediatrics**

Reducing the use of IV antimicrobials compared to PO was a CQUIN target for the financial year 2023-2024. The CQUIN target is for 40% (or fewer) patients audited to still be receiving IV antibiotics past the point at which they meet the IV to PO switch criteria. MKUH has achieved the target in 2023-24. Despite the CQUIN for the financial year 2024-2025 being non mandatory, a target of less than 15% of patients remaining on IV antibiotics past the point at which they could have been switched has been specified. As such, IV to PO antimicrobial switch should remain priority for AMS. The non mandatory CQUIN target has been expanded to include paediatrics. Data is currently being collected but extra resources for ongoing data collection and implementation of improvement in paediatrics may be required.

2. **Update of guidelines/ Microguide- Paediatric guidelines**

The Microguide app provides easy availability of MKUH antimicrobial guidelines to prescribers. Microguide was introduced in 2021 and needs constant review to ensure it is up to date and accurate, in terms of accommodating local and national changes. The AMS team has been working closely with various clinical teams across the trust and updated the adult AM guidance in 2023-24. The AMS team is working with the paediatric team to update the paediatric guideline in 2024-25. This will be pertinent to the current CQUIN extension to paediatrics to ensure rational practice.

3. **Safe use of gentamicin**

Gentamicin remains a critical antibiotic in the MKUH antimicrobial guidance and is used widely in sepsis of unknown origin, pre and peri operative prophylaxis and in intra-abdominal and urinary tract infections. The toxicity of gentamicin is mostly related to higher doses of the drug, particularly when renal function is poor. The AMS team have performed several audits to improve the use of gentamicin in sepsis. The gentamicin policy and dose calculator have been updated to ensure gentamicin is dosed safely.

A safety alert was issued by the MHRA in 2021 to address some cases of deafness following gentamicin use in some hospitals. A rare mitochondrial mutation has been linked to the likelihood of gentamicin related deafness. MKUH has experienced some significant incidences concerning the safety of gentamicin prescribing. A number of mitigating measures have been taken to safeguard gentamicin prescriptions and minimise the risk to patients. The gentamicin safety mitigation report is attached to this report as an appendix.

4. **Strategic planning to reduce the broad-spectrum antibiotics**

The disproportionate increase of pressure on the NHS has made antimicrobial stewardship susceptible to various challenges including a rapid rise in general antimicrobial consumption. The NHS standard contract target for antimicrobials for the financial year 2023-2024 has been amended to be in line with the 5-year national action plan for antimicrobial resistance which will be published soon.

Despite the year wise sequential reduction of meropenem use in the trust since 2017-18, there was a sudden upsurge of 30% use of meropenem in 2023-24. The increase/ aging population and complexity of individual patient factors including multiple comorbidities are likely to have contributed to the rising number of multidrug resistant organisms in the hospital and the requirement for frequent use of broad-spectrum antibiotics. A rising trend of MDR organisms with a delay in clinical response is a genuine threat to AM stewardship for the years ahead.

A strategic plan is required to counteract the ongoing rise of broad-spectrum antimicrobial use and to prevent future antimicrobial resistance. The antimicrobial ward round is an extremely useful method to mitigate unnecessary antimicrobial use, thus should be resourced and used optimally. It also requires co-operation of clinical teams, pharmacists, nurses, IT and other stakeholders. The AMS team is encouraging junior doctors and pharmacists to pick up AMS related local issues to develop focused solutions through quality improvement projects. Further development of focused teaching, improved educational tools, technical support and governance, may help establish new ideas to address the rising AMS challenges. Alongside the AMS ward round, the AMS team is working on specific target areas to reduce the use of broad-spectrum antibiotics.

a. **Temocillin use:** Temocillin is a narrower spectrum antibiotic than meropenem and has potential for using as a meropenem sparing agent in specific clinical scenarios. Temocillin is costly but has been incorporated into the MKUH formulary in 2024 for use as a meropenem sparing agent in selected indications following microbiology approval.
b. **Surgical prophylaxis & intraabdominal infections:** Use of standard surgical prophylaxis with amoxicillin, metronidazole and gentamicin needs to be reinstated within the trust to reduce the use of coamoxiclav. The resistance to coamoxiclav isincreasing and therefore there is a risk of delay in clinical response if current practice of using co-amoxiclav and metronidazole instead of the antibiotics outlined in the antimicrobial guidelines continues.
c. **Penicillin de-labelling project:** Penicillin allergy remained a significant cause of use of meropenem and fluroquinolones at MKUH. Nationally, many trusts are focussing on potential penicillin de-labelling projects for patients who haven't reported serious allergic reactions to penicillin. The AMS team will look for a suitable framework within MKUH to pilot this project on a small scale to identify the requirement for resources for widespread implementation and long-term sustainability.

5. **Safe use of Fluoroquinolones**

In January 2024 the MHRA published an updated alert on fluoroquinolones stating that they should only be used when other antimicrobials are inappropriate due to risks of tendonitis, rupturing aortic aneurysm, risk of suicide and decline in mental health.

Following this alert MKUH are implementing a number of safety strategies.

1. Full guideline review to ensure fluoroquinolones removed where possible or appropriate to remain in the guideline due to minimal alternatives
2. Patient information leaflet developed. Awaiting approval from AMSG and PMGC prior to distributing widely with TTOs and outpatient prescriptions for fluoroquinolones

3. Pharmacy teaching undertaken in April 2024 to advise pharmacists to counsel patients which are being discharged on fluroquinolones
4. Microguide app updated with fluoroquinolone warning advice
5. Sensitivity to fluoroquinolones supressed when microbiology reports released when alternative antimicrobial options are available

A regional fluoroquinolone working group meeting with NHS England has also been attended to ensure regional advice and guidelines on the use of fluoroquinolones are implemented accordingly.

6. CPE (Carbapenemase producing enterobacteriacae) prevention strategies

CPE are emerging as the most challenging resistant bacteria. The limited number of suitable antibiotics to treat CPE infections leads to high mortality and morbidity. In a regional audit, we found that if CPE is isolated from a patient (colonized or infected), the length of stay becomes significantly increased (average 25-30 days). Therefore, prevention of CPE transmission in the hospital setting is extremely important. In 2023-24, we have anecdotally noted a significant rise of CPE cases at MKUH.

Since 2022 the AMS team has been working on strategies to reduce CPE infections. Prolonged courses of meropenem and transfer of complex patients with exposure to multiple antibiotics between secondary care facilities are the major challenges for CPE development and transmission at MKUH. Support from the IPC team is required to run the appropriate CPE screening procedure throughout the hospital. All CPE positive patients need to be isolated as a high priority. CPE related infections need broad-spectrum WHO reserve category antibiotics which are costly and associated with a risk of adverse effects.

6. Microbiology laboratory service reforms

The microbiology laboratory provides substantial support to AMS activity. The laboratory has been modernized significantly. The lab provides a service between the core hours of 8am and 9:30 pm and an on-call service outside of these hours. Clinical service is provided 24 x 7 by a microbiology consultant. The laboratory is currently undergoing service reforms with ongoing work on the LIMS project and serology transfer to Oxford. Work has progressed significantly to improve quality management in different sections of microbiology, to ensure the lab is ready for the UKAS accreditation in 2025.

7. Research and audits

The ongoing CwPAMS project with University of Nigeria Teaching Hospital in Enugu, will continue until December 2024. Antimicrobial guidelines are in production and tracking of antimicrobial consumption data in the University Hospital of Nigeria has also started. We are expecting the AM pharmacist from Nigeria to visit MKUH to strengthen the current activities between the two organisations. We also hope that this project may enable MKUH to enhance the AMS team to 'backfill' the lead antimicrobial pharmacist's time by undertaking audit and other project work.

Conclusion

The year 2023-24 was a challenging year for MKUH with regards to AMS performance. The AMS service continued to provide strong support and vigilance on antimicrobial consumption at MKUH. MKUH met the IV to oral CQUIN target in 2023-24. The overall antibiotic consumption remained lower than the national average and comparable within the neighbouring trusts. However, analysis of local data showed rise of total consumption of antimicrobials along with use of piperacillin-tazobactam, co-amoxiclav and meropenem in 2023-2024, which is concerning. The cause of sudden increase in the local AM consumption is possibly multifactorial with a risk in the data accuracy due to a change in the organisational process of reporting admission data in 2023-24. This trend needs close monitoring in 2024-25. High NHS activity, increasing numbers of complex admissions, increased length of stay, delayed source control interventions, financial stress and staffing issues due to multiple strikes, illness, vacancies etc. played a complex role on increasing organisational stress impacting overall AM use and the quality of care and service provided. One example of this phenomenon has been shown in recent data where virtual GP clinics in the community have been shown to prescribe more antibiotics compared to when patients are seen face to face for similar conditions. AMS and infection control are still the most effective tools for long-term patient safety, therefore these need to be supported and promoted throughout the organisation despite financial constraints within the NHS.

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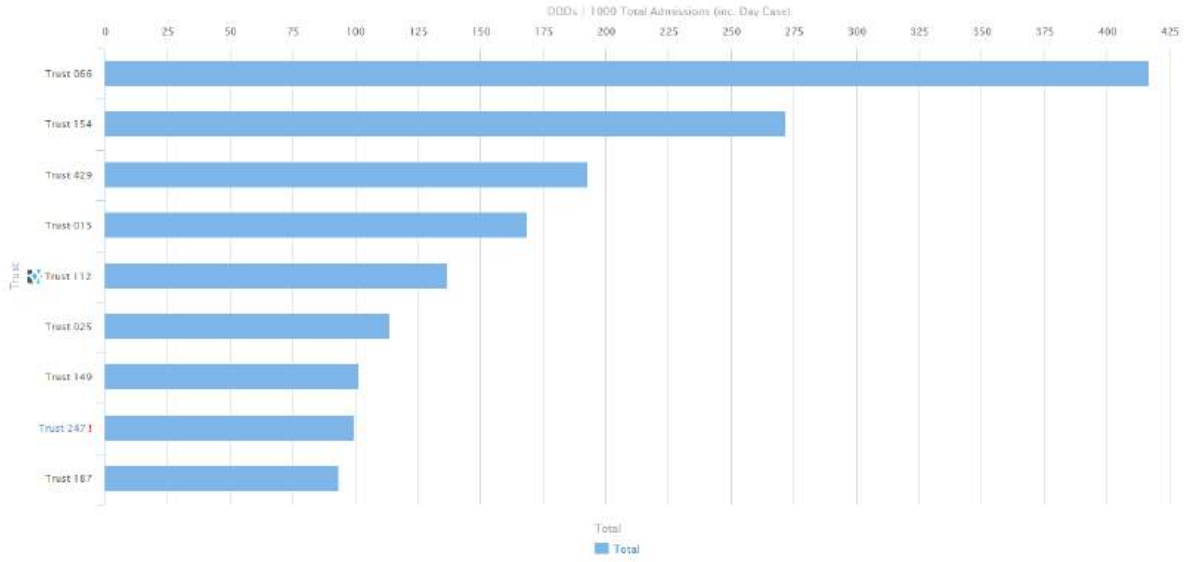
Appendix:1

Gentamicin Incident Report- May 2024

Gentamicin is an aminoglycoside which has a narrow therapeutic index requiring caution when prescribing and administering. Therapy with gentamicin also requires careful therapeutic drug monitoring of trough gentamicin levels. If prescribed correctly, gentamicin is an excellent antibiotic which can be used in a wide variety of circumstances, especially to avoid the use of broad-spectrum agents and reduce the development of antimicrobial resistance. If not prescribed and administered correctly, giving gentamicin can result in toxicity and long-lasting effects including nephrotoxicity and ototoxicity.

As per MKUH local antimicrobial sensitivity data, gentamicin has wide range of bacterial cover and therefore is a crucial part of the policy for management of sepsis of unknown source at MKUH. We use a moderate amount of gentamicin when weighted per 1000 admissions compared to the other local trusts.



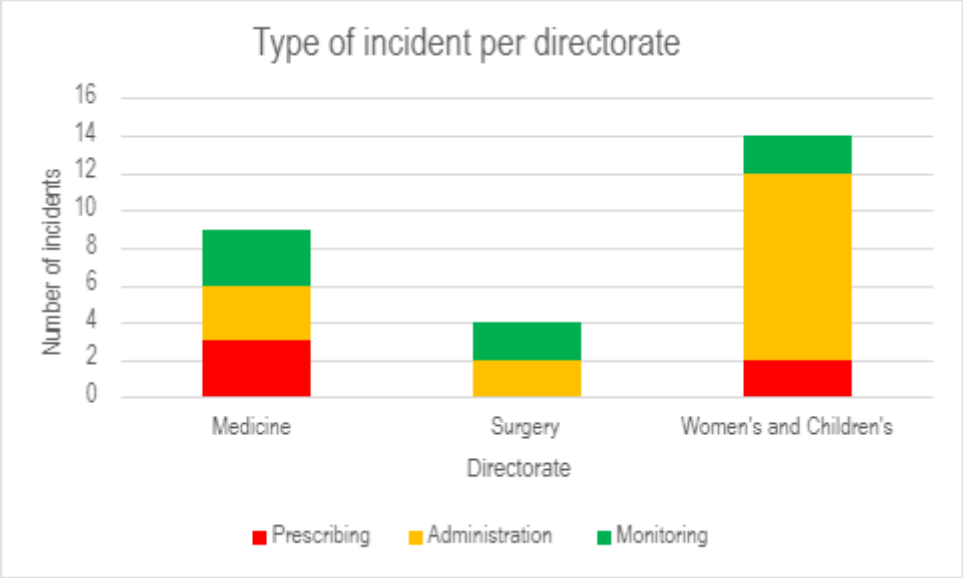
MKUH is trust 112 on the graph above. The other trusts represented here are trusts in the south of England.

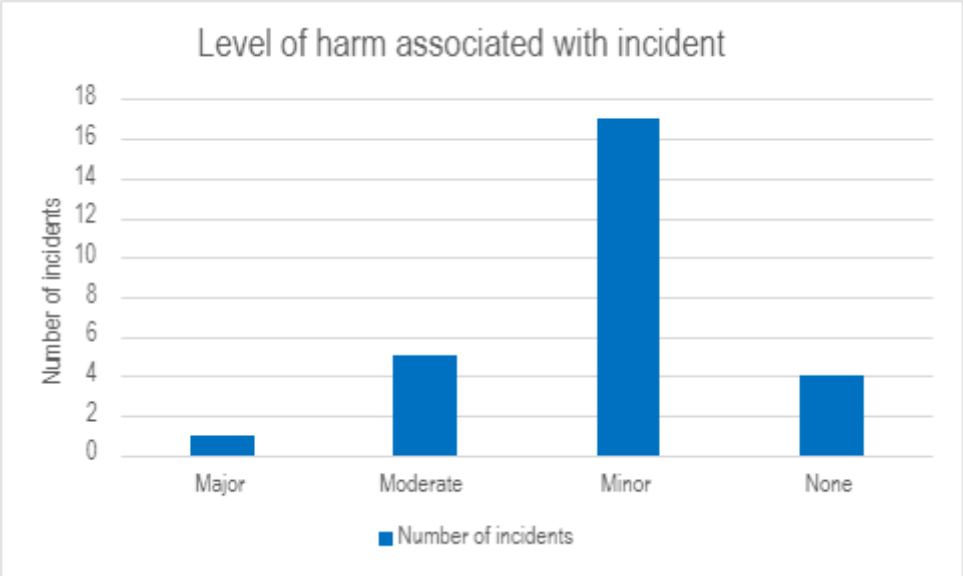
We have noted an increased number of incidents/ increased severity of incidents related to gentamicin in recent months, and have been continuously working on putting a number of measures in place to mitigate the risks of prescribing, monitoring and administration.

This report aims to give an overview of incidents since the introduction of the RADAR reporting system including any themes or commonalities demonstrated, and it will also outline the measures we have implemented to offset this risk. We are hopeful that this will give relative assurance that appropriate measures have been considered, and that a discussion will be prompted into any potential areas for improvement/ gaps within our current guidance, eCare templates or common practice which we can use to further improve the safety of prescribing, monitoring and administration of gentamicin.

27 incidents involving gentamicin were reported since the trust moved to reporting incidents through RADAR in 2021. The first incident was reported via RADAR on 1/6/2021 and the last incident reviewed was reported on 14/3/2024.

Type of incident	Number of reported incidents
Administration	15
Therapeutic drug monitoring	7
Prescribing	5





The majority of incidents were involving the administration of gentamicin and occurred in the Women's and Children's directorate. The majority of incidents were noted to have caused minor harm.

Following review of these incidents, it is evident that continuous training is necessary for all staff involved in the administration and prescribing of gentamicin. Designing alerts in e-Care can help to minimise the number of incidences but training and increased vigilance when using gentamicin is still required to reduce the risk of human error. We are cautious that creating a hard stop alert in eCare may delay gentamicin administration in critically ill or septic patients and therefore have carefully considered a number of alert options. All e-care based prompts which have been, or will be implemented, will require monitoring for a period of time after introduction to ensure fine adjustments balancing risk and benefits to patients can be implemented. The following e-Care based solutions have been identified to minimise the risk of gentamicin related incidences, some of those have already been implemented.

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Theme	Mitigation	Action completed?
Higher doses prescribed than those advised by the guideline	Gentamicin calculator updated to allow easier calculation of the dose based on ideal or adjusted weight for adults. Dose caps introduced on eCare for adults. Max 360mg gentamicin for patients >65 years of age (3mg/kg) and max 560mg for patients <65 years of age (5mg/kg).	Completed
Doses of gentamicin given/ prescribed too close in time to previous dose	Paediatrics- mandatory eCare forms introduced at point of administration to ensure gentamicin prescribed, monitored, and administered appropriately. Adults- Multiple daily dosing of gentamicin which was previously used, has been amended to allow only single daily dosing in both the policy and eCare system.	Completed
Gentamicin levels not taken	Alerts added to eCare to prompt nurses that no level has been taken prior to the dose being administered for patients >65 years. Level to be checked prior to administration.	Alerts created and undergoing demo testing before going live- awaiting approval.

	Currently no prompt for patients aged <65 years as risk is lower and levels are not mandated before each dose.	Alerts are being tested for patients with reduced renal function
Gentamicin level taken but high level not checked prior to next dose being administered	Alerts added to eCare at the time of administration to state that the patient has had a recent high gentamicin level and to check with a prescriber before administering the dose	Alerts created and undergoing demo testing before going live- awaiting approval
Gentamicin given without consideration of renal function	Alert added to eCare for adults on prescribing gentamicin to advise that the patient's eGFR is <20ml/min so gentamicin should not be given. A separate alert is also being considered for patients with a declining renal function during the period of gentamicin prescription.	Alerts created and undergoing demo testing before going live - awaiting approval Alerts in the process of being created

Upon further analysis, it was found that incidents reported since the introduction of RADAR often involved the administration of gentamicin too early in relation to the previous dose. Incidents of this type have not been completely mitigated in paediatrics, but appear to have reduced in frequency since the implementation of the eCare form to prompt nurses to review levels and the time and date of previous administration of gentamicin. There have been no reported incidents relating to the frequency or dose of gentamicin prescribed in adult patients since the introduction of eCare mandatory OD dosing and dose cap when prescribing gentamicin.
A review of the gentamicin policy has occurred and is currently awaiting approval from the antimicrobial stewardship group. Alerts are in the process of being developed to prompt levels to be taken and checked and to alert doctors of reduced renal function or changes in renal function when prescribing gentamicin.
We are conscious that the newer alerts should go live in phases and need monitoring after introduction to avoid any unnecessary delays in gentamicin administration. Education and training will continue at junior doctor training/ induction to ensure safe prescribing of gentamicin. Further gentamicin specific training iprovided on an individual basis during antimicrobial ward rounds. Nurse training will also be necessary before new alerts go live as the majority of these alerts are targeted at nursing staff when they are administering gentamicin.
Overall, we have attempted to mitigate the risks of gentamicin prescribing through a review of the gentamicin policy, alerts and prompts through eCare and a review of the

gentamicin calculator to ensure easy access and use. Regular communication, feedback and training on gentamicin prescribing and administration need to continue with further monitoring and analysis of trends in future gentamicin incidents.

TheMKWay

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Infection Prevention and Control

Annual Highlights 2023 – 2024

Authors: Angela Legate & Sharon Burns

Welcome

We are pleased to share our Infection Prevention and Control (IPC) highlight report for the period April 2023 – March 2024, the publication of which meets the requirement to demonstrate good governance, our adherence to Trust values and public accountability, and is in line with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infection and related guidance.

MKUH maintains a specific IPC Board Assurance Framework (BAF) and adopts new guidance as appropriate. Adherence to guidance remains the responsibility of the organisation, with all registered care providers required to demonstrate compliance with the Health and Social Care Act 2008.

This highlight report is intended to be more concise than those published in prior years.

Key topics of discussion:

The highlight report covers a range of topics that are of critical importance as we continue our work in reducing infection associated with healthcare, tackle the serious threat of antimicrobial resistance, and the significant lessons learned from the pandemic in preparing for increasingly complex challenges in IPC.

Performance against National thresholds for mandatory reporting:

The following organisms are subject to National Health Service England (NHSE) mandatory reporting: Methicillin-resistant Staphylococcus aureus bacteraemia (MRSA); Methicillin-sensitive Staphylococcus aureus bacteraemia (MSSA); Clostridioides difficile (CDI); and, Gram-negative bloodstream infections (Escherichia coli, Klebsiella species, Pseudomonas aeruginosa).

MKUH complies with all external reporting requirements.

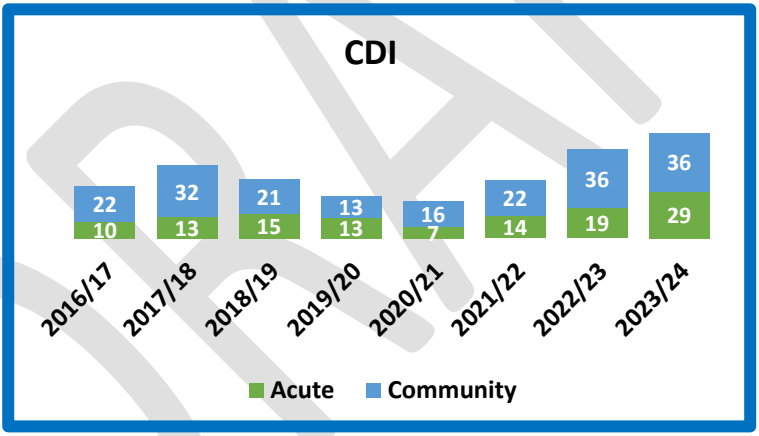
National thresholds remain for MRSA (set at zero, with MKUH reporting zero MRSA cases); CDI; Klebsiella and Pseudomonas aeruginosa.

The following graphs show the number of cases reported through this mandatory system for Milton Keynes in 2023/24, along with historic data for appreciation of trend.

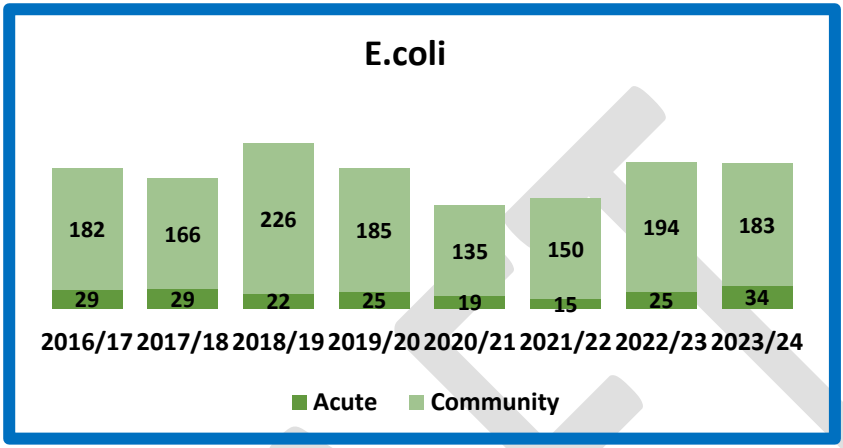
CDI

Despite concerted effort to reduce the number of C diff cases apportioned to healthcare in our hospital, we have noted an increase this year. Two factors play an important role in intestinal pathogenesis: (i) the suppression of the resident intestinal microbiota by antibiotic administration and (ii) the production of exotoxins responsible for intestinal symptoms. Risk factors contributing to increased risk of infection include advanced age, chemotherapy, use of proton pump inhibitors, chronic kidney disease, chronic liver disease, and malnutrition.

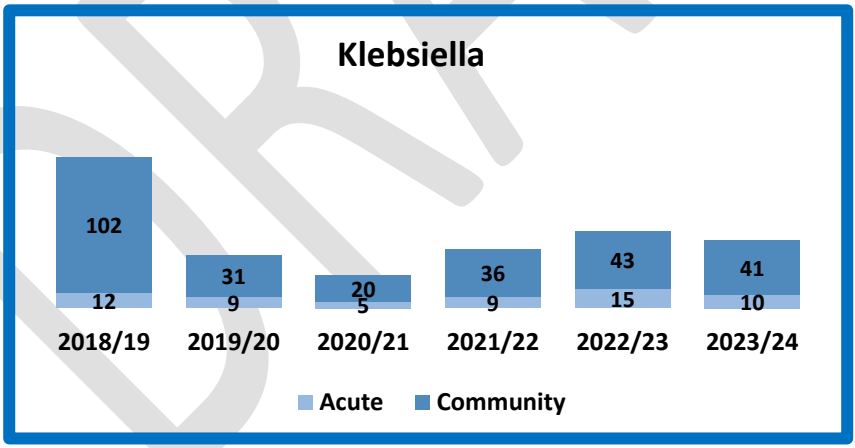
An NHSE review of the national increase in cases has not identified a link to a newly emergent strain and or antibiotic prescribing. The pandemic is still felt to be contributory to the rise, although the specific mechanism is not immediately evident.



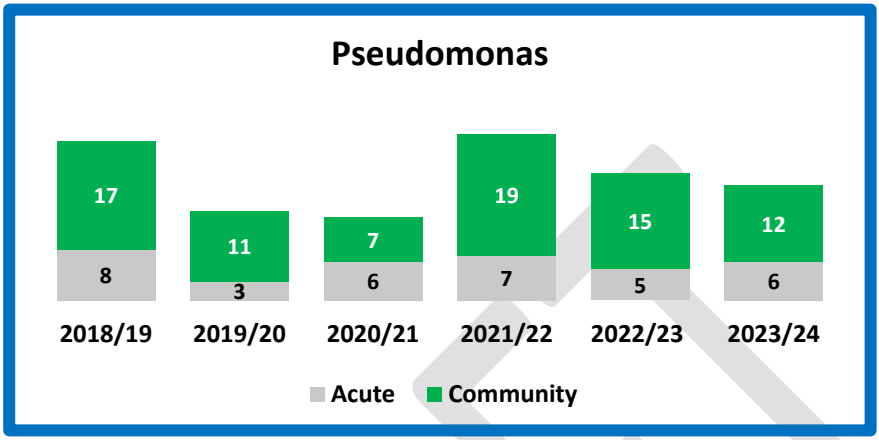
Escherichia coli (E coli) is reported to be the most researched microbial organism in the world, and despite its harmless existence as a gut commensal, it is also a major cause of human disease. The bacterium is the causative agent of a variety of intestinal pathologies such as watery and/or bloody diarrhoea, haemolytic uremic syndrome (HUS), and colitis. It also causes extraintestinal diseases such as bacteraemia and sepsis, meningitis, and urinary tract infections (UTI), and is one of the most common causes of both healthcare-associated and community-onset invasive bacterial disease. Levels in Milton Keynes are static year-on-year.



Klebsiella: MKUH finished the year below the published threshold, with the majority of cases attributed to the urinary or biliary tracts. Klebsiella pneumoniae is a common species of bacteria found in the gut, mouth or nose, and is the most prevalent cause of pneumonia associated with healthcare and the second most frequent cause of urinary tract infection worldwide.



Pseudomonas: MKUH has remained below the published threshold, but the role of urinary catheters continues as a significant risk for *Pseudomonas aeruginosa* bacteraemia. Tackling this together as a concerted and coordinated effort both in the hospital and community is to remain one of our priorities for 2024/25.



Combatting antimicrobial resistance

One of the key focus areas that will remain is how we successfully combat antimicrobial resistance (AMR), exploring antibiotic developments, building on stewardship, and the potential to consider viable alternatives to antibiotics, especially for Gram-negative bacteria. Where increases in consumption of antibiotics has been noted, it is likely due to the increase in the number of patients admitted to the Trust with influenza/respiratory illness requiring treatment. The Trust produces a separate / linked annual report in respect of Antimicrobial Stewardship.

Disposable gloves

Disposable gloves are not generally needed for core care activities such as feeding or moving patients, administering medicines, or taking observations.

The IPC team is pleased to be involved in the work underway to offer assurance on sustainable glove use: *protecting our hands while protecting the planet, the principles and practice of glove use — why and when to wear gloves, donning and doffing guidance and contamination transfer.* The positive outcome benefits patients but also contributes to a more economically viable healthcare system.

Rapid identification techniques

Our onsite laboratories offer rapid identification techniques for both respiratory and blood borne diseases, a critical factor in quick treatment and prevention of outbreaks.

We have maintained a continued focus on respiratory and gastrointestinal diseases, which have moved away from the more historical seasonal patterns (i.e., autumn / winter) to an almost continuous pattern throughout the year.

Tuberculosis (TB)

During the first quarter of 2024, United Kingdom Health Security Agency (UKHSA) tuberculosis (TB) notifications increased by 7.5% compared with the same quarter in 2023. The MKUH nurse team received a commendation from the Regional TB Lead (Consultant in Health Protection) for their innovative approaches to “spreading the word to reduce stigma and the incidence of TB” in the MK communities. The education offered by the TB nurses forms an integral part of learning for primary care colleagues, local secure services (penal and mental health), charitable organisations working with the homeless, and our patients, healthcare staff and the general public.

Addressing Healthcare Associated Infection

We continue to work with our Integrated Care Board (ICB) colleagues to explore the issues of health care associated blood and urinary tract infections in particular, but also to share good practice, innovative ways of working to reduce avoidable HCAI, and to improve practice through education and training.

Adding to our Prevention Strategies

Across 2024 and in collaboration with the learning and development team, the IPC Education Framework will be introduced.

The framework is in addition to the programme of education provided by the MKUH IPCT and is designed to support a culture of ongoing learning and development. The NHSE commissioned Skills for Health (SfH) to develop an IPC education framework outlining the behaviours, knowledge and skills required by the health and social care workforce to improve the quality of IPC practice and thereby improve patient outcomes. This framework encourages organisations to commit to demonstrating:

- strong IPC leadership at board/executive level, supported by visible IPC role models
- that IPC education and training is developed by and with IPC experts, using the expertise of the multidisciplinary team to promote delivery, which is tailored to all staff needs, focusing on behaviour as well as developing knowledge and skills.

Key objectives are to:

- support system-wide improvement in IPC and AMR
- align practice to a national IPC manual
- align practice to evidence-based best practice
- support IPC practitioner professional development.

Recognising the need to work differently.

Following changes in the IPC team (due to retirements) and a review of the team structure, the Trust has been able to achieve a modest uplift in dedicated IPC staff headcount. Increasing the workforce will improve the ability to oversee a growing number of processes for health protection incidents which include contact tracing, enabling the IPCT to return to a more operational role that seeks to make better use

of data arising from audits, and have greater flexibility to work with patients, staff, and the public.

Infection Prevention and Control in the built environment.

As new building and refurbishment of existing buildings in which to deliver healthcare services continues apace at MKUH, the IPC team has been involved in the planning, design and commissioning of: Milton Mouse (providing more space for paediatric clinics); Willow Ward (a specialised urology facility); and, a state-of-the-art Radiotherapy unit. In addition, there has been refurbishment and upgrade of patient bathrooms, staff showering facilities and staff rest rooms.

Hand Hygiene at the MKUH.

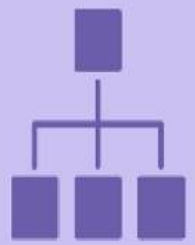
Across the year we have looked to:

- **Strengthen learning approaches** to empower our health staff to improve hand hygiene and IPC at the point of care with enhanced knowledge, skills and behaviours.
- **Promote access** to hand hygiene products through the update and renewal of dispensers and signage across the Trust.
- **Raise awareness** about the importance of knowledge and learning on hand hygiene at the right times to prevent the opportunity for infection to start, or where infection exists, its transmission onward.
- **Encouraged** the use of personal hand sanitisers for staff where practicable.

As the challenges increase, so does our commitment to arresting avoidable HCAI through the following routes:

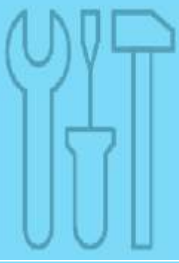
Increasing IPC staff numbers

Developing staff competencies with IPC practices



Facilitate implementation of the IPC education framework

Building on relationships with local, regional and national IPC networks



Developing research opportunities

Raising the profile of IPC at MKUH internally and externally

Raising the profile of IPC

The team has continued to work hard to raise the profile of IPC in the Trust and wider community, supporting and engaging with all opportunities to work smarter and safer.

Conclusion

Under the leadership of the Director for Infection Prevention and Control (DIPC), the IPC team, in conjunction with a range of colleagues across the Trust, has contributed to an annual programme of work.

In the forthcoming year, the IPC team will continue to focus on the harmonisation of IPC practices, policies, and processes. Key objectives include: continuing to minimise the risk of healthcare associated infections; infection audit and surveillance; further developing the skills and knowledge of staff; and, ensuring evidence based clinical guidance on IPC practices and improving accessible patient information.

The overarching IPC objectives for 2024/25 can be found within the IPC BAF:

2024-BAF-review .pdf

Meeting Title	**Trust Board in Public**	**Date: 14th November 2024**
Report Title	**Risk Register Report**	**Agenda Item Number: 17**
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 November 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	*N/A*
Appendices/Attachments	Supplementary Shelf Appendix 1: Corporate Risk Register Appendix 2: Significant Risk Register

Risk Management Dashboard (Radar):

Exception Reporting:

The above dashboard provides a summary of the key metrics to provide assurance that the risk management process is working as intended.

The key highlights are as follows:

1. The total number of risks remains quite static at around 250-260 risk. This shows that whilst risks are being identified and added to the Risk Register, a similar number of risks are being closed month on month.

2. Just under a quarter of the risk identified (59) are currently graded as significant. The heat map shows that around half of the risks are graded as moderate harm. Around three quarters of the risks identified are either moderate or significant risks to the Trust objectives – therefore highlighting the importance of these being effectively managed.

3. There are currently 32 risks (12.5%) that are overdue their review date. This is **a reduction of 20** from the previous report. Risks need to be reviewed frequently to ensure decision are being made using up to date / correct information.

4. 6 of the 32 overdue risks are more than 1 month overdue:

Reference	Risk Owner	CSU	Days Overdue
RSK-475	Julian Robins	Head & Neck	131
RSK-183	Andrew Scott	Diagnostic & Screening	118
RSK-131	Paula Robinson	Diagnostic & Screening	97
RSK-498	Jose Samoes	Internal Medicine	79
RSK-084	Amanda Taylor	Head & Neck	66
RSK-518	Catherine Watson	Head & Neck	66

5. There are 311 controls that have been identified and are in progress. This shows that when risks are identified, controls are being identified to mitigate the risk. Of these 102 are past their due date. This is **an increase of 16**, which is a significant improvement from the last report.

6. Following Internal Audit recommendations, a proposal has been made to the Education Board that Risk Management training is made mandatory for all staff bands 7 and above, with a 3 yearly renewal. This should support staff understanding of the importance of the process and their role in ensuring risks are regularly identified, assessed, controlled and reviewed.

   Update: Risk Management Training to be discussed at the October Education Board. Awaiting decision.

Risks Escalated by Division/Corporate Department:

There are 3 risks for escalation onto the Corporate Risk Register:

Reference	Risk Owner	Summary of Risk	CSU / Department	Rationale
RSK-574	Oliver Chandler	Insufficient staff within the Cyber Security Team	IT	If it occurred, the risk could have Trustwide impact
RSK-575	Craig York	Method for using smart cards to log into eCARE is not updated by Oracle Health	IT	If it occurred, the risk could have Trustwide impact
RSK-587	Ian Fabbro	Trust engagement in the adoption of clinical digital systems	IT	If it occurred, the risk could have Trustwide impact

Recommendations:

1. Divisions/Corporate Department to ensure that their risks are being regularly reviewed in line with the Risk Management Framework. Risks graded 1-6 must be reviewed at least annually. Risks graded 8-25 must be reviewed at least monthly.
    a. All overdue risks to be updated by 30th November 2024.

2. Divisions/Corporate Departments to ensure that controls are reviewed and updated as part of reviewing each risk.
    a. All controls to be updated and either closed or their due dates extended by 30th November 2024.

3. The 3 risks for adding to the Corporate Risk Register to be approved by the Committee.

Meeting Title	**Trust Board in Public**	**Date: 14th November 2024**
Report Title	**Board Assurance Framework**	**Agenda Item Number: 18**
Lead Director	Kate Jarman, Chief of Corporate Services	
Report Author	Paul Ewers, Senior Risk Manager	

Introduction	Assurance Report		
Key Messages to Note	• SR1 - Continued industrial action resulting in significant disruption to service/ care provision – Risk has been mitigated to an acceptable level. Moved from Current Risk to Longer-term risk for monitoring. • SR7 - Political instability and change. Decision at Board Seminar (Oct 2024) for risk to be moved to the list of Longer-term risks. • There are 6 potential new risks identified at Board Seminar in October 2024.		
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 and retaining 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 seven risks against the achievement of the Trust's strategic objectives in 2024:

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
8. Head & Neck cancer pathway
9. Insufficient staffing levels to maintain safety

At the Board Risk Seminar in October 2024, the strategic risks around industrial action and political instability/change were moved to the list of Longer-Term risks (see below).

The board identified 6 potential new strategic risks. These will be reviewed and considered by the relevant Board Committees:

To be reviewed and considered at FIC:

- Capital funding for deteriorating quality of estate
- Recording and reporting of SDEC dataset
- Pathology LIMS system contract. System is no longer sufficient for the needs of the department

To be reviewed and considered at Audit & Risk Committee

- Partnership working
- Data and Cyber Security

To be reviewed and considered at Quality Clinical Risk Committee:

- Widening health inequalities

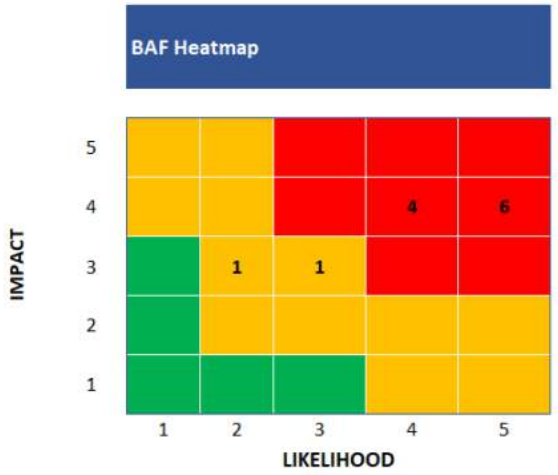
Longer-term Risks: Seven longer-term risks have been identified.

- Conflicting priorities between the ICS and providers
- Lack of availability of skilled staff
- Increasing turnover
- Lack of time to plan and implement long-term transformational change
- Long-term financial arrangements for the NHS
- Growing/ageing population
- A pandemic
- Continued industrial action resulting in significant disruption to service/ care provision
- Political instability and change

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)

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
BAF0001	16	16	20	20	20	20	20	20	20	20	20	20	
BAF0002	20	20	20	20	20	20	20	20	20	20	20	20	
BAF0003	20	20	20	20	20	20	20	20	20	20	20	20	
BAF0004	16	16	16	16	16	16	16	16	16	16	16	16	
BAF0005	16	16	20	20	20	20	20	20	20	20	20	20	
BAF0006	15	15	20	20	20	20	20	20	20	20	20	20	
BAF0007	16	16	16	16	16	16	16	16	16	16	16	16	
BAF0008	20	20	20	20	20	20	20	20	20	20	20	20	
BAF0009	16	16	16	16	16	16	16	16	16	16	16	16	
BAF0010			9	9	9	9	9	9	9	9	9	9	
BAF0011							16	16	16	16	16	16	
BAF0012											6	6	

- 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					SR9 Insufficient staffing levels to maintain safety
3 Moderate					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

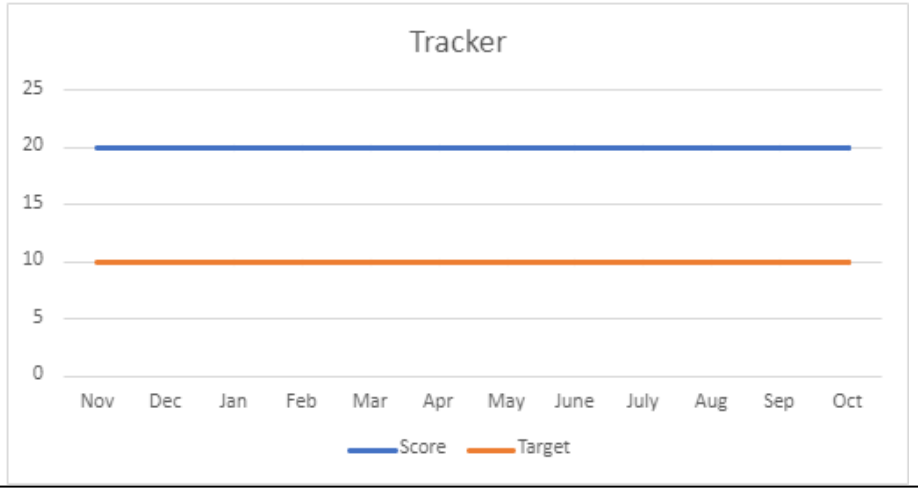
Assurance ratings:

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:

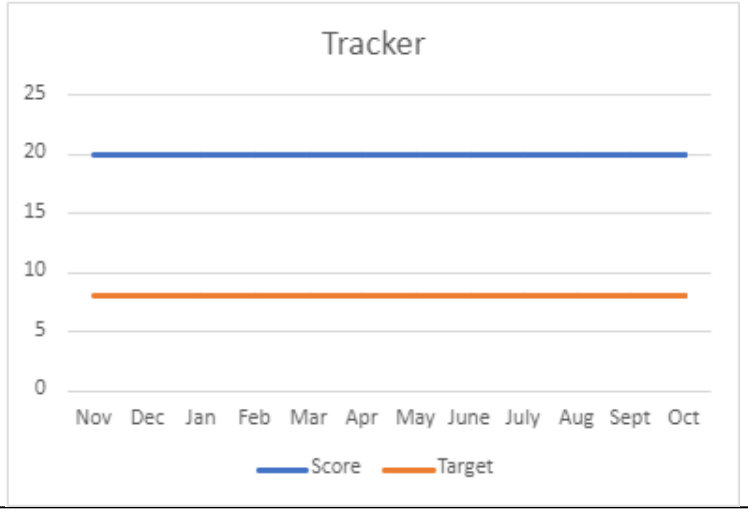
			Likelihood				
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost certain
Consequence	1	Insignificant	1	2	3	4	5
	2	Minor	2	4	6	8	10
	3	Moderate	3	6	9	12	15
	4	Major	4	8	12	16	20
	5	Catastrophic	5	10	15	20	25

BAF 2024/25

Strategic Risk 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	October 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-134 | RSK-202 | 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 base line capital budget available for 2024/25 is not sufficient to cover the planned depreciation requirement for operational capital investment. It has been topped up in year through the annual planning incentives relating to the revenue break even position 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. • In year oversight of BC approvals to ensure early	• 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 revised plan is £0.6m in excess of its approved allocation but the Trust has allocated capital contingency funding to align spend to its capital allocation	• Continued dialogue with Regional and National Capital teams at NHS England by CFO from MKUH and BLMK ICB during 2024/25. Ongoing	**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 align capital funding to planned depreciation spend for future capital allocations **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 assurance around future capital allocations	Continued dialogue at an ICB /Regional and National CFO level regarding future capital allocations. Ongoing

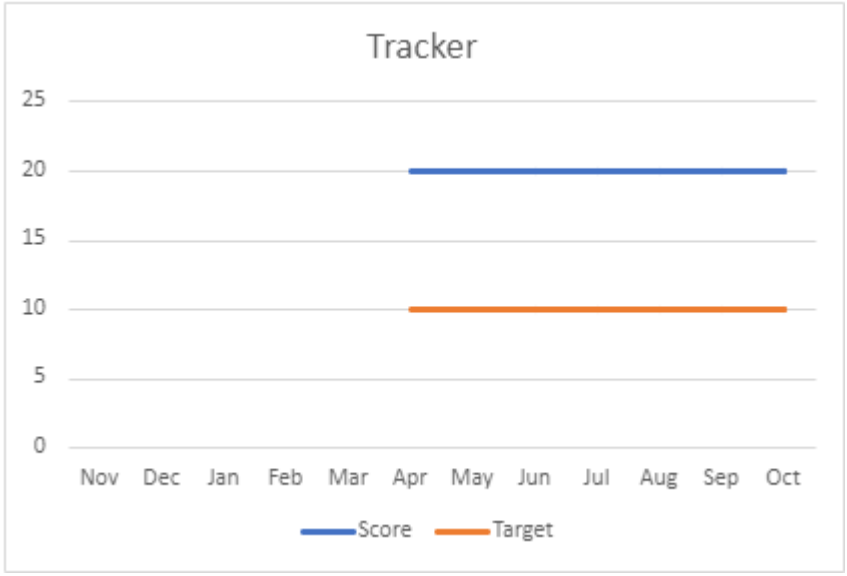
	oversight of any potential slippages. All BC have been through the internal process as of the end of September					

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	October 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. • Management oversight of	• 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 for both BLMK ICS and Spec	• Maximisation of ERF income. Ongoing monthly tracking • Pro-active procurement to minimise inflationary pressures. Part of CIP programme above (non-pay cross cutting) • Workforce planning in areas of where market forces are a significant inflationary factor. Part of CIP programme above (non-pay cross cutting) • Discussion with commissioners regarding block contract value and	**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) • Urgent work to identify and de-risk the CIP delivery plan of £23.8m	• Systematic monitoring of inflationary price changes in non-pay expenditure. • Limited ability to directly mitigate demand for unplanned services. • The break-even plan for 2024-25 has a target of £23.8m CIP's which is not fully identified and remains high risk. • ERF target is at risk due to re-categorisation of SDEC activity	• Urgent work to identify and de-risk the CIP delivery plan of £23.8m. Target to have fully identified end of Sept 2024 • The cash implications and need for cash support are also being progressed with NHSE so that any cash drawdowns are planned in advance. Monthly monitoring • Service reviews are planned as part of CIP planning as well as demand management and access to diagnostics both internally and by GP's. Ongoing • SDEC activity recategorization risk: action to

• Affordability of 2024/25 planning objectives (e.g., backlog recovery) in the context of the evolving financial regime for 2024/25	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 and Spec Comm on sufficiency of the block element of the service contract • Delivery of CIP programme of £23.8m in 2024-25. Ongoing monthly tracking of CIP plan development via Transformation Board.	Comm • Inability to recover ERF for growth in Spec Comm contract due to ERF target being set at a level which does not recognise growth	demand pressures thereon Timing: pressures communicated to ICB by Nov 24, to inform next year's block • Resetting of ERF target for Spec Comm from 145% to 106% in line with ICB target: Timing: National appeal was rejected, new appeal via regional team Nov 2024	Timing: on-going monthly tracking of CIP plan development via Transformation Programme Board **Second Line:** • Monthly Performance Board reporting • Trust Executive Committee reporting • Finance & Investment Committee reporting. • Consultancy support has been approved by Board and EoE region. They have now been engaged and are helping to deliver the CIP plan **Third Line:** • Review of drivers of deficit by external consultancy		apply for adjustment of the baseline and additional workstream to mitigate through correct categorisation of activity to in-scope outpatient attendances. • NHSE seeking SDEC categorisation changes to be applied to the data from Q2 2024/25. *Timing: complete SDEC reporting categorisation change by mid Nov 24, backdated to July 2024* • Divisional recovery plans are being developed for Medicine, Core Clinical and Surgery. October 2024

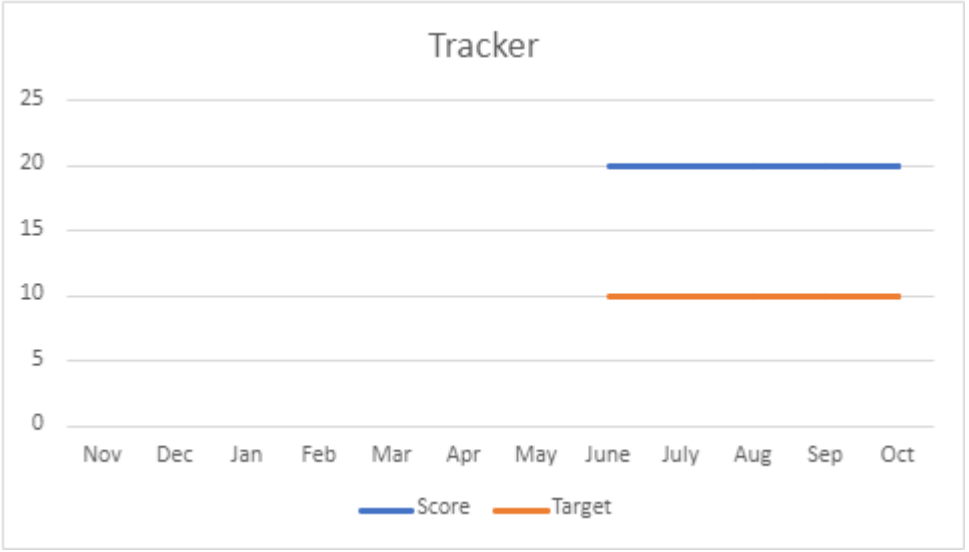
	• Maximisation of ERF income. *Timing: ongoing with monthly tracking*					

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	October 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	RSK-131 | RSK-374 | RSK-110 | RSK-439 | RSK-457 | RSK-036 | RSK-080 | RSK-107 | RSK-142 | RSK-157 | RSK-523 | RSK-550 | RSK-564						
Trend							

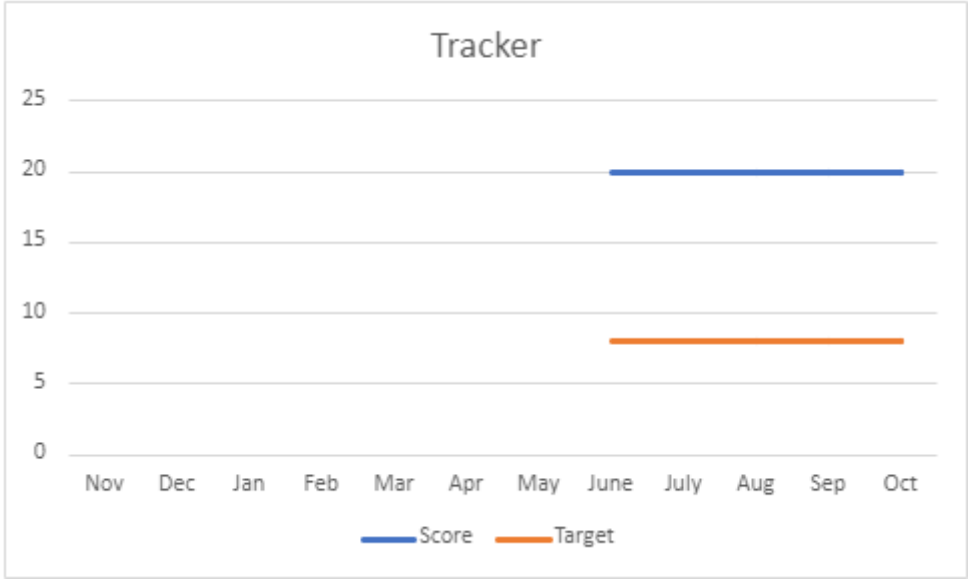
Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
• Patients delayed in elective backlogs (including cancer)	• Routine and diligent validation and clinical prioritisation of patient records on waiting lists. • Daily/Weekly management of PTL (Patient 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). • Additional executive capacity to provide greater scrutiny and oversight. • Short term provision of additional resources to clear backlogs.	• 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.	• Detailed capacity and demand analysis at specialty level. November 2024 • Development of specialty level action plans based on capacity and demand outputs. November 2024 • Additional investment and capacity being sourced through alternative options outside the Trust, support by the Cancer Alliance. TBC • Increase availability of HALO. TBC • Spot purchase additional capacity within MK. TBC • Send patients out of area ICB support processes. TBC • Additional activity internally and externally. TBC	**First Line:** • Internal escalation meetings with performance monitoring of key indicators. • Specialty validation and weekly PTL meetings. **Second Line:** • ICB & regional scrutiny via performance meetings. **Third Line:** • National performance profile monitoring.	• Better understanding of the capacity required to meet emergency demand • Better understanding of capacity required for patients discharged on a pathway • Real-time oversight of bed capacity within organisation	• Full capacity and demand exercise. April 2025 • Explore option for real-time oversight of bed capacity through eCARE. January 2025 • Roll out of electronic whiteboards across organisation. November 2025

	• Due diligence in IPC procedures and uptake of national vaccination programmes. • Ongoing recruitment drive and review of staffing models and skill mix. • International recruitment. • Bank and agency staffing deployed.					
• 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 equilibrium with Executive oversight. • Effective daily discharge processes to keep elective capacity protected and avoid cancellations –	• Capacity limitations to meet demand in other providers (health and social care). • IPC outbreaks such as flu/ norovirus • Staffing vacancies in different professions required to meet specific needs. • Unplanned short term sickness absence.				

• Inability to discharge elective patients to onward care settings.	Board rounds. • Daily review and MK system call of all Non-Criteria to Reside patients.	• Increased volume of ambulance conveyances and handover delays. • Capacity limitations to meet demand in other providers (health and social care)				

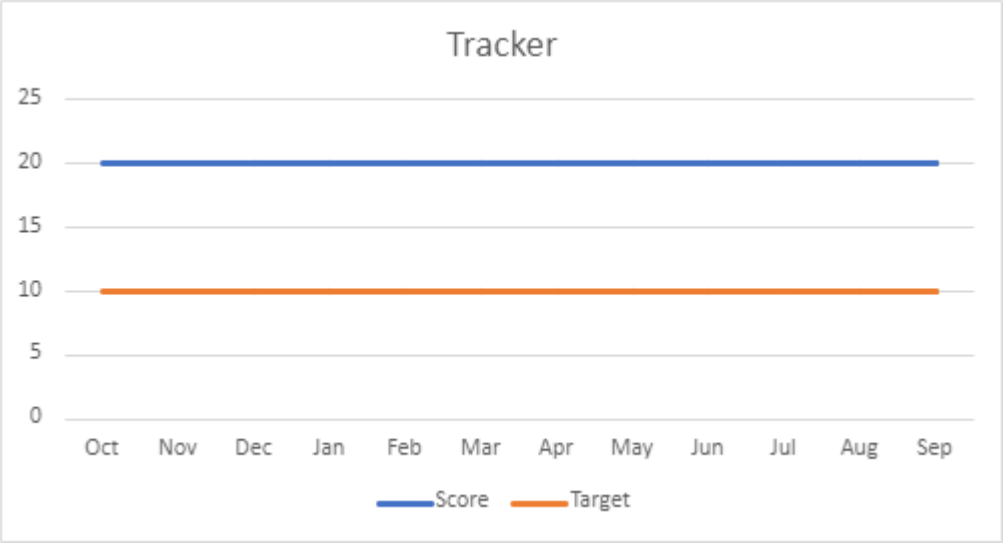
Strategic Risk 5	**Patients experience poor care or avoidable harm due to inability to manage emergency demand.**						
Lead Committee	Quality Clinical Risk Committee	**Risk Rating**	**Inherent**	**Current**	**Target**	**Risk Type**	Safety
Executive Lead	Chief Operating Officer – Unplanned Care	**Consequence**	5	5	5	**Risk Appetite**	Avoid
Date of Assessment	June 2024	**Likelihood**	5	4	2	**Risk Treatment Strategy**	Treat
Date of Review	October 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	RSK-016 | RSK-131 | RSK-409 | RSK-427 | RSK-457 | RSK-036 | RSK-095 | RSK-523 | RSK-550 | RSK-564						
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 • Risk assessed redeployment of staff to where there is greatest need.	• 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. Dec 2024 • Review alternative pathway options into community and admission avoidance. March 2025 • Maximise potential of discharges with partner agency and escalate where issues. TBC • Completion of Integrated Discharge Hub project. December 2024 • Transformation project to reduce LOS. March 2025 • UEC Steering Group with key workstreams identified. December 2024	**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.	• Better understanding of the capacity required to meet emergency demand • Better understanding of capacity required for patients discharged on a pathway • Real-time oversight of bed capacity within organisation	• Full capacity and demand exercise. April 2025 • Explore option for real-time oversight of bed capacity through eCARE. January 2025 • Roll out of electronic whiteboards across organisation. November 2025

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 – Unplanned Care	**Consequence**	5	5	4	**Risk Appetite**	Avoid
Date of Assessment	June 2024	**Likelihood**	4	4	2	**Risk Treatment Strategy**	Treat
Date of Review	October 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	RSK-438						
Trend							

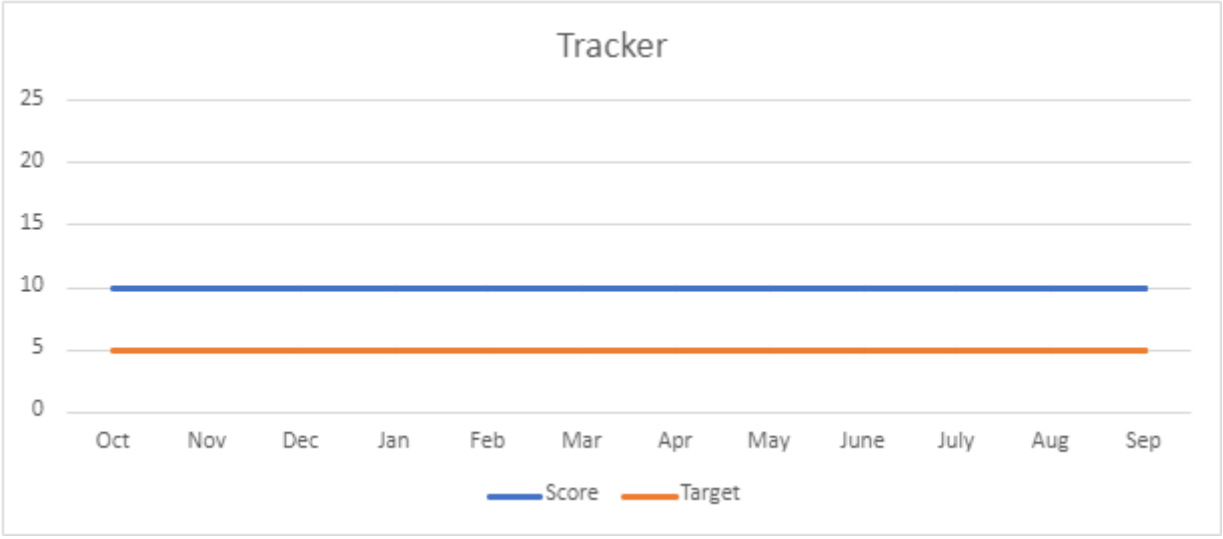
Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
• Lack of inpatient mental health provision (including in specialist settings) leading to patients in mental health crisis with no physical health need remaining in the ED or inpatient beds	• Lower 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. November 2024	**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 • Better understanding of the capacity required to meet emergency demand • Better understanding of capacity required for patients discharged on a pathway	• System-wide mental health care meeting to be convened by September 2024 to agree escalation model and SOP. November 2024 • Full capacity and demand exercise. April 2025
• 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	• 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	• 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. November 2024			• System-wide social care meeting to be convened by September 2024 to agree escalation model and SOP. November 2024 • Full capacity and demand

specialist care settings or placements		‘safe place’ which exacerbates delays in finding an appropriate bed in a specialist setting.				exercise. April 2025

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	September 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. Deadline: Out of the control of the Trust • Regular operational meetings (with OUH) to articulate the service model going forward to the satisfaction of commissioners and others. Deadline: Out of the control of the Trust	**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. Deadline: Out of the control of the Trust

	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)					

Strategic Risk 9	**Insufficient staffing levels to maintain safety**						
Lead Committee	Workforce & Development Assurance Committee	**Risk Rating**	**Inherent**	**Current**	**Target**	**Risk Type**	Patient Harm
Executive Lead	Chief People Officer	**Consequence**	5	5	5	**Risk Appetite**	Avoid
Date of Assessment	April 2024	**Likelihood**	3	2	1	**Risk Treatment Strategy**	Treat
Date of Review	September 2024	**Risk Rating**	15	10	5	**Assurance Rating**	Positive Assurance
Linked Trust Objectives	1 Keeping you safe in our hospital 8 Employing and retaining the best people to care for you						
Linked Corporate Risks	RSK-035 | RSK-457 | RSK-529 | RSK-095 | RSK-414 | RSK-456 | RSK-481 | RSK-490						
Trend							

Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
• Increasing turnover • Sickness absence (short and long term) • Inability to recruit	**Staffing/Roster Optimisation** • Exploration and use of new roles. • Check and Confirm process • Safe staffing, policy, processes and tools • Divisional ownership of staff and rostering practices **Recruitment** • Recruitment premia • Bespoke recruitment for hard to fill roles • Apprenticeships and work experience opportunities. • Use of the Trac recruitment tool to reduce time to hire and candidate experience. • Rolling programme to recruit pre- qualification students. • Use of enhanced adverts, social media and recruitment days • Rollout of a dedicated workforce website	• Processes in development and review, yet to embed fully • Lack of Divisional ownership and understanding of safe staffing and efficient roster practices • Monitoring Divisional processes to ensure timely recruitment • Focused Executive intervention in areas where vacancies are in excess of 20% • Increased talent management processes.	• Talent management strategy refreshed and revised. Will be delivered as part of 24-27 Workforce Plan	**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

	• Creation of recruitment "advertising" films • Targeted recruitment to reduce hard to fill vacancies. • Divisional ownership of vacancies • Workforce team monitor vacancies to ensure recruitment taking place • Executive oversight of areas with vacancies in excess of 20% **Retention** • Retention premia • Leadership development and talent management • Succession planning • Enhancement and increased visibility of benefits package • Schwartz Rounds and coaching collaboratives. Onboarding and turnover strategies/reporting • Learning and development programmes					

	• Health and wellbeing initiatives • Staff recognition - staff awards, long service awards • Review of benefits offering and assessment against peers.					

TheMKWay

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Meeting Title	**TRUST BOARD IN PUBLIC**	**Date: 14 November 2024**
Report Title	**Annual Review of Terms of Reference**	**Agenda Item Number: 19**
Lead Director	Kate Jarman, Chief Corporate Services Officer	
Report Author	'Kemi Olayiwola, Trust Secretary	

Introduction	Terms of Reference will normally be reviewed annually, with recommendations for changes submitted to the Trust Board for approval in line with clause 15 of the Board's Terms of Reference (as adapted in the Board Committees' ToRs).		
Key Messages to Note	The Board are invited to: 1. **APPROVE** the change in title of the '*Audit Committee*' to 'Audit & Risk Committee' for better oversight of risks at the committee level 2. **NOTE** the amendments to the Trust Board's, Board Committee's and Council of Governors' Terms of Reference 3. Following the recommendations from the Board committees, **APPROVE** the Terms of References		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** [x]	**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	Board Committees Council of Governors
Next Steps	Notify the Council of Governors about the change in meeting title from 'Audit Committee' to 'Audit & Risk Committee'
Appendices/Attachments	Trust Board ToR Audit & Risk Committee ToR Finance & Investment Committee ToR Workforce & Development Assurance Committee ToR Quality & Clinical Risk Committee ToR Remuneration Committee ToR Charitable Funds Committee ToR Council of Governors ToR

Introduction

i. Change of Committee Title - Audit & Risk Committee

This report proposes a change in the title and remit of the *Audit Committee* to the ***Audit & Risk Committee***, a standing committee of the Trust Board. This proposal is in line with standing orders 5.1 (subject to SO2.7) which empowers the Board with the responsibility of establishing committees consisting of Directors of the Trust.

The following factors necessitate this proposal:

- There is a need for more effective support for the Trust Board in its responsibility of scrutinising, assessing, monitoring and oversight of the risks to the delivery of the Trust objectives vis a vis the Board Assurance Framework.
- A need for an effective and regular review of the Trust's risk management assurance processes.
- The Trust's Risk and Compliance Board has been disbanded, and at present, there is no Board committee dedicated to holistic risk oversight.
- The need for a Board committee to oversee and manage the associated risks and assurance processes of the Trust's present and future Capital Projects, including the New Hospital Programme (NHP) and ancillary development projects that the Trust may embark upon.
- The Trust will benefit from a dedicated committee responsible for the annual review of internal audit arrangements and the Board Assurance Framework (BAF). Where required, the committee will provide a recommendation to the Board on any concerns around risk appetite or management of high-level strategic and operational risks, including the BAF.

ii. Annual Review of Terms of Reference (ToR)

Terms of Reference will normally be reviewed annually, with recommendations for changes submitted to the Trust Board for approval in line with clause 15 of the Board's Terms of Reference (as adapted in the Board Committees' ToRs). In line with the Board Forward Agenda Plan on timings, the ToR for the Trust Board, Board Committees and Council of Governors have been duly reviewed at the various committees, amended, and recommended for the approval of the Trust Board.

Recommendation

The Board are invited to:

i. **APPROVE** the change of the Audit Committee's name to Audit & Risk Committee

ii. **NOTE** the amendments to the Trust Board's, Board Committee's and Council of Governors' Terms of Reference

iii. Following the recommendations from the Board committees, **APPROVE** the Terms of References

Milton Keynes University Hospital NHS Foundation Trust

Board of Directors
TERMS OF REFERENCE

1. Constitution

1.1 The Board of Directors is mandated under paragraph 23 of the Constitution.

2. Authority

2.1 The powers of the Board of Directors are set out in the Trust Constitution and relevant legislation.

3. Accountability

3.1 The Board of Directors is accountable to the various bodies set out in statute, including NHS England and other third-party bodies and is also accountable to the Trust Membership via the Council of Governors.

4. Duties

4.1 The Board of Directors will exercise the powers of the Foundation Trust, as set out in the 2006 NHS Act, Health and Social Care Act 2022 and as stated in the Trust Constitution (paragraph 3.2):

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

4.2 The Board will set the strategic direction, aims and values of the Trust, taking into consideration the views of the Council of Governors, ensuring that the necessary financial and human resources are in place to enable the Trust to meet its objectives and review management performance.

4.3 The Board will ensure that the Trust is compliant with its Provider Licence, its constitution, mandatory guidance issued by NHS England, relevant statutory requirements and contractual obligations. In particular the Board will:

- review the Annual Plan submission to NHS England
- receive sufficient high-level reports to assure itself that the Trust is compliant with its terms of authorisation

4.4 The Board as a whole is responsible for ensuring the quality and safety of healthcare services, education, training and research delivered by the Trust and applying the principles and standards of clinical governance set out by the Department of Health and Social Care, the Care Quality Commission, and other relevant NHS bodies and as documented within the Trust's Risk Management Strategy. In particular the Board will:

- review the Trust's Registration and compliance monitoring arrangements

4.5 The Board should also ensure that the NHS foundation trust exercises its functions effectively, efficiently and economically.

4.6 The Board will recognise that all directors have joint responsibility for every decision of the Board regardless of their individual skills or status and recognise that all directors have joint liability.

5. Risk Management

The Board Assurance Framework will be scrutinised by the Board at each of its meetings. Risks which are rated 15 or over are escalated from service risk registers, via the Divisions, ~~Risk and Compliance Board~~, Trust Executive Committee (TEC), ~~Management Board~~ Audit & Risk Committee and to the Trust Board for inclusion in the Significant Risk Register. The Board will assess risks to the delivery of the Trust Objectives and include these on the Board Assurance Framework.

6. Membership

6.1 The Chairman of the Board shall be appointed by the Council of Governors

6.2 The Membership of the Board of Directors shall be as mandated in paragraph 18 of the constitution and shall consist of:

- a Non-Executive Chair
- 7 other Non-Executive Directors
- the Chief Executive Officer
- 6 voting Executive Directors including the positions of Chief Medical Officer, Chief Nursing Officer, Deputy Chief Executive Officer, Chief Finance Officer, Chief Operating Officer and Chief People Officer.

The above comprise the voting membership of the Board of Directors

6.3 Additionally the following will fully participate in Board of Directors meetings but not be entitled to vote:

- any Aassociate Non-Executive Directors
- any other Executive Directors

6.4 The meeting is deemed **quorate** when at least six directors are present including not less than three voting Executive Directors (one of whom must be the Chief Executive Officer or acting Chief Executive Officer) and three voting Non-Executive Directors (one of whom must be the Chair or Deputy Chair).

6.6 The Board may invite non-members to attend its meetings as it considers necessary and appropriate. The Trust Secretary, or whoever covers those duties, shall be Secretary to the Board and shall attend to take minutes of the meeting and provide appropriate advice and support to the Chair and Board members.

7. Responsibilities of Members

7.1 Members of the Board of Directors have a responsibility to attend at least **5** ~~**75%**~~ formal meetings of the Trust Board (private and public as one meeting) in a financial year~~of meetings~~, having read all papers beforehand

7.2 Identify agenda items for consideration by the Chair at least 14 days before the meeting

7.3 Submit papers to the Trust Secretary by the published deadline (at least 10 days before the meeting). Papers received after this deadline will normally be carried over to the following meeting except by prior approval from the Chair

7.4 Members must bring to the attention of the Board any relevant matters that ought to be considered by the Board within the scope of these terms of reference that have not been able to be formalised on the agenda under Matters Arising, or Any other Business

7.5 Executive members must send apologies to the Trust Secretary and seek the approval of the Chair to send a deputy if unable to attend in person

7.6 Members must maintain confidentiality in relation to matters discussed in the Private session of the Board

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

8. Frequency of Meetings

8.1 Formal m~~M~~eetings will normally take place every two months. Meetings may take place more frequently at the Chair's discretion

8.2 The business of each meeting will be transacted within a minimum~~aximum~~ of two-and-a-half hours.

9. Board~~Committee~~ Administration

9.1 Board~~Committee~~ administration will be provided by the Trust Secretariat

9.2 Papers should be distributed to the Board members no less than five clear days before the meeting

9.3 Draft minutes of meetings should be made available to the Chair for review within 14 days of the meeting

10. Review

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

Version Control

Draft or Approved Version:	DRAFT
Date:	October 2024~~3~~
Date of Approval:	02 November 2023
Author:	Trust Secretary
To be Reviewed by:	Trust Board
To be Approved by:	Trust Board
Executive Responsibility:	Chief ~~of~~ Corporate Services Officer
Date of Approval	14 November 2024
Date of Approval	
Date of Approval	

Milton Keynes University Hospital NHS Foundation Trust

AUDIT & RISK COMMITTEE TERMS OF REFERENCE

1. Constitution

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

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

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

2. Delegated Authority

2.1 The Committee has the following delegated authority:

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

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

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

3. Accountability

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

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

4. Reporting Lines

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

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

4.24.3 The Committee will receive evidence-based assurance and timely advice from the chairs of the other committees of the Board on their activities and operation by exception. Members of this Committee who sit on other committees of the Board have a responsibility to report on an exception basis to the Committee on the statements made and assurances given in those committees

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

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

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

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

5. Purpose

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

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

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

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

6. Duties of the Audit Committee

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

6.1 Integrated Governance, Risk Management and Internal Control

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

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

Commented [OO1]: Clause introduced pursuant to discussions.

Commented [OO2]: Now covered in 4.3

Commented [OO3]: Recommended as this is now a priority for the Board

Commented [OO4]: EDI has now become a Board priority. Committee recommended to support the Board with oversight.

- the Board Assurance Framework;
- the Annual Governance Statement, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to discussion by the Board where possible;
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the disclosure statements in the above;
- the policies for ensuring compliance with NHS Improvement and other regulatory, legal and code of conduct requirements;
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority;
- the Trust's insurance arrangements.

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

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

6.2 Internal Audit

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

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal
- reviewing and approving the Internal Audit programme and operational plan, ensuring that this is consistent with the audit needs of the organisation
- reviewing the major findings of internal audit work, management's response, and ensuring co-ordination between the Internal and External Auditors to optimise audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- reviewing the responses by management to the internal audit recommendations
- ensuring that internal audit reports with adverse findings (i.e. in the bottom two quadrants of scores) are presented to the Committee for formal discussions and where required, referred to the relevant oversight committee
- annually reviewing the effectiveness of internal audit

6.3. External Audit

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

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

6.4 Whistleblowing

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

6.5 Other Assurance Functions

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

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

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

6.5.3 The committee will assist the Board in its oversight of the associated risks, as well as ensure the effectiveness of the risk management assurance processes of the Trust's capital projects including but not limited to the New Hospital Programme (NHP) and any other projects that the Trust may embark upon. .

6.5.4 The Audit & Risk Committee will receive, review and approve where required, write offs, credit notes, waivers and losses and special payments

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

6.6 Counter Fraud

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

7. Membership

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

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

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

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

7.4 ~~7.4~~ At least one member of the Audit Committee must have recent and relevant financial experience and hold a relevant registered financial qualification. Where this is not possible, for example due to that member's term as Non-Executive Director coming to an end, the Committee should seek to appoint another member with the required experience and qualifications at the earliest opportunity. Where there is not another Non-Executive Director with the required experience and qualifications immediately available to become a member, the Committee may, in consultation with the Trust Chair and Chief Corporate Services Officer, co-opt another individual as a member during the interim period should it deem this necessary.

~~.~~ Other members of the Committee must receive suitable training and induction on taking on their role.

8. Attendance

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

- Chief Finance Officer
- ~~Deputy of Director of Finance~~ Deputy Chief Finance Officer
- ~~Financial Controller~~ Head of Financial Control and Capital
- Chief ~~of~~ Corporate Services Officer
- The Internal Auditor
- The External Auditor
- A Counter Fraud Specialist
- The Trust Secretary

8.2 The following posts shall be invited to attend meeting of the Audit Committee if there are agenda items which are specific to their roles or functions:

- Chief Medical Officer (or their representative)
- Deputy Chief Executive

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

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

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

9. Responsibilities of Members, Contributors and Attendees

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

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

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

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

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

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

10 Information Requirements

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

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

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

• key issues emerging from the work of internal audit;

• management response to audit recommendations;

- any changes to the agreed internal audit plan; and
- any resourcing issues affecting the delivery of the objectives of internal audit;
- a progress report (written/verbal) from the External Audit representative summarising work done and emerging findings (this may include, where relevant to the organisation, aspects of the wider work carried out by the National Audit Office, for example, Value for Money reports and good practice findings);
- management assurance reports; and
- reports on the management of major incidents, "near misses" and lessons learned.

10.2 As appropriate the Committee will also be provided with:

- proposals for the terms of reference of internal audit / the internal audit charter;
- the internal audit strategy;
- the Head of Internal Audit's Annual Opinion and Report;
- quality assurance reports on the internal audit function;
- the draft accounts of the organisation;
- the draft Governance Statement;
- a report on any changes to accounting policies;
- external Audit's management letter;
- a report on any proposals to tender for audit functions;
- a report on the Trust's approach to cyber-security, including updates on how cyber threats have been dealt with
- a report on co-operation between internal and external audit; and
- the organisation's Risk Management Strategy.

11 Frequency

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

11.2 The Committee will meet once in a year to review the Trust's internal audit arrangements and the Board Assurance Framework (BAF) and provide a recommendation to the Board on any concerns around risk appetite or management of high-level strategic and operational risks, including the BAF.

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

12 Management

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

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

13 Financial Reporting

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

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

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

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

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

14 Committee Administration

14.1 The Trust Secretary shall provide secretarial support to the Committee;

14.2 Papers should be distributed to Committee members no less than five clear days before the meeting;

15. Review

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

Version Control

Version	Date	Author	Comments	Status
0.1	December 2008	James Bufford	Approved for Board by Audit Committee December 2008	Draft

1.0	January 2009	James Bufford	Approved by Board	Approved
1.1	Dec 09	Maria Wogan	Reviewed by Audit Committee – proposed amendments to the Board March 2010	For approval
1.2	March 10	Maria Wogan	Annual Review by the Board	Approved
2.0	Sept 2011	Geoff Stokes	Annual review by the Board	Approved
2.1	Jan 2012	Geoff Stokes	Add clinician to attendees list	
2.2	June 2012	Michelle Evans-Riches	Change to membership as Clinician cannot be a member	Approved
3.0	March 2013	Michelle Evans-Riches	Review by Audit Committee and Trust Board	Approved
4.0	Sep 2013	Michelle Evans-Riches	Annual Review	Approved
5.0	Sep 2014	Michelle Evans-Riches	Annual Review	Approved
6.0	Nov 2017	Adewale Kadiri	Annual Review	Approved
7.0	Oct 2018	Adewale Kadiri	Annual Review	Approved
8.0	Nov 2020	Julia Price	Annual Review by the Board	Approved
9.0	November 2021	Kwame Mensa-Bonsu	Annual Review by the Trust Board	Approved
10.0	November 2022	Kwame Mensa-Bonsu	Annual Review by the Trust Board	Approved
11,0	November 2023	Kwame Mensa-Bonsu	Annual Review by the Trust Board	Approved
12.0	November 2024	Oluwakemi Olayiwola	Change to Audit & Risk Committee; Add relevant registered financial qualification to at least one NED member	

NHS
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AUDIT & RISK COMMITTEE

Forward Plan 2025-26

	Sub Heading	Agenda Item	Lead	Purpose	Frequency - Paper/Verbal	14-Apr-25	19/05/2025 Annual Report	16/06/2025 Annual Report	14-Jul-25	15-Sep-25	08-Dec-25	16-Mar-26
1	Introduction & Administration	Apologies	Chair	Receive	Standing Item (V)	■			■	■	■	■
2	Introduction & Administration	Declarations of Interest	Chair	Noting	Standing Item (V)	■			■	■	■	■
3	Introduction & Administration	Minutes of the Previous MAeeting	Chair	Approval	Standing Item (V)	■			■	■	■	■
4	Introduction & Administration	Matters Arising/Action Log	Chair	Receive	Standing Item (V)	■			■	■	■	■
5	Governance & Assurance	Board Assurance Framework	Chief of Corporate Services	Receive & Discuss	Standing Item (P)	■			■	■	■	■
6	Internal Audit	Internal Audit Progress Report	RSM	Receive & Discuss	Standing Item (P)	■			■	■	■	■
7	Counter Fraud	Counter Fraud Progress Report	KPMG	Receive & Discuss	Standing Item (P)	■			■	■	■	■
8	Governance & Assurance	Corporate and Significant Risk Register Report	Chief of Corporate Services	Receive & Discuss	Standing Item (P)	■			■	■	■	■
9	Financial Report	Financial Controllers Report	Chief Finance Officer	Receive & Discuss	Standing Item (P)	■			■	■	■	■
10	External Audit	External Audit Update	Grant Thornton	Receive & Discuss	Ad Hoc (P)				■			■
11	Internal Audit	Internal Audit Assurance Update	RSM	Receive & Discuss	As required				■			■
12	Internal Audit	Draft Head of Internal Audit Opinion	RSM	Receive & Discuss	Ad Hoc (P)							■
13	Annual Report	Draft Annual Report	Chief Finance Officer	Receive & Discuss	Annually (P)			■				■
14	Annual Report	Draft Quality Report	Chief of Corporate Services	Receive & Discuss	Annually (P)			■				■
15	External Audit	Draft Going Concern Review	Chief Finance Officer	Receive & Discuss	Ad Hoc (P)	■	■					■
16	Governance & Assurance	Accounting Policies for Completion of Annual Accounts	Chief Finance Officer	Receive & Discuss	Annually (P)							■
17	Governance & Assurance	Annual Report and Annual Accounts & Quality Report Timetable	Chief Finance Officer	Receive & Discuss	Annually (P)							■
18	External Audit	External Audit Findings Improvement Action Plan	Chief Finance Officer	Receive & Discuss	Ad Hoc (P)					■	■	■
19	Governance & Assurance	Health & Safety Report	Chief of Corporate Services	Receive & Discuss	Ad Hoc (P)				■	■	■	■
20	External Audit	Early Significant Judgements Paper	Chief Finance Officer	Receive & Discuss	Annually (P)	■						
21	Assurance	Urgent Care Service Paper		Receive & Discuss	(P)	■						
22	Internal Audit	Head of Internal Audit Opinion	RSM	Receive & Discuss	Annually (P)		■					
23	Governance & Assurance	Draft Annual Report (with the Annual Governance Statement) and Annual Accounts	Chief of Corporate Services/Chief Finance Officer	Receive & Discuss	Ad Hoc (P)		■	■				
24	External Audit	Going Concern Review	Chief Finance Officer	Receive & Discuss	Annually (P)		■					
25	Governance & Assurance	Declarations of Interest Report	Chief of Corporate Services	Receive & Discuss	Annually (P)		■					
26	External Audit	Independent Auditors' Report and Management Response	Chief Finance Officer	Receive & Discuss	Annually (P)			■				
27	Internal Audit	Internal Audit Annual Report & Workplan	RSM	Receive & Discuss	Annually (P)			■				
28	Counter Fraud	Counter Fraud Annual Report & Workplan	KPMG	Receive & Discuss	Annually (P)			■				

29	Governance & Assurance	Committee Evaluation Reports: *Audit * FIC * WDAC * QCRC * CFC	Chief of Corporate Services	Receive & Discuss	Annually (P)								
30	Governance & Assurance	Information Governance Toolkit	Chief of Corporate Services	Receive & Discuss	Annually (P)								
31	External Audit	Auditor Representation Letter	Grant Thornton	Receive & Discuss	Annually (P)								
32	Governance & Assurance	Terms of Reference	Chief of Corporate Services	Receive & Discuss	Annually (P)								
33	Assurance	Cybersecurity (Risk) Update	Deputy Chief Exec	Receive & Discuss	Bi-annually (p)								
34	Governance & Assurance	Policy Development & Review	Chief Corporate Services Officer	Receive & Discuss	Bi-annually (p)								
35	Assurance	New Hospital Programe (NHP) Risk Update	Deputy Chief Exec	Receive & Discuss	Quarterly (p)								
36	Assurance	BAF Review & Escalation Report to Trust Board or System	Chief Corporate Services Officer	Dioscuss	Annually (P)								
37	Annual Report	ADMK Annual Accounts	Chief Finance Officer	Receive & Discuss	Annually (P)								
38	Governance & Assurance	By exception Assurance Reports from Board Sub-Committees	NED Chairs of Committees	Discuss	Standing Item (p)								
39	Financial Report	Standing Financial Instructions & Standing Orders	Chief Finance Officer	Receive & Discuss	Annually (P)								
40	Closing & Administration	Risks Highlighted During the Meeting for consideration to CRR/BAF	Chair	Discuss	Standing Item (V)								
41	Closing & Administration	Any Other Business	Chair	Note & Discuss	Standing Item (V)								
42	Closing & Administration	Escalation Items for Board Attention	Chair	Discuss	Standing Item (V)								
43	Closing & Administration	Forward Agenda Planner	Chair	Discuss	Standing Item (P)								

NHS
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Finance and Investment Committee
TERMS OF REFERENCE

1. CONSTITUTION

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

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

2. ACCOUNTABILITY

The Finance and Investment Committee is a committee of the Board of Directors of the Trust and accountable to them.

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

The Committee will annually review its own effectiveness and report the results of that review in an annual report to the Board. The Chair of the Committee will also ~~, based on the Trust Secretariat's schedule,~~ provide written reports to the Council of Governors.

3. PURPOSE:

The Finance and Investment Committee will provide assurance to the Board on:

- the effectiveness and robustness of financial planning
- effectiveness and robustness of financial reporting
- the effectiveness and robustness of capital investment management
- the robustness of the Trust's cash management~~investment strategy~~
- business case assessment and scrutiny (including ensuring that quality and safety considerations have been taken into account)
- the management of financial and business risk
- the capability and capacity of the finance function
- the administration, investments and financial systems relating to all charitable funds held by the Trust
- the impact of performance issues being properly understood, in so far as they have implications upon the Trust finances
- the effectiveness of the Trust's health informatics and information technology strategies and their implementation

- decisions for future investment in information technology
- the effective implementation and management of the Trust's estates strategy, ensuring that this is in line with the Trust's overall strategy.

The Finance and Investment Committee will review the findings of other assurance functions where there are financial and business implications.

4. MEMBERSHIP, ATTENDANCE AND QUORUM

Membership

The Membership of the Finance and Investment Committee shall be as follows:

- A Non-Executive Director who is not the Chairman, or Chair of another Board Committee will be appointed by the Chair of the Trust to Chair the Finance and Investment Committee
- Two other Non-Executive Director, who should not be the Chair of the Audit or Quality and Clinical Risk Committees. One of these Non-Executive Directors can chair a meeting in the absence of the Committee's Chair
- The Chief Executive Officer or the Deputy Chief Executive Officer
- The Chief Finance Officer or appointed Deputy
- The Chair of the Trust (ex-officio)
- Chief Medical Officer or appointed Deputy
- The Chief Operations Officers.

Other Non-Executive Directors of the Trust may substitute for members of the Finance and Investment Committee in their absence and will count towards achieving a quorum.

Members of the Finance and Investment Committee are expected to attend all meetings of the Committee.

Attendance

The following should attend Finance and Investment Committee meetings:

- The Deputy Chief Finance OfficerDeputy Director of Finances
- Deputy Chief Executive (as Executive lead for Performance, Information and Estates)
- Trust Secretary or nominated representative

Quorum

A meeting is deemed quorate when two Non-Executive Directors and the Chief Finance Officer or nominated deputy are present.

5. MEETINGS AND CONDUCT OF BUSINESS

Frequency

The Committee will meet regularly as agreed by the Chair of the Committee and the Board.

Calling of additional meetings

An additional meeting may be called by the Chair of the Committee or any two of the other Members of the Committee.

In exceptional circumstances where an urgent business case approval ~~capital investment~~ decision is required, which cannot wait until the next meeting of the relevant authorising group, ~~e.g. essential medical equipment which has failed,~~ the approval of the Chairman and one other member of the Group may be sought. Where approval is sanctioned, the decision must be recorded and formally reported at the next meeting of the relevant authorising group where the decision would have been made

Committee Administration

The Committee will at least annually review these terms of reference.

Committee administration will be provided by the Trust Secretariat. The agenda for meetings will be circulated to all Board members who have requested to receive particular papers. In line with Standing Order 3.4, full papers will be sent to members of the Board so that they are available to them at their normal electronic address 5 clear days before the meeting. Draft minutes of meetings should be available to the Chair for review within fourteen days of the meeting.

Responsibilities of Members

Members of the Committee are expected to attend at least 75% of meetings.

In the event that they identify any items for consideration by the Committee, these should be brought to the attention of the Chair at least 14 days before the meeting.

Members must declare any conflicts of interest or potential conflicts of interest at the start of each meeting in accordance with the Trust's Conflicts of Interests Policy (even if such a declaration has previously been made).

6. DUTIES OF THE FINANCE AND INVESTMENT COMMITTEE

Financial Management

- To have oversight of the Trust's position and performance, both as an organisation in its own right and in the context of the wider BLMK ICS. ~~'s performance.~~
- To ensure a comprehensive budgetary control framework that accords with guidance and legislation.
- To review financial plans and strategies and ensure they are consistent with the overall Trust Strategic Planning process.
- To approve budget setting timeframes and processes and recommend budgets to the Board of Directors.

- To monitor business performance against planned levels and hold to account for corrective action planning, including finance, activity, workforce, and capacity.
- To scrutinise and assess business cases.

Financial Reporting

- To review the content and format of financial information as reported to ensure clarity, appropriateness, timeliness, accuracy and sufficient detail.

Performance Management

- To review the potential or actual financial impact of operational performance against a defined set of indicators, such indicators to be subject to on-going review.
- To review any specific operational performance issues in greater detail where these have the potential to impact upon Trust finances materially.

Business and Financial Risk

- To consider business risk management processes in the Trust.
- To review arrangements for risk pooling and insurance.
- To consider the implications of any pending litigation against the trust.

Value for Money and Efficiency

- To ensure at all times the Trust receives value for money and operates as efficiently as possible.

Capital Investment

- To ensure robust capital investment plans are in place, kept updated, and progress monitored. (reporting arrangements as per Appendix 1)

Cash

- To act as the Investment Committee in line with approved Investment Policy.
- Ensure cash investments are monitored and give best returns.
- Ensure cash balances are robust, and continue to be so, both on a 12-month rolling basis and with a view to longer term period.~~.~~
- Ensure that any steps to ensure Trust liquidity are taken in a timely and necessary fashion

Technology

- To ensure that the Health Informatics strategy is implemented effectively and to review decisions for future investment in technology
- To oversee the implementation of the Trust's information technology strategy and ensure that this is developed in line with best practice within the sector and in accordance with the Trust's overall strategy.

Estates

- To oversee the implementation and development of the Trust's estate strategy in line with the Trust's overall strategy, and that of the wider BLMK ICS.
- To ensure that issues that arise, resultant from any challenges with Trust estate, are well understood and appropriate mitigations agreed.
-

7. RELATIONSHIP WITH AUDITORS AND AUDIT COMMITTEE

The auditors interact with the Trust through the Audit Committee, neither internal nor external audit are therefore included as members of the Finance and Investment Committee. However, both parties can, if required, request an invitation to attend.

The Audit Committee is distinct and separate from the Finance and Investment Committee, and as such areas of overlap should be minimised. The Finance and Investment Committee should specifically exclude itself from:

Audit

- Review of audit plans and strategies.
- Review of reports from auditors.
- Review of the effectiveness of the internal control framework and controls assurance plans.
- Any recommendations or plans on auditor appointments.

Annual Accounts

- Consideration of the content of any report involving the Trust issued by the Public Accounts Committee or the Controller and Auditor General and the review of managements proposed response.

SFI's and SO's

- Examinations of circumstances when waivers occur.
- Review of schedules of losses and compensations.
- Monitoring of the implementation on standards of business conduct for members and staff.

Fraud

- The review of the adequacy of the policies and procedures for al***l*** work related to fraud and corruption as set out in the Secretary of State Directions and as required by the Directorate of Counter Fraud Services.

Version Control

Version	Date	Author	Comments	Status
0.1	5 January 2009	Wayne Preston	Approved for Board	Draft
1.0	January 2009	James Bufford	Approved by Board	Approved
1.1	11 Sept 2009	James Bufford	Added requirement for annual review of these terms of reference	Draft for Finance Cttee
1.2	March 2010	Maria Wogan	Additional amendments from Finance Director re: meeting frequency	Draft for approval by Board
1.3	March 10	Maria Wogan	Annual Review by the Board	Approved
2.0	Nov 2011	Geoff Stokes	Annual review by the Board	Approved
2.1	Aug 2012	Michelle Evans-Riches	Financial Reporting triggers included as appendix	Approved
3.0	Mar 2013	Michelle Evans-Riches	Review by Committee and Trust Board	Approved
4.0	Sep 2013	Michelle Evans-Riches	Annual Review	Draft for approval by Board
5.0	Oct 2013	Michelle Evans-Riches	Annual review by the Board	
6.0	March 2015			
7.0	October 2017	Ade Kadiri	Annual Review	Draft for approval by Board

8.0	October 2018	Ade Kadiri	Annual Review	Draft for approval by the Board
9.0	November 2020	Julia Price	Annual Review by the Board	Approved
10.	November 2021	Kwame Mensa-Bonsu	Annual Review by the Board	Approved
11	November 2022	Kwame Mensa-Bonsu	Annual Review by the Board	Approved
12	November 2023	Kwame Mensa-Bonsu	Annual Review by the Board	Approved
13	November 2024	Oluwakemi Olayiwola	Annual Review by the Board; additional amendments from Chief Finance Officer re: duties of the committee	

Milton Keynes University Hospital NHS Foundation Trust

Quality and Clinical Risk Committee
TERMS OF REFERENCE

1. CONSTITUTION:

The Quality and Clinical Risk Committee (QCRC) is a sub-committee of the Board of Directors and has no powers other than those specifically delegated in these terms of reference.

The QCRC is constituted under Paragraph 5.8 of Annex 7 to the constitution. The Terms of Reference will be reviewed annually.

1.1 Authority

The QCRC is authorised by the Board to investigate any activity within its terms of reference. It is authorised to request the attendance of individuals from inside or external to the Trust with relevant experience and expertise if it considers this necessary. All employees are directed to co-operate with any request made by the Committee.

2. PURPOSE:

The QCRC is charged by the Board with the responsibility for providing assurance to the Board that the Trust is providing safe, effective and ~~high quality~~high-quality services to patients, supported and informed by effective arrangements for monitoring and continually improving the safety and quality of care, and the patient experience. It will receive information from the CSUs and Divisions via the Trust Executive Committee and will, where necessary, escalate issues to the Board.

3. MEMBERSHIP, ATTENDANCE AND QUORUM:

3.1 Membership

The Membership of the QCRC shall be as follows:

- A Non-Executive Director (NED) who is not the Chairman, Deputy Chairman or Chair of another Board committee will be appointed by the Chair of the Trust to chair the QCRC
- Two other Non-Executive Directors
- The Chair of the Trust Board (ex-officio)
- The Chief Executive Officer (ex-officio)
- The Chief Nursing Officer (or Deputy)
- The Chief Medical Officer (or Deputy)

- The Chief Operations Officer (or their representative)
- The Chief ~~of~~ Corporate Services Officer

Other Non-Executive Directors of the Trust may substitute for members of the QCRC in their absence and will count towards achieving a quorum.

Members of the QCRC are expected to attend all meetings of the Committee.

3.2 Attendance

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

- Head of Patient Safety & Legal Services
- Senior members of Divisional Management will be invited to attend meetings as required.

3.3 Quorum

A quorum of the Committee shall be two NEDs and one Executive Director who shall either be the Chief Medical Officer or their deputy, or the Chief Nursing Officer or their deputy. Other Directors of the Trust, including Directors who are substituting for members can be counted in the quorum. Ex-officio members of the Committee also count for quorum but are not required to attend every meeting

4. ACCOUNTABILITY:

The QCRC is a committee of and accountable to the Board of Directors. ~~A m~~Minutes of each meeting will be taken and approved by the subsequent meeting.

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

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

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

5. MEETINGS AND CONDUCT OF BUSINESS:

5.1 Frequency of Meetings:

The Committee will meet at least on a quarterly basis, with the possibility that additional meetings may be scheduled as necessary at the request of the Committee Chair.

5.2 Agenda

The Agenda for meetings will be circulated to all Board members who have requested to receive particular papers.

In line with Standing Order 3.4, full papers will be sent to members of the Committee so that they are available to them **5 clear days before the meeting**.

There will be an expectation for information from the Committee to be cascaded to front line staff by managers.

6. DUTIES OF THE QUALITY AND CLINICAL RISK COMMITTEE:

- To define the Trust's approach to ensuring the quality of its services as part of its overall strategic direction and organisation objectives.
- To promote clinical leadership so that the culture of the Trust reflects a strong focus on quality, clinical effectiveness, safety and patient experience.
- To ensure appropriate structures and systems are in place to support and deliver quality governance including clinical effectiveness, patient safety and patient experience.
- To assure the Board that systems operate effectively within each Division and to report any specific problems as they emerge.
- To receive reports on serious incidents, incidents and near misses, complaints, inquests, claims and other forms of feedback from patients, ensuring learning from all clinical risk management activity, identifying trends, comparing performance with external benchmarks and making recommendations to the Board as appropriate.
- To identify serious unresolved clinical and non-clinical risks to the Audit & Risk Committee and the Board.
- To oversee the effective management of risks, as set out within the Board Assurance Framework (BAF) as appropriate to the purpose of the Committee.
- To ensure that the views and experience of patients and staff are heard and acknowledged in the work of the Committee and by the Board, and that this drives the delivery of the Trust's services.
- To monitor strategies and annual plans for quality governance, clinical audit and effectiveness, research and development, public and patient engagement and equality and diversity.
- To oversee the production of the Trust's annual Quality Accounts, ensuring compliance with national guidance.
- To ensure that effective consultation with stakeholders takes place, and to monitor the delivery of the quality targets.
- To agree and submit annual quality governance assurance report to the Board.
- To receive relevant reports from internal reviews and external bodies and assurance regarding the implementation of associated action plans.
- To commission, as appropriate, internal and external audits and reviews of services to assure the Board that the Trust is compliant with statutory and regulatory requirements.

- To approve and monitor the Trust's clinical audit programme ensuring it is aligned with Trust priorities, responds to trends in complaints and incidents and is led by and involves staff from all disciplines, liaising with the Audit & Risk Committee as appropriate.
- To monitor compliance with the terms of the Trust's CQC registration and NHS Resolution Risk Management Standards.

Version Control

Version	Date	Author	Comments	Status
1.0	26.05.10	Maria Wogan Trust Secretary	Final draft approved by the Board of Directors	Approved
2.0	Aug 2011	Geoff Stokes	Annual review by the Board	Approved
3.0	May 2012	Michelle Evans-Riches	Review by Quality Committee following Committee Review by Board	Approved
4.0	March 2013	Michelle Evans-Riches	Review by Quality Committee recommended to Board	Approved
5.0	April 2017	Adewale Kadiri	Review by Quality and Clinical Risk Committee recommended to Board	Approved
6.0	November 2018	Adewale Kadiri	Review by Quality and Clinical Risk Committee recommended to Board	Approved
7.0	November 2020	Julia Price	Annual Review by the Board	Approved
8.0	November 2021	Kwame Mensa-Bonsu	Annual Review by the Board	Approved
9.0	November 2022	Kwame Mensa-Bonsu	Annual Review by the Board	Approved
10.0~~0~~	November 2023	Kwame Mensa-Bonsu	Annual Review by the Board	Approved
11.0	November 2024	Oluwakemi Olayiwola	Annual Review by the Board	

Milton Keynes University Hospital NHS Foundation Trust

REMUNERATION COMMITTEE TERMS OF REFERENCE

1. CONSTITUTION

The Committee is a sub-committee of the Trust Board and will report to the Trust Board on an annual basis.

The Committee is authorised by the Trust Board on the matter of remuneration to obtain outside legal, remuneration or other independent professional advice to secure the attendance of individuals and authorities from outside the Trust with the relevant experience and expertise if it considers it necessary for or expediant to the exercise of its functions.

2. ACCOUNTABILITY

The Remuneration Committee is accountable to the Board of Directors of the Trust.

Minutes~~A minute~~ of each meeting will be taken and approved by the subsequent meeting. ~~Once the draft minutes have been approved by the Chair of the Committee, these unapproved minutes will be submitted to the next meeting of the Board of Directors.~~

The Chair of the Committee shall make a verbal report to the Board immediately following each Committee meeting, drawing Board's attention to any issues that require disclosure to the full Board or Board approval.

3. PURPOSE:

The purpose of the Committee is:

- The Committee will have delegated authority from the Trust Board to set the remuneration, allowances and other terms and conditions of office for the Executive Directors and to recommend and monitor the structure of remuneration including setting pay ranges.

4. MEMBERSHIP, ATTENDANCE AND QUORUM

Membership

The membership of the Committee shall comprise:

- All Non-Executive Directors
- The Trust Chairman
- The CEO and Director of Workforce shall normally be in attendance except when issues regarding their own remuneration is discussed

Attendance

Members of the Remuneration Committee are expected to attend all meetings of the Committee.

Quorum

The Committee shall be quorate when the Chair and at least three Non Executive Directors are present.

5. MEETINGS AND CONDUCT OF BUSINESS

Frequency

Annually, or more freqeuently should it be necessary

Agenda

The Agenda for meetings will be circulated to all Board members who have requested to receive particular papers.

In line with Standing Order 3.4, full papers will be sent to members of the Committee so that they are available to them at their normal address 5 clear days before the meeting.

The Committee will at least annually:

- review these terms of reference

DUTIES OF THE REMUNERATION COMMITTEE:

The main duties of the Committee are to:

- To agree and keep under review the overall remuneration policy of the Trust.
- To set the individual remuneration, allowances and other terms and conditions of office (including termination arrangements) for the Trust's Executive Directors
- To recommend and monitor the structure of remuneration, including setting pay ranges.
- To monitor and evaluate the performance of the Trust's Chief Executive and Executive Directors against objectives for the previous year and note forward objectives. Performance of other senior managers will be monitored and evaluated by their line managers.
- To ratify decisions taken between meetings by the Chair of the Committee.
- In determining remuneration policy and packages, to have due regard to the policies and recommendations of the Department of Health and Social Care and the NHS, and to adhere to all relevant laws, codes and regulations.
- To keep abreast of executive level remuneration policy and practice and market developments elsewhere in the NHS and in other relevant organisations, drawing on external advice as required.
- To agree those Compromise Agreements, Settlements and Redundancy Payments which require final approval by HM Treasury as well as any proposed termination payment to the Chief Executive or an Executive Director.

- To receive regular reports on other Compromise Agreements, Settlements and Redundancies approved in accordance with Trust policies.
- ~~Receive an annual report on the outcome of the employer-based (local) Clinical Excellence Awards round~~.
- To undertake any other duties as directed by the Trust Board.

Version Control

Version	Date	Author	Comments	Status
1.0	October 2013	Norma French	Separated the functions of the Combined Terms of reference of Remuneration and Workforce Committee	Approved
1.1	October 2021	Danielle Petch	Annual review by Committee – updated to reflect amended terminology/practice	Approved
1.2	September 2024	Louise Clayton		

Milton Keynes University Hospital NHS Foundation Trust

COUNCIL OF GOVERNORS
TERMS OF REFERENCE

1 Constitution

The Council of Governors is mandated under paragraph 12 of the Constitution as such will comprise of both elected and appointed Governors.

Authority

The powers of the Council of Governors are set out in the Trust Constitution.

Accountability

The Council of Governors is accountable to the various bodies set out in statute, including Monitor and other third-party bodies and is also accountable to the Trust Membership.

~~A m~~Minutes of each meeting will be taken and approved by the subsequent meeting. The draft public minutes will be posted on the Trust website.

2 Purpose

To provide oversight of the leadership of Milton Keynes University Hospital NHS Foundation Trust; to have input, review, scrutinize and approve its strategic direction, aims and values; to ensure accountability to the public and to assure that the Trust is managed with integrity.

3 Membership, Attendance and Quorum

3.1 Membership

The membership of the Council of Governors shall be as mandated in Annex 3 of the Trust Constitution and shall consist of:

- Chair of the Trust, who will Chair the meeting.
- 15 Public Governors;
- 7 staff Governors;
- One ~~the~~ Integrated Care System (ICS) Governor appointed by the Bedford Luton Milton Keynes ICS (if they wish to continue with this practice);
- One Local Authority Governor to be appointed by Milton Keynes Borough Council;
- Three Partnership Governors to be appointed by partner organisations.

The above comprise the voting membership of the Council of Governors.

A table naming the current Council of Governors is appended (Appendix 1).

3.2 Attendance

Members of the Council of Governors are expected to attend all Council meetings and should, in line with the provisions of the Trust Constitution, not absent themselves from three successive Council meetings.

The Constitution determines that a Governor immediately ceases to be a Governor if they absent themselves from three successive Council meetings without reasonable cause. With reference to paragraph 9 of the Constitution's Annex 5 – Additional Provisions – Council of Governors:

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

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

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

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

3.3 Administration

The Council of Governors may invite non-members to attend its meetings as it considers necessary and appropriate. The Trust Secretary, or whoever covers those duties, shall be Secretary to the Council of Governors and shall attend to take minutes of the meeting and provide appropriate advice and support to the Chair and the Governors.

3.4 Quorum

A quorum of the Council of Governors shall be as specified in the constitution:

"Ten Governors, including not less than four Public Governors, not less than one Staff Governor and not less than one appointed Governors shall form a quorum."

4. Meetings and Conduct of Business

4.1 Frequency

The Council of Governors will meet at least five times in each financial year, including the Annual Members Meeting, save in the case of emergencies or the need to conduct urgent business.

4.2 Calling meetings

Meetings may be called by the Trust Secretary or by the Chair, or by ten Governors (including at least two elected Governors and two appointed Governors) who will give written notice to the Trust Secretary specifying the business to be carried out.

4.3 Declarations of Interest

Any member or attendee of the Council of Governors shall declare any interests which may or may be seen to conflict or potentially impact on any item of business.

They shall absent themselves from the discussion of that item if the meeting so requires.

4.4 Agenda

The Council of Governors will at least annually:

- review these terms of reference
- receive the Annual Report & Accounts;
- receive the Annual Quality Account.
- receive and approve the Trust's annual quality priorities

The rules of procedure for each meeting will be followed in line with the Standing Orders for the practice and procedure of the Council of Governors meetings - paragraph 18 (Annex 6) of the Trust Constitution.

Duties of the Council of Governors

The Council of Governors, as set out in paragraph 16 of the Trust Constitution, will:

1. Hold the non-executive directors individually and collectively to account for the performance of the Board of Directors; and
2. Represent the interests of the members of the Trust as a whole and the interests of the public

Version	Date	Author	Comments	Status
1.1	Oct 2013	Michelle Evans-Riches	Annual Review	Approved
1.2	Jan 2021	Julia Price	Review	Approved
1.3	February 2023	Kwame Mensa-Bonsu	Review	Approved
1.4	July 2023	Kwame Mensa-Bonsu	Update – Attendance at CoG meeting	Approved
1.5	October 2024	Oluwakemi Olayiwola	Annual Review	

Appendix 1

CONSTITUENCIES AND GOVERNORS OCTOBER 2024~~3~~

		Constituency	No.	Governors	Term of Office	
					From	To
PUBLIC (ELECTED)	A	Bletchley & Fenny Stratford, Denbigh, Eaton Manor & Whaddon	2	Babs Lisgarten	02 Sept 2019	01 Sept 2022
					21 Oct 2022	20 Oct 2025
				Ken Rowe	06 Oct 2023	05 Oct 2026
	B	Emerson Valley, Furzton, Loughton Park	2	William Butler	26 Oct 2017	25 Oct 2020
					01 Nov 2021	31 Oct 2024
				Andrea Vincent	22 Feb 2023	21 Feb 2026
	C	Linford South, Bradwell, Campbell Park	2	VACANT		
				VACANT		
	D	Hanslope Park, Olney, Sherington, Newport Pagnell	2	John Gall	07 May 2024	06 May 2027
				Christine Thompson	22 Feb 2023	21 Feb 2026
	E	Walton Park, Danesborough, Middleton, Woughton	2	Clare Hill	14 Mar 2017	13 Mar 2020
					14 Mar 2020	13 Mar 2023
					26 Apr 2023	25 Apr 2026
				Adam Chapman-Ballard	07 May 2024	06 May 2027
	F	Stantonbury, Stony Stratford, Wolverton	2	Andy Forbes	01 Sep 2023	31 Aug 2026
				Fran Vernon	12 Dec 2023	12 Dec 2026
	G	Outer catchment area	2	VACANT		
				Tom Daffurn	22 Feb 2023	21 Feb 2026
	H	Extended area	1	VACANT		

STAFF (ELECTED)	I	Doctors and Dentists	1	Hany Eldeeb	22 Feb 2023	21 Feb 2026
	J	Nurses and Midwives	2	Caroline Kintu	29 Mar 2023	28 Mar 2026
				VACANT		
	K	Scientists, technicians and allied health professionals	1	Matthew Burnett	07 May 2024	06 May 2027
	L	Non-clinical staff groups e.g. admin & clerical, estates, finance, HR, management	3	Emma Isted	26 Feb 2024	25 Feb 2027
				Stevie Jones	01 Nov 2021	31 Oct 2024
				Fiona Burns	07 May 2024	06 May 2027
APPOINTED	M	Milton Keynes Business Leaders	1	Nicholas Mann	31 Mar 2023	30 Mar 2026
	N	Healthwatch Milton Keynes	1	Maxine Taffetani	29 Aug 2017	28 Aug 2020
					29 Aug 2020	28 Aug 2023
					29 Aug 2023	28 Aug 2026
	O	Community Group (Seat to be filled)	1	VACANT		
	P	Milton Keynes Council	1	Cllr Ansar Hussain	18 Jun 2024	17 Jun 2027
	Q	University of Buckingham	1	Professor Doug McWhinnie	18 Oct 2023	17 Oct 2026

Milton Keynes University Hospital NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE TERMS OF REFERENCE

1. Constitution

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

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

2. Delegated Authority

2.1 The Committee has the following delegated authority:

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

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

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

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

3. Accountability

- The Charitable Funds Committee is a committee of the Trust Board. MA ~~m~~inutes of each meeting will be taken and approved by the subsequent meeting.
- Following each meeting, the Chair of the Committee will provide a written report to the next available meeting of the Trust Board meeting in public, drawing the Board's attention to any issues requiring disclosure or Board approval.
- The Chair of the Committee shall provide written reports to the Audit & Risk Committee, highlighting matters which provided information and assurance around risk management and internal control systems across the organisation.

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

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

4. Duties of the Charitable Funds Committee

The Charitable Funds Committee is charged by the Board to:

i) support, guide and encourage the fundraising activities of the Trust;
ii) monitor charitable and fundraising income;
iii) oversee the administration, investment and financial systems relating to all charitable funds held by the hospital charity;
iv) develop policies for fundraising and for the use of funds;
v) ensure compliance with all relevant Charity Commission regulations, and other relevant items of guidance and best practice;
vi) review the work of other committees within the organisation, whose work can provide relevant assurance to the Charitable Funds Committee's own scope of work;
~~vii)~~ consider any funding request above ~~the Directorate Fund level~~£15,000 (as per the Charitable Funds Policy), or outside the scope of these funds, which is made to the Charitable Funds Committee. These must have been through the agreed charitable funds approvals process. All orders greater than £5,000 will still need an approved business case before funds are released. ~~relevant standard Trust approvals processes for either Capital or Revenue (See Appendix One).~~
~~viii)~~vii) consider and approve any urgent requests in advance of any formal meeting, on an exceptional basis through the approval of the named executive director and the committee chair.
~~ix)~~viii) oversee and advise on the running of major fundraising campaigns.

Commented [VH1]: For orders greater than £5,000 an approval in principle can be obtained from the charity to support a full business case. The charitable funds request can be fully approved once agreement has been given by CBIG.

How is this?

5. Membership, Attendance and Quorum

5.1 Membership

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

- A Non-Executive Director will be appointed by the Chair of the Board of Directors to Chair the Charitable Funds Committee.
- One Non-Executive Director who may be an associate Non-Executive Director
- Chief ~~of~~ Corporate Services Officer
- Chief Finance Officer or their nominated representative~~A named representative from~~ the Finance Directorate
- A named Governor from the Council of Governors.
- Associate Director of Charity
-

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

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

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

Other Governor(s) from the Council of Governors may substitute for the named Governor member of the Charitable Funds Committee in their absence. Such Governor will count towards the achievement of quorum

The Secretary of the Committee will be the Trust Secretary.

A meeting is deemed **quorate** when one Non-Executive Director, the Chief Finance Officer or their nominated representative ~~named representative~~ from the Finance Directorate and the named Governor or their substitute from the Council of Governors are present.

6. Attendance

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

- ~~Head of Charity~~
- Head of Financial Control and Capital or their nominated deputy~~A representative~~ from the Finance Directorate
- Trust Secretary
- Invited representatives from the clinical directorates

Commented [HH2]: Why isn't the Head of Charity a member out of curiosity?

Commented [OO3R2]: Although the Exec lead for Charity is the Chief Corporate Services Officer who is already a member, we have just discussed this point and Kate agrees that the Associate Director of Charity can be added as a member.

7. Responsibilities of Members and Attendees

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

7.1.1 Attend at least 75% of meetings (at least 3 meetings in a financial year)
7.1.2 Identify agenda items for consideration by the Chair at least 14 days before the meeting
7.1.3 Submit papers, as required, by the published deadline (7 days before the meeting) on the approved template
7.1.4 If unable to attend, send apologies to the Trust Secretary and where appropriate seek the approval of the Chair to send a deputy
7.1.5 Maintain confidentiality, when confidential matters are discussed within the Committee.
7.1.6 Declare any conflicts of interest or potential conflicts of interest at the start of each meeting in accordance with Milton Keynes University Hospital NHS Foundation Trust policy, even if such a declaration has already been made.

8. Meetings and Conduct of Business

8.1 Frequency

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

8.2 Calling Meetings

Meetings of the Charitable Funds Committee are subject to the same procedures as specified in Standing Order 3 of Annex 8 of the Constitution for the Board of Directors. A meeting may be called by the Secretary of the Committee or the Chair of the Committee or the other Non-Executive Director Member of the Committee.

8.3 Agenda

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

Version Control

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

9	10 September 2021	Kwame Mensa-Bonsu	Review Completed	Draft
10	November 2021	Kwame Mensa-Bonsu	Annual Review by the Board	Approved
11	January 2023	Kwame Mensa-Bonsu	Annual Review by the Board	Approved
12	November 2023	Kwame Mensa-Bonsu	Annual Review by the Board	Approved
13	November 2024	Oluwakemi Olayiwola	Updated to reflect the Committee's Approval Limit, Update Membership and Quorum Requirements	

Workforce and Development Assurance Committee
TERMS OF REFERENCE

1. Constitution

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

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

1.3. Ensure that the workforce has the capacity and capability to provide high quality, effective, safe patient care in line with the Trust's strategic objectives and values;

~~**1.3.**~~**1.4.** Monitor the health and wellbeing of our workforce and the attraction and retention of people across all professional groups,

~~**1.4.**~~**1.5.** Monitor the governance of the Trust's workforce strategy, ensuring accountability for the continuous improvement of quality and performance.

~~**1.5.**~~**1.6.** The Committee is established under Standing Order 5 of Annex 7 of the Trust's Constitution.

2. Delegated Authority

2.1. The Committee has the following delegated authority:

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

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

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

3. Accountability

3.1. The Committee is accountable to the Trust Board. Any changes to the Terms of Reference must be approved by the Trust Board.

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

4. Reporting Lines

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

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

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

4.4. The Committee will receive regular reports from the Workforce Board on specific initiatives, business cases and activities that support the delivery of the Trust's Workforce Strategy.

4.5. The Committee will receive formal reports from directors and other Trust staff, covering the breadth of the workforce agenda, including statutory requirements.

4.6. The Committee will receive at each meeting, either via the attendance of a member or members of staff, or a representation made on their behalf, an account of their experience of working in the Trust, taking account of relevant workforce strategies, initiatives and activities.

4.7. The Committee will receive at each meeting, or as they become available, quarterly reports from the Trust's Guardian of Safe Working Hours to confirm compliance with the relevant terms and conditions relating to trainee doctors and dentists.

5. Duties

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

5.2. To keep under review the development and delivery of the Trust's workforce strategy to ensure performance management is aligned to strategy implementation and promote this across the organisation.

5.3. To hold the executives to account for the delivery of the Trust's strategic objectives to improve workforce effectiveness.

5.4. To review progress on clinical and non-clinical training, development and education for Trust employees.

5.5. To ensure that the Trust meets its statutory obligations as an employer on equality, diversity and inclusion.

5.6. To monitor the progress of the Trust's plans to improve staff engagement.

5.7. To ensure that processes are in place to understand and improve staff health and wellbeing.

5.8. Provide assurance to the Board that there are mechanisms in place to allow staff to raise concerns and that these are dealt with in line with policy and national guidance.

5.9. The Committee will provide **assurance** to the Trust Board in relation to the following:

5.9.1. Ensure all workforce indicators are measured and monitored;

5.9.2. Ensure that all key performance indicators of a well-managed workforce are regularly reviewed and remedial action is put in place as necessary

5.9.3. Ensure that legal and regulatory requirements relating to workforce are met.

5.9.4. Review and provide assurance on those elements of the strategic risk register/board assurance framework are identified, seeking where necessary further action/assurance

6. Membership

6.1. A Non-Executive Director will be appointed by the Chair of the Board of Directors to Chair the Workforce and Development Assurance Committee.

6.2. The Committee will comprise the following members:

- Two other Non-Executive Directors
- Chief People Officer

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

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

7. Attendance

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

- Trust Board Chair
- Deputy Chief People Officer
- Assistant Director of HR – Education & OD
- Assistant Director of HR – Services & Systems
- Freedom to Speak Up Guardian
- Head of Employee Relations & Business Partnering

7.2. Other Directors and Trust staff may be invited to attend at the discretion of the Chair.

8. Responsibilities of Members

8.1. Members of the Committee are required to

8.1.1. Attend at least 75% of meetings,

8.1.2. Identify any agenda items in addition to those included on the Committee's workplan, for consideration by the Chair at least 14 days before the meeting;

8.1.3. Submit papers to the Trust Secretary by the published deadline (at least 7 days before the meeting);

8.2. Members should bring to the attention of the Committee any relevant matters that ought to be considered by the Committee that are within the scope of these terms of reference, but have not been included on the agenda

8.3. In the event that Committee members are unable to attend a meeting they must send apologies to the Trust Board Secretary and where appropriate seek the approval of the Chair to send a deputy if unable to attend in person;

8.4. Members must maintain confidentiality in relation to matters discussed by the Committee;

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

9. Frequency of Meetings

9.1. Meetings will normally take place quarterly and at least 14 days prior to the Trust Board to allow a Committee report to be submitted. Meetings may take place more frequently at the Chair's discretion;

9.2. The business of each meeting will be transacted within a maximum of two hours.

10. Committee Administration

10.1. Committee administration will be provided by the Trust Secretariat;

10.2. Papers should be distributed to Committee members no less than five clear days before the meeting;

10.3. Draft minutes of meetings should be made available to the Chair for review within 14 days of the meeting.

11. Review

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

Version Control

Version	Date	Author	Comments	Status
1.0	Nov 2019	Adewale Kadiri Trust Secretary	Final draft approved by the Board of Directors	Approved
2.0	Nov 2020	Julia Price	Annual review by the Board	Approved
3.0	November 2021	Kwame Mensa-Bonsu	Annual Review by the Board	Approved
4.0	November 2022	Kwame Mensa-Bonsu	Annual Review by the Board	Approved
5.0	September 2023	Kwame Mensa-Bonsu	Annual Review by the Board	Approved
6.0	November 2024	Oluwakemi Olayiwola	Annual Review by the Board	

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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
5	Leave of Car Park	Milton Keynes City Council and Milton Keynes University Hospital NHS Foundation Trust	Leave of Car Park B4.4 Land South of Avebury Boulevard, Central Milton Keynes	N/A	17/09/24	Joe Harrison – Chief Exec John Blakesley – Deputy Chief Exec

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TRUST BOARD MEETING IN PUBLIC

Forward Plan 2024-25

	Agenda Item	Lead	Purpose	Frequency Paper(P)/Verbal (V)	Seminar 04-Apr-24	Formal 02-May-24	Seminar 06-Jun-24	Formal 04-Jul-24	Formal 05-Sep-24	Seminar 03-Oct-24	Formal 14-Nov-24	Seminar 05-Dec-24	Formal 09-Jan-25	Seminar 06-Feb-25	Formal 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/Staff Story (Rotational)	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	Patient Safety Update	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)											
	Research & Development Annual Report	Chief Medical Officer	Assurance Receive and Discuss	(P)											
30	Emergency Preparedness, Resilience and Response Annual Report	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)											
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 Safety Update	Chief Medical Officer/Chief Corporate Services Officer	Patient Safety	Standing Item (P)											
37	Maternity Assurance Group Update	Chief Nursing Officer	Assurance Receive and Discuss	Standing Item (P)											
	Update to the Terms of Reference of the Board and its Committees	Chief Corporate Services Officer	Assurance Discuss and Approve	Annually (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												

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TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 14 November 2024

Questions from Members of the Public

Heidi Travis
Chair

Verbal/Discuss

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TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 14 November 2024

Motion to Close the Meeting

Heidi Travis
Chair

Verbal/ Approve