Bundle Trust Board Meeting in Public 1 May 2025

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

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 - Patient Story
Chief Nursing Officer
Item 3 Placeholder Patient Story

4 10:22 - Minutes of the Last Meeting
Chair
Item 4 Minutes Trust Board Meeting in Public 06.03.25 HT

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

6 10:26 - Chair's report
Chair
Item 6 Chair's Report 1 May 2025

7 10:31 - Chief Executive's Report
Chief Executive
Item 7 Chief Executive's Report
Item 7.1 BR Inquest Outcome Board Paper May 25
Item 7.2 BLMK ICB Update May 2025

8 10:41 - Patient Safety Update
Chief Medical Officer/Chief Corporate Services Officer
Item 8 Patient Safety Update

9 10:51 - Maternity Assurance Group Update
Chief Nursing Officer
Item 9 Maternity Assurance Group Update

10 11:01 - Patient Annual Experience Report
Chief Corporate Services Officer
Item 10 Patient Experience Annual Report 2024-25

11 11:11 - Performance Report
Chief Operating Officer – Planned Care

Item 11 2024-25 Executive Summary M12 Coversheet
Item 11.1 2024-25 Executive Summary M12
Item 11.2 2024-25 Board Scorecard M12

12 11:21 - Finance Report
Chief Finance Officer
Item 12 Finance Report Month 12

13 11:31 - People and Culture Committee Report
Chief People Officer
Item 13 People and Culture Committee Report

14 11:41 - Nursing Workforce Update
Chief Nursing Officer
Item 14. Nursing Workforce Update Cover sheet
Item 14.1 May 2025 submission

15 11:46 - Declaration of Interests Report Annual Report
Chief Corporate Services Officer
Item 15 Declaration of Interest Annual Report 2024-25

16 11:51 - Risk Management Report
Chief Corporate Services Officer
Item 16 Risk Management Report

17 11:56 - Board Assurance Framework
Chief Corporate Services Officer
Item 17. Board Assurance Framework

18 12:01 - Board Committees Assurance Reports
Chairs of Board Committees
Item 18.1 Committee Assurance Report - Audit and Risk Committee
Item 18.2 Committee Assurance Report - Charitable Funds Committee
Item 18.3 Committee Assurance Report - People and Culture Committee

19 12:06 - Annual Review of Committee Effectiveness
Chief Corporate Services Officer
Item 19 Annual Review of Effectiveness Coversheet
Item 19.1 Annual Review of Effectiveness - Audit and Risk Committee
Item 19.2 Annual Effectiveness Report to Board - Quality and Clinical Risk Committee

20 12:11 - Use of Corporate Seal
Chief Corporate Services Officer

Item 20 Cover Page - Use of Corporate Seal
Item 20.1 Use of Corporate Seal

21 12:16 - Forward Agenda Planner
Chair

Item 21 Trust Board in Public Forward Plan 2025-26

22 12:20 - Questions from Members of the Public

23 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."

24 12:28 - Next Meeting in Public: Thursday, 03 July 2025

TRUST BOARD MEETING IN PUBLIC

Thursday 1 May 2025, 10:00 -12:30 hours
Conference Room at the Academic Centre and via MS Teams

AGENDA

Item No.	Timing	Title	Purpose	Lead	Paper
Introduction					
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		Patient Story	Discuss	Chief Nursing Officer	Presentation
4		Minutes of the Trust Board meeting held in public on 6 March 2025	Approve	Chair	Paper
5		Matters Arising and Action Log	Note	Chair	Paper
Chair and Chief Executive Updates					
6	10:20	Chair's Report	Note	Chair	Paper
7	10:25	Chief Executive's Report • BLMK ICB Update	Discuss Note	Chief Executive	Paper
Patient Safety					
8	10:35	Patient Safety Update	Discuss	Chief Medical Officer/Chief Corporate Services Officer	Paper

Item No.	Timing	Title	Purpose	Lead	Paper
Patient Experience					
9	10:45	Maternity Assurance Group Update	Note	Chief Nursing Officer	Paper
10	10:50	Patient Annual Experience Report	Discuss	Chief Corporate Services Officer	Paper
Break – (10 mins)					
11	11:00	Performance Report	Discuss	Chief Operating Officer – Planned Care	Paper
Finance					
12	11:10	Finance Report	Discuss	Chief Finance Officer	Paper
People and Culture					
13	11:20	People and Culture Committee Report	Discuss	Chief People Officer	Paper
Assurance and Statutory Items					
14	11:30	Nursing Workforce Update	Discuss	Chief Nursing Officer	Paper
15	11:40	Declaration of Interests Report Annual Report	Discuss	Chief Corporate Services Officer	Paper
16	11:50	Risk Management Report • Corporate Risk Register • Significant Risk Register	Note	Chief Corporate Services Officer	Paper Supplementary Shelf
17	12:00	Board Assurance Framework	Discuss	Chief Corporate Services Officer	Paper
18	12:10	Board Committees Assurance Reports • Audit & Risk Committee • Charitable Funds Committee • People & Culture Committee	Note	Chairs of Board Committees	Paper
19	12:15	Annual Review of Committee Effectiveness • Audit & Risk Committee • Quality & Clinical Risk Committee	Note	Chief Corporate Services Officer	Paper

Item No.	Timing	Title	Purpose	Lead	Paper
20	12:20	Use of Corporate Seal	Note	Chief Corporate Services Officer	Paper
Administration and Closing					
21	12:25	Forward Agenda Planner	Note	Chair	Paper
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 following resolution to exclude the press and public and /move into private session to consider private business: "That representatives of the press and members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted."	Approve	Chair	
12:30		Close			
Next Meeting in Public: Thursday, 03 July 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 - Chair
2	Joe Harrison	Executive Director- Chief Executive Officer
3	Gary Marven	Non-Executive Director
4	Haider Husain	Non-Executive Director
5	Piers Ricketts	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	Ian Reckless	Executive Director - Deputy Chief Executive
11	John Blakesley	Executive Director
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

TheMKWay

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 1 May 2025

Agenda Item 1:
Apologies

Heidi Travis
Chair

Note

TheMKWay

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 1 May 2025

Agenda Item 2:
Declarations of Interest

Heidi Travis
Chair

Note

TheMKWay

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 1 May 2025

Agenda Item 3:
Patient Story

Fiona Hoskins
Chief Nursing Officer

Presentation/Discuss

TheMKWay

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Minutes of the Trust Board of Directors Meeting in Public held on Thursday, 6 March 2025 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 Ian Reckless	Chief Medical Officer	(IR)
John Blakesley	Chief Strategic Development Officer	(JB)
Kate Jarman	Chief Corporate Services Officer	(KJ)
Mark Versallion	Non-Executive Director	(MV)
Haider Husain	Non-Executive Director	(HH)
Gary Marven	Non-Executive Director	(GM)
Precious Zumbika	Non-Executive Director	(PZ)
Prof Ganesh Baliah	Non-Executive Director	(GB
Piers Ricketts	Non-Executive Director	(PR)
Sarah Whiteman	Non-Executive Director	(SW)
Fiona Hoskins	Chief Nursing Officer	(FH)
Helen Beck	Chief Operating Officer – Planned Care	(HB)
Jonathan Dunk	Chief Finance Officer	(JD)

In Attendance:

Louise Clayton	Deputy Chief People Officer	(LC)
Andy Forbes	Public Governor	(AF)
Tom Daffurn	Public Governor	(TD)
Caroline Kintu	Staff Governor	(CK)
David Cattigan	Staff Governor	(DC)
Jane Bignall (Item 3)	Integrated Discharge Hub (IDH) Lead	(JB)
Kevin Forster (Item 3)	Housing Officer IDH	(KF)
Kerry Wright (Item 3)	Deputy Manager IDH	(KW)
Blessing Mushaninga (Item 3)	Social Worker	(BM)
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.

1.2 There were apologies from Catherine Wills, Chief People Officer and Fay Gordon, Chief Operating Officer – Unplanned Care.

2 Declarations of interest

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

3 Staff Story

3.1 FH and the team presented the Integrated Discharge Hub (IDH) project, highlighting its success in improving patient discharge processes, reducing bed stays, and enhancing communication between health and social care services. FH introduced the IDH project, emphasising its collaborative nature with local partners and its success in improving discharge processes.

3.2 The IDH had successfully reduced bed stays, improved patient experience, and enhanced communication between health and social care services. Specific achievements included a 56% reduction in bed days and a 60% reduction in 21-day bed stays.

3.3 Challenges faced by the IDH include navigating a complex system, improving communication across services, and reducing duplication in patient assessments. The team was actively working on addressing these issues.

3.4 KF highlighted the integration of a housing officer into the IDH, which had significantly reduced the length of stay for homeless patients and improved the efficiency of discharge process. He explained that the integration of a housing officer into the IDH had streamlined the discharge process for homeless patients by reducing the time taken to address their housing needs. The integration had led to a 50-60% reduction in the length of stay for homeless patients. The housing officer's presence had improved communication and coordination with the Council, leading to more efficient discharge planning. Previously, the process of addressing housing needs for homeless patients could take weeks or months. With the housing officer integrated into the IDH, initial assessments were conducted within hours or a day, significantly speeding up the discharge process.

3.5 The team outlined the next steps for the IDH, including a review of achievements to identify successes and improvements. Addressing IT issues was crucial, especially creating a shared inbox for all team members to improve communication. Efforts would also standardise ward rounds for consistent discharge planning and patient management across wards. Discharge policies would be updated to reflect IDH changes and align with national guidelines. Training would be provided to staff, focusing on equipping discharge practitioners to manage caseloads and cross-cover roles effectively.

3.6 The Board praised the IDH project for enhancing patient discharge processes and success. They discussed strengthening primary care links, standardising ward rounds, and empowering staff through training and support.

4 Minutes of the Trust Board Meeting in Public held on 9 January 2025

4.1 The minutes of meeting held on 9 January 2025 were **reviewed** and **approved** by the Board.

5 Matters Arising and action log

5.1 There were no matters arising and there were no open actions due for review.

6 Chair’s Report

6.1 HT highlighted her attendance at the BAME Network meeting on 28 February 2025, alongside JH and Chief People Officer, Catherine Wills. The meeting reinforced that the leadership and Board were making significant progress in fostering a positive cultural shift within the organisation. Feedback from staff indicated that steps taken towards Equity, Diversity, and Inclusion were being recognised and appreciated, with visible changes in the organisational culture. HT commended the work of Catherine Wills and JH in driving this agenda and emphasised the Trust’s ongoing commitment to making MKUH an inclusive and supportive workplace for all.

6.2 HT attended the "Speak Up" Conference at the ICB, which provided valuable insights into creating an open and supportive culture for raising concerns. The discussion covered best practices in encouraging staff to speak up, with a focus on reducing anonymous reporting by building trust within the organisation. The conference reaffirmed the importance of ensuring that staff felt safe and supported when raising issues, with clear access to leadership and the Board.

6.3 The Board **noted** the Chair’s Report.

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

7.1 The Chief Executive's Update report highlighted key activities and developments since the last Public Board meeting. Improvements had been made in long waiting times and cancer waiting lists, though ED waiting times still require attention. The 2025/26 NHSE Planning Guidance sets targets for timely care and productivity, with a focus on mental health services and collaboration with ICB partners. Two MPs visited the hospital, and positive feedback was received for the new radiotherapy centre. Changes in the Executive portfolio were noted, and a programme on the fundamentals of Nursing and Midwifery care was being rolled out to enhance patient experience.

7.2 Regarding the Freedom to Speak Up (FTSU) process, it was noted that the reporting line is transitioning from the Workforce Team to the Trust Secretariat to enhance independence and accessibility. The Board reaffirmed its commitment to fostering an open and transparent culture, ensuring that staff feel empowered to raise concerns freely. The Board emphasised the importance of direct access to Board members for the Speak Up Guardian, ensuring that no procedural barriers hinder open communication.

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

7.3.1 The Board reviewed the BLMK ICB report, which summarised key discussions from the ICB Board meeting held on 13 December 2024. The report included updates from the Chair and Chief Executive, discussions on strategic priorities such as *dying well in BLMK*, and the Primary Care Transformation Plan. The Board also received reports on improving health equity, operational planning for 2025/26, and the Month 7 ICS Finance Report. Committee reports were noted, including updates from the Audit and Risk Assurance Committee, Quality and Performance Committee, Finance and Investment Committee, Primary Care Commissioning and Assurance Committee, and Mental Health and Learning Disabilities and Autism Collaborative Committee. The next meeting was scheduled for 21 March 2025.

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

8 Patient Safety Update

8.1 IR presented the Patient Safety Update Report emphasising the positive impact of learning events, the investigation of significant incidents, and the importance of timely reviews. He reported that the multidisciplinary learning events discussions focused on patient events to identify opportunities for improvement. The events had fostered a positive culture for both staff and patients, though organising them could be logistically challenging.

8.2 IR highlighted key incidents, including never events and a small cluster of maternity-related issues. These cases were being thoroughly investigated, with external oversight where necessary. Delays in maternity-related investigations were noted, primarily due to the involvement of the Maternity and Neonatal Safety Investigations (MNSI) body and the need for parental consent. He noted that these factors could slow down the review process.

8.3 The increase in reported incidents was viewed positively, though discussions focused on how to measure whether the system was leading to actual improvements. Future efforts would concentrate on thematic reviews to track progress and ensure that learning translates into improved patient outcomes.

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

9 Maternity Assurance Group (MAG) Update

9.1 FH provided an update on the Maternity Assurance Group (MAG), summarising key discussions and progress made within the maternity service. The update covered themes such as safe care, communication, the impact of high birth rates, and ongoing efforts to improve patient safety and experience.

9.2 Ongoing efforts to ensure safe maternity care, including robust processes to mitigate risks was noted. Measures had been implemented to address delays in obtaining timely manual reviews, with daily CTG monitoring introduced to manage these challenges.

9.3 Enhancing communication within the maternity team and with patients was identified as a key priority. Work continued to improve dialogue and ensure that information was clearly presented and accessible to all stakeholders. The team had received positive feedback regarding recent improvements in clarity and presentation of maternity-related data.

9.4 The service had been operating at the upper threshold of its capacity for several months, affecting patient flow and resource allocation. A significant number of out-of-area bookings, particularly from Bedford and surrounding areas, had added pressure on the system. Strategies to manage this demand and ensure continued high-quality care were discussed.

9.5 Since October 2024, no new significant maternity incidents had been recorded, indicating the positive impact of the quality improvement program. The team continued to monitor this progress to sustain improvements.

9.6 A maternity risk review was conducted, identifying Risk 10 (related to infections of waters during labour) as overdue due to updates in national guidance. The overdue status had been resolved with the implementation of the revised policy.

9.7 Efforts to improve the maternity environment, especially for patients with pregnancy concerns like suspected miscarriages, had been positively received for space improvements and overall patient experience.

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

10 New Hospital Programme (NHP) Update

10.1 JB provided an update on the progress of the New Hospital Programme, emphasising the significant population growth in Milton Keynes, which was expected to reach approximately 450,000 by 2020. This rapid growth was a central factor driving the need for the new hospital. He also noted that the hospital programme was unique within the NHS, as it focused on growth rather than replacing existing hospitals due to deteriorating conditions, as was the case with other NHS projects.

10.2 A key point raised was the meeting with the local Council and the ONS (Office for National Statistics), where the ONS acknowledged that the local population data, which included housing growth figures, was more accurate than their own estimates. The ONS had agreed to consider this more accurate data in their future projections, which was a significant development for the project.

10.3 JB mentioned that a clinical advisory team, which included obstetricians and other healthcare professionals, had been recruited to ensure the design reflected the needs of clinical departments. These advisors had been instrumental in communicating insights back to the clinical teams. The team was also focused on extensive external communication, including engaging with the local parish council to address concerns and keep the community informed.

10.4 In response to a question from SW regarding the composition of the clinical advisory team, JB confirmed that while the advisors were largely internal, they were well-linked with the wider healthcare community. They were also collaborating with regional roles to learn from other hospitals' experiences and ensure all clinical interdependencies were addressed in the design process.

10.5 JB reassured the Board that the central NHS team, including bodies like the Royal College of Surgeons were actively involved in setting best practices for the programme. The advice from these organisations was crucial in ensuring the hospital design meets national standards, though some exceptions may be made for site-specific needs, which will need to be justified.

10.7 Further updates were provided on the construction progress, noting that the foundations for the new Imaging Centre were complete, and the building was expected to rise quickly from the ground. The multi-storey car park, which was planned to open in June 2025, was nearly complete, though there had been some challenges with drainage and planning for the electric vehicle charging stations.

10.8 JB highlighted the rapid progress of the Oak ward building, which, while not formally part of the New Hospital Programme, was viewed as an enabling project to increase bed capacity on-site. This building was quickly coming out of the ground, with a ceremony planned to mark its progress.

Action: A new master plan for the site would be presented to the Board in the coming months, which would further detail how the new development would integrate with the existing hospital infrastructure.

10.9 The Board **noted** the New Hospital Programme (NHP) Update

11 Performance Report Month 10

11.1 HB presented the performance report, reflecting on the challenging month of January, which saw an increase in respiratory infections and frailty patients. These factors led to a rise in the length of stay for patients. Despite the progress made in integrated discharge hubs, HB highlighted that a significant number of patients were still waiting in hospital beds beyond 21 days. However, this number was beginning to decrease.

11.2 Data was shared regarding the patients waiting over 65 weeks for treatment. As of the report, the number had decreased to 96 patients, with a forecast of reducing this figure to less than 20 by the end of March 2025. The delay for many of these patients was due to patient choice, with some electing to wait until after Easter, as well as cases where patients were unfit for surgery.

11.3 The report indicated that in January, the hospital's performance was 73%, ranking ninth out of similar Trusts and 29th out of 127 nationally. HB emphasised that the hospital was already planning for the next winter season to ensure that patient care is effectively managed during peak times, noting the creation of a strong steering group to guide preparations.

11.4 HT expressed appreciation for the detailed update and questioned the efforts to manage the patients waiting over 65 weeks. HB responded that about half of these patients were waiting due to personal choice, while the other half faced complex cases that required more time for resolution. The team was working hard to ensure that this cohort is reduced by the end of March 2025, with the expectation that patient choice would remain a significant factor.

11.5 PR raised a question about cancer care, specifically regarding the 62-day and 31-day standards. He noted that the hospital was exceeding the 31-day standard but struggling with the 62-day standard. HB clarified that the 62-day standard related to the referral process from the GP to the hospital, which was not fully within the hospital's control. However, the hospital was performing well on the 31-day standard, which measured the time from diagnosis to treatment.

11.6 HB answered a follow-up question regarding discharge times, noting that the hospital was aiming to meet the target of discharging patients by 12 noon to free up capacity for new admissions. This was critical for ensuring smooth patient flow and reducing emergency department congestion. She emphasised that achieving this target required careful management of ward rounds and timely transfers to discharge areas.

11.7 The Board **noted** the Performance Report for Month 10

12 Finance Report Month 10

12.1 JD presented the finance report, providing an update on the financial position at the end of January 2025. The report highlighted a financial loss of £1m for January, contributing to a year-to-date deficit. This was primarily driven by the increase in activity, which generated both additional income and costs.

12.2 The impact of winter pressures was highlighted, particularly the need to keep all escalation capacity open. This, along with an increase in staff sickness, contributed to the financial run rate being higher than expected. Despite the underlying issues, JD indicated that the financial year was on track to break even. This forecast was based on improvements in the actual run rate and non-recurring interventions, although these challenges would continue to require attention.

12.3 The Board **noted** the Finance Report for Month 10

13 Green Plan Update

13.1 JD provided an update on the current Green Plan, summarising progress made and outlining the process for developing the next phase. The discussion covered achievements in carbon reduction, interventions undertaken, and the benefits observed. The Board's target remained achieving net-zero emissions by 2030.

13.2 Significant progress had been made, particularly through large-scale estate decarbonisation schemes. Various smaller initiatives, such as reducing plastic usage and eliminating unnecessary travel, had also contributed. However, some challenges remained, particularly in areas like sustainable procurement and reducing medical gas emissions.

13.3 HT inquired about financing and prioritisation, emphasising the need to balance sustainability efforts with other organisational priorities. JD noted the importance of financial planning and resource allocation in collaboration with partners to ensure continued progress.

13.4 A key focus moving forward was enhancing data accuracy to better measure progress. JD noted that while successes had been achieved, the robustness of current measurement systems required improvement. Updated national guidance had recently been published, and the intention was to align future plans with these expectations, ensuring more precise tracking and reporting.

13.5 The Board **noted** the Green Plan Update

14 2025/26 Planning

14.1 JD provided an overview of the planning priorities for 2025/26, highlighting the challenges of delivering required efficiencies within financial constraints. The focus areas included urgent care, diagnostics, and productivity improvements. He noted that the financial assessment made achieving these priorities particularly challenging.

14.2 JD emphasised the need to meet efficiency targets, including a 5% improvement in productivity. However, concerns were raised about the NHS's historical difficulty in achieving such efficiency levels. Additional ring-fenced funding was being considered for urgent care and diagnostics, but overall financial pressures remained a concern.

14.3 There was a discussion on capital funding, with JD noting that while resources for the next year were available, long-term sustainability remained uncertain. The Board acknowledged the risks associated with financial gaps and the reliance on efficiency improvements to close them.

14.4 GM requested clarification on how productivity opportunities were identified and categorized, and inquired whether efficiencies achieved in the current year would be counted towards next year's targets. JD responded by explaining that productivity metrics were nationally determined and assessed based on submitted financial data. Opportunities were mapped against organisational needs to determine feasibility. JD clarified that efficiency savings were reset annually, requiring new savings to be identified for 2025/26.

14.5 The Board recognised the complexity of financial planning for 2025/26 and agreed to revisit the topic in future meetings to track progress and adjust strategies as needed.

14.6 The Board **noted** the 2025/26 Planning

15 Workforce Report Month

15.1 LC presented the Workforce report, which included progress in staffing and ongoing areas of focus. Temporary staffing had been reduced, and efforts would continue in the next financial year to minimise agency usage. Short-term absences were high in the previous quarter, mainly due to seasonal illnesses such as colds, coughs, and flu. International recruitment had exceeded target levels, contributing positively to overall staffing levels.

15.2 LC reported that while temporary staffing remained a focus, the Trust had managed to reduce agency usage. However, certain roles that attracted premium rates continued to pose challenges. A dual approach was being taken to reduce both agency and bank staffing, with this remaining a key priority moving forward.

15.3 Delays in the recruitment process were acknowledged, particularly in transitioning from resignations to filling vacancies. It was noted that improvements could be made to expedite this process, with regular resourcing panels in place to ensure oversight. The importance of focusing on specific roles that had a direct impact on hospital flow, such as physiotherapists and radiologists, was emphasised.

15.4 The Board noted the need for targeted recruitment strategies to address staffing vulnerabilities and key roles affecting operational efficiency. Workforce challenges would continue to be monitored, with reports highlighting priority roles requiring urgent recruitment.

15.5 The Board **noted** the Workforce Report

16 Risk Management Report

16.1 KJ provided an analysis of all risks recorded on the Risk Register as of 25 February 2025, highlighting key movements within the corporate risk register and significant risks related to diagnostics and maternity. Efforts to mitigate these risks through strategic investments were outlined.

16.2 A discussion followed regarding the distinction between the corporate risk register and the significant risk register, with concerns raised about potential duplication. It was noted that this issue has been reviewed multiple times, with different recommendations over the years. The current approach differentiates significant risks based on their severity and broader impact.

16.3 The Board was updated on ongoing efforts to mitigate diagnostic risks, including the construction of a new imaging centre with expanded scanning facilities. Additionally, work was in progress to finalise the right-sizing of the diagnostics team to ensure sufficient clinical manpower. While further actions were needed, these initiatives were aimed at addressing the risks outlined in both registers.

16.4 The Board **noted** the Risk Management Report

17 Board Assurance Framework (BAF)

17.1 KJ provided an overview of key updates from the BAF report. The strategic risk of insufficient staff levels had been split into two separate risks: one addressing challenges in recruiting for 'hard-to-recruit' roles, and the other focusing on staff retention. Two new strategic risks, relating to insufficient or poor data quality and cybersecurity, were being added to the BAF. Additionally, it was noted that the Trust Risk Appetite Statement had been reviewed and updated during the BAF Board Seminar in February 2025.

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

18 Board Committees Assurance Reports

18.1 The **Charitable Funds Committee Assurance Report** provided an update on fundraising activities, income, and the installation of a new donation wall in the Neonatal Unit. The committee approved the closure of the Radiotherapy Wellbeing Appeal and noted the Finance Report, discussing cash position, income, expenditure, and reallocation of restricted funds. The potential impact of a partnership with Friends of MK and the funding position of Arts for Health MK were also considered. The committee escalated concerns about the impact of the departure of the Individual Giving Fundraising Lead and the future of Friends of MK Charity to the Trust Board for further discussion.

18.2 **The Finance & Investment Committee Assurance Report** provided an overview of the Trust's financial performance, highlighting a £5.5m deficit by the end of January, driven by pay award pressure and unfunded support for RTT premium costs. The Efficiency Report forecasted an outturn of £23.8m, including £7.3m from ERF overperformance. Capital updates included an increased CDEL allocation to £59.8m and discussions on improving capital project reporting. The Integrated Performance Report highlighted inpatient occupancy for January 2025. The committee also noted the NHP Financial Overview, with a budget of £335,951,799 against a forecasted cost of £355,402,6115. Several items were recommended for escalation to the Trust Board, including contracts for managed services and security officers.

18.3 **The Workforce & Development Assurance Report** provided an overview of key discussions and decisions from the last meeting held on 27 February 2025. The committee approved changes to its Terms of Reference and **recommended** that the Board **approve** its renaming to the **People & Culture Committee.** Discussions included a review of the Workforce Board Assurance Framework and Risk Register, highlighting gaps in control and governance. Updates on the Inclusion Programme emphasised leadership engagement and future initiatives. The Freedom to Speak Up Report showed increased trust in the process but raised concerns regarding fairness and managerial support. The Workforce Strategy focused on values-based recruitment and targeted campaigns, while the Safe Staffing Report underscored the importance of ongoing monitoring and adjustments.

18.3.1 The Board **noted** the Board Committees Assurance Reports and **approved** the renaming of the Workforce & Development Assurance Committee to the **People & Culture Committee** and **approved** the changes to its Terms of Reference.

19 Board Committees Annual Report 2024/25

19.1 The Annual Review of Effectiveness Report 2024/25 for the **Workforce Development & Assurance Committee (WADAC**) provided an update on the committee's activities and effectiveness over the past financial year. The report highlighted that the committee had fulfilled its roles and responsibilities in line with its Terms of Reference, including overseeing the Board Assurance Framework and Workforce Risk Register, and reviewing progress against the NHS Annual Staff Survey and other key metrics. The committee also recommended renaming itself to the People and Culture Committee to better reflect its focus on organisational culture. The evaluation of the committee's effectiveness showed positive results, with an overall score of 4.6 out of 5, and identified areas for improvement, such as a greater focus on employee fulfilment.

19.2 The Board **noted** the Board Committees Assurance Report

20 Use of Corporate Seal

20.1 The Board discussed the use of the Corporate Seal, with suggestions to explore transitioning to an electronic signatory system. There were no objections to investigating this option, provided it aligned with the Trust’s standing orders and constitution. It was noted that while contracts requiring a physical

seal would still follow the existing process, the practicality of handling large volumes of paperwork should be considered.

Action: The Board agreed that JB and KJ would review the current use of the corporate seal and explore potential improvements, including the feasibility of an electronic alternative.

21 Forward Agenda Planner

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

22 Questions from Members of the Public

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

Question 1:
NURSES: Radio 5 live news just covered the challenges for the NHS, a senior NHS nurse pointed out that the largest body of skilled care providers are the nurses, and that NHS UK currently has 40,000 nursing vacancies which have not been filled. Does MKUH have nursing vacancies, and if so, what is our strategy to address this?

Question 2:
MORALE: What is the current morale among MKUH staff after doctors & nurses disputes and pay awards etc, and how do we continually keep this in an ever-increasing positive place? –
- Doctors
- Junior Doctors
- Nurses
- Support Staff
- Porters etc

23 Any Other Business

23.1 None

The meeting closed at 12:21pm

Updated:23.04.25

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Trust Board Action Log

Action No.	Date added to log	Agenda Item No.	Subject	Action	Owner	Completion Date	Update	Status Open/ Closed
40	14-Nov-24	3	Staff Story	FH to present a detailed plan on career progression pathways at an upcoming meeting.	FH	**01-May-25**		**Open**
41	06-Mar-25	9	New Hospital Programme (NHP) Update	A new master plan for the site will be presented to the Board in the coming months, outlining how the new development will integrate with the existing hospital infrastructure.	JB	01-Sep-25		**Open**
42	06-Mar-25	20	Use of Corporate Seal	JB and KJ to review the current use of the corporate seal and explore potential improvements, including the feasibility of an electronic alternative	KJ	TBC		**Open**

Meeting Title	**TRUST BOARD PUBLIC**	**Date: 1 May 2025**
Report Title	**Chair's Update**	**Agenda Item Number: 6**
Lead Director	**Heidi Travis**, Chair	
Report Author	**Heidi Travis**, Chair **Timi Achom**, Assistant Trust Secretary	

Introduction	This report is a standing agenda item		
Key Messages to Note	This report informs the Board of key points arising from the Council of Governors and members' discussions and the Chair's and Non-Executive Directors most significant activities since the last Trust Board held in public. The Board is invited to NOTE the report		
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	*N/A*
Next Steps	*N/A.*
Appendices/Attachments	*N/A*

1. Introduction

1.1 This report aims at updating the Board on the Acting Chair's main activities, Non-Executive Directors (NEDs) ward visits, Governors' visits and discussions as well as systems and place collaborations as part of the MKUH Board's commitment to transparency and accountability. The report further informs the Board of key points arising from the Council of Governors' discussions and the Chair's and Non-Executive Directors most significant activities since the last Trust Board held in public.

1.2 The Board is invited to NOTE the report.

2. Chair's Update

2.1 At the Board Seminar on 3 April, Board members focused on various aspects of board effectiveness and strategic planning. The meeting included an objectives review and a strategy planning discussion. In addition, we continued to plan Board development.

2.2 Francesco Fiore, Catering Manager, was awarded Caterer of the Year by the Hospital Caterers Association

2.3 The Board noted progress in reducing waiting lists, placing the Trust among the top in the East of England

2.4 On 13 March, participated in the Chairs and Chief Executives Day in London, where we discussed strategies for 2025 initiatives and performance, as well as the planned changes for NHS England.

2.5 Attended an event at Sandhurst for Armed Services Gold Standard Employers, which focused on leadership across various sectors.

Council of Governors Update

2.6 <u>Governor Engagement</u>

The Governor Engagement Committee is due for its first meeting on Wednesday 30 April at 5pm on Teams, as a formal sub-committee of the Council of Governors (COG). The aim of the committee is to support MKUH Governors in their engagement activities, in turn supporting Governors' overarching roles and responsibilities.

Final preparations are being made for the MKUH 'Hospital in the Community' health event at King's Community Centre in Wolverton on Tuesday 13 May, 10am-2pm.

2.7 Council of Governors Meeting

The Council of Governors held on 16 April 2025. The meeting was well attended by Governors and NEDs. The meeting included updates on Trust business and the 2025/26 plans, discussions on quality priorities for the year, and an excellent presentation on Dementia services at the Trust from Janet Page, the Lead Dementia Nurse.

3. Other Engagements

Over the past two months, participated in regular one-to-one meetings with Non-Executive Directors and chaired interview panels for various roles, alongside our medical and non-medical colleagues. Additionally, attended Board Committees and engaged in the following activities:

3.1 Attended a panel update for International Women's day with Kate Jarman and Precious Zumbika.

3.2 Met with Richard Sumray – the new Chair of Bedfordshire Hospitals NHS Trust and David Carter – the CEO of Bedfordshire Hospitals NHS Trust.

3.2 Attended the BLMK leaders and Chairs meeting.

4. Recommendation

The Board is invited to NOTE the report.

Meeting Title	**TRUST PUBLIC BOARD**	**Date: 1 May 2025**
Report Title	**Chief Executive's Update**	**Agenda Item Number: 7**
Lead Director	Joe Harrison, Chief Executive	
Report Author	Joe Harrison, Chief Executive	

Introduction	This report is a standing agenda item		
Key Messages to Note	This report informs the Board of key points arising from the Chief Executive's most significant activities since the last Trust Board held in public. The Board is invited to NOTE the report		
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	*N/A*
Next Steps	*N/A*
Appendices/Attachments	*N/A*

1. Chief Executive's Update

1.1 2025-26

Our new financial plan for 2025-26 has been set. It is critical that we operate in line with this plan throughout the year, continually focussing on the quality of care being given to our patients as well as controlling costs and identifying more efficient ways of spending taxpayers' money. Delivering further improvements in performance will be challenging within our funding allocation this year. Whilst we expect to see a further reduction in the overall size of the waiting list and improvements in waiting time performance, A&E waiting times are likely to be static as a result of an anticipated increase in attendance volumes.

I am keen that, amidst this context of change and efficiency drives, we never lose focus on supporting the team here at MKUH to deliver the highest quality of care.

1.2 2024-24 Performance Summary

The last financial year saw a significant reduction in the total number of patients waiting for planned appointments and operations, along with a reduction in the longest amount of time each patient has to wait.

By the end of March 2025, the number of people waiting more than 18 weeks for a planned appointment or operation fell by over 6,000 patients to 16,425 (2023-24: 22,626). In the same period, the number of people waiting more than 65 weeks fell from 1,006 patients to 44.

Cancer waiting times for treatment also improved, with the number of patients waiting two or more months before getting treatment improving to 152 as at 31 March 2025 (31 March 2024: 170).

The improvements come despite another year of record referral numbers and winter pressures and have been supported by innovative approaches to managing flow.

1.3 Chair appointment

I am pleased to advise you that, following a formal selection process and ratification by the Council of Governors, Heidi Travis has been appointed to the post of Chair.

1.4 National Staff Survey

On 13 March, the NHS National Staff Survey was published. Our scores remain above the national average and response rates continue to go up. Colleagues are asked to respond to the survey during the winter which is always a time of great pressure. As we have already identified, there are growing concerns nationally

about violence and abuse. Our work to address this issue will require continuous efforts which are now underway. Notably, we are increasing the prominence of 'zero tolerance' messaging across the hospital.

1.5 ICB Visit

Interim Chair of BLMK ICB, Manjeet Gill, visited the hospital on 5 March. She received a tour of the hospital, and an update on our performance and development plans. We continue to work closely with the ICB and all partners to deliver improved health outcomes for local people and navigate effectively through the many changes that are affecting us all.

1.6 Inquest Conclusion

The inquest into the death of Mr Brian Ringrose in February 2021 concluded on 23 April. I would like to say how deeply sorry I am for Brian's death and send heartfelt condolences to his mother and other family members. The inquest jury returned a detailed set of findings. We respect and accept the conclusion the jury has reached, and the comments made by HM Coroner. We have learnt and changed a great deal since Brian's death to prevent anything similar from happening again. An updated action plan, focussed on embedding and sustaining learning and improvement following Brian's death, will be shared through internal governance meetings and through our public Trust Board meeting.

Recommendations

The Board is invited to note the report.

Meeting Title	**Board of Directors Public**	**Date:** 1 May 2025
Report Title	**Inquest into the Death of Brian Ringrose (Concluded 24th April 2025)**	**Agenda Item Number: 7**
Lead Director	Kate Jarman, Chief Corporate Services Officer	
Report Author	Kate Jarman, Chief Corporate Services Officer	

Introduction	Update following the conclusion of the inquest into the death of Mr Brian Ringrose		
Key Messages to Note	Action and assurance		
Recommendation *(Tick the relevant box(es))*	**For Information** ☒	**For Approval** ☐	**For Review** ☐

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	Safety, experience, effectiveness (and well led).

Report History	Previous updates to Board
Next Steps	Regular reporting for oversight and transparency
Appendices/Attachments	Paper follows

Inquest into the Death of Brian Ringrose (Concluded 24th April 2025)

Summary

The inquest into the death of Brian Ringrose concluded on 24th April 2025. This inquest was heard before a jury, who returned a conclusion of unlawful killing, unlawful act manslaughter (one police officer) and neglect (other police officers and healthcare staff).

The inquest was heard before His Majesty's Coroner Dr Sean Cummings. HM Coroner indicated he would issue a Prevention of Future Deaths Notice (PFD) to Thames Valley Police, Milton Keynes University Hospital NHS Foundation Trust and Central and North West London NHS Foundation Trust. This is expected to be received in May.

This paper is designed to provide a brief overview of the actions taken following Mr Ringrose's death, to provide assurance that the Trust has acted and continues to act to prevent any future incidents. Progress will be monitored, including through the Board of Directors meeting (in public).

Statement from MKUH on the Conclusion of the Inquest

MKUH Chief Corporate Services Officer, Kate Jarman, said:

"On behalf of MKUH I would like to say how deeply sorry I am for Brian's death. This inquest has been harrowing, especially so for Brian's mother and other family members to whom I would like to offer my heartfelt condolences.

"The inquest jury has today returned a detailed set of findings. We respect and accept the conclusion the jury has reached, and the comments made by HM Coroner.

"We have learnt a great deal and changed a great deal since Brian's death to prevent anything similar from happening again. Brian's death will continue to shape practice at MKUH. His memory will continue to define what we do and how we work to provide patients with the safest, best care we can deliver."

Action Plan – for Information and Assurance

The following table provides a summary of the safety actions that have been undertaken and are ongoing following Mr Ringrose's death. A full report, including any further actions indicated as required in the PFD will be brought back to Board in June (and July in public).

Safety Action Description	Action	Owner	Date Implemented or Planned	Reporting and Oversight
Distribute a memorandum to all Emergency Department clinicians on adherence to Toxbase guidance or documented alternative management plan authorised by the Emergency Physician in Charge (EPIC)	Memorandums issued December 2024 February 2025 March 2025 Toxbase Quick Guide issued March 2025	Chief Corporate Services Officer	December 2024	ED Clinical Governance Improvement Group Quality Executive Board Patient Safety Board
Implement the policy: Patients in Police Custody – Care in and Discharge from the Emergency Department (based on RCEM Guideline: Emergency Department Patients in Police Custody) Implement the guideline: RCEM Guideline: Emergency Department	Implementation of Royal College of Emergency Medicine Guidance	Chief Corporate Services Officer	March 2024	Trust Executive Committee Quality Executive Board Patient Safety Board

Safety Action Description	Action	Owner	Date Implemented or Planned	Reporting and Oversight
Patients in Police Custody				
Implement the Right Care, Right Person best practice protocols between MKUH and Thames Valley Police Service for people in mental health crisis	Implementation of updated national guidance on Right Care, Right Person (and local partnership agreements	Chief Corporate Services Officer	Updated local partnership agreement January 2025, agreed and signed	Trust Executive Committee Quality Executive Board Patient Safety Board
Task and finish group to develop communication pathways between MKUH ED and TVP	Establish and embed a task and finish group between clinical and operational staff in the ED and TVP operational leads to develop and monitor transfer arrangements for patients in police custody	ED Matron and Lead Consultant for Mental Health	In place since March 2023	ED Clinical Governance Improvement Group
Gap analysis of policies and procedures for the care and discharge of patients in police custody in the ED	Conduct a review of all policies and standard operating procedures in place to identify any gaps or areas for further development	Chief Corporate Services Officer	June 2025	ED Clinical Governance Improvement Group Quality Executive Board Patient Safety Board
Implement a standard operating procedure for patient safety events with	Implement a standard operating procedure to ensure there is a clear and agreed process for the	Chief Corporate Services Officer	May 2024	Trust Executive Committee

Safety Action Description	Action	Owner	Date Implemented or Planned	Reporting and Oversight
police involvement	timely co-ordination and completion of internal (patient safety) investigations into a potential harm event, where there is an active criminal investigation.			Quality Executive Board Patient Safety Board
Review MHLT referral pathways to ensure they are consistent with national guidance	Implementation of electronic mental health triage form integrating Side by Side guidance (consensus statement from the Royal College of Psychiatrists, the Royal College of Nursing, the Royal College of Emergency Medicine, and the Royal College of Physicians). Continue monthly interface meetings with Central and North West London NHS FT (mental health services provider) and ED clinical and operational leads Create a policy to capture the mental health referral pathway, the protocol that is already	ED Matron and Lead Consultant for Mental Health and CNWL Operations Manager (and relevant Clinical Leads) ED Matron and Lead Consultant for Mental Health and CNWL Operations Manager (and relevant Clinical Leads)	June 2024 In place since 2024 July 2025	ED Clinical Governance Improvement Group Quality Executive Board Patient Safety Board

Safety Action Description	Action	Owner	Date Implemented or Planned	Reporting and Oversight
	embedded in our mental health triage form, the working arrangement with CNWL and our expectation of what service is delivered from the MHLT. This will include engagement with CNWL to ensure the policy aligns with their operational policy.	Chief Corporate Services Officer		
Development of an ED Discharge Protocol	Ensure that all professional groups in the ED understand their role in this discharge process by introducing an ED discharge protocol. This will seek to provide clarity in use of terminology (both formal and informal use) and in terms of process – i.e. preparing for discharge versus has now been discharged. This will include ensuring ways of working align with documentation on eCARE, and eCARE workflows, providing an	Chief Corporate Services Officer ED Chief Nurse and Matron; Lead Consultant for Mental Health and CNWL Operations Manager (and relevant Clinical Leads)	June 2025	ED Clinical Governance Improvement Group Quality Executive Board Patient Safety Board

Safety Action Description	Action	Owner	Date Implemented or Planned	Reporting and Oversight
	aligned, documented protocol for discharge from the eCARE system, printing of discharge information and the physical discharge of a patient from the department. A multi-professional group will be convened in order that this protocol adequately engages the multi-disciplinary team. The first meeting of this group has been scheduled for 14th May 2025.			
Implement new Restraint and Restrictive Practices Policy	Implementation of the Restraint and Restrictive Practices Policy		May 2024	
Revise the policy framework, training and approach to ensure our staff are well informed and able to manage complex and high risk situations appropriately and safety.	Undertake review to encompass the following: **Preventing violence and abuse framework** (review and replace the current violent and unacceptable behaviour prevention strategy;	Chief Corporate Services Officer	July 2025	Trust Executive Committee Health and Safety Committee Patient Safety Baord

Safety Action Description	Action	Owner	Date Implemented or Planned	Reporting and Oversight
	incorporate assault on hospital staff support procedure) **Managing violence and abuse from patients and the public policy** (review and replace managing unacceptable behaviour, abuse, harassment and discrimination from patients and the public policy; incorporate behavioural letters/ escalation process to banning order) **Managing violence and abuse - de-escalation guidelines** (new) **Restraint policy** (review and replace the current restraint and restrictive practices policy; incorporate quick guides) **Rapid tranquilisation policy** **Administration of the Mental Health**			

Safety Action Description	Action	Owner	Date Implemented or Planned	Reporting and Oversight
	Act policy (review and simplify) **Administration of the Mental Capacity Act policy** (review and simplify) **Security officer training framework** (new) **De-escalation, conflict resolution and breakaway training framework** (new) **Security policy: people and premises** (review and replace security of people and premises policy)			
Issue Quick Guide on Safe Restraint to ED	Implement Quick Guide on Safe Restraint to ED	Chief Corporate Services Officer	March 2025	ED Clinical Governance Improvement Group
Training on conflict management and on the Restraint and Restrictive Practices Policy for all ED staff	Conflict resolution training is mandatory for ED nursing staff and this includes HCAs.	ED Chief Nurse	Established mandatory training programme	ED Clinical Governance Improvement Group
Remind staff about appropriate	Staff will continue to be reminded to consider the	All managers	Established values and behaviours	People and Culture Committee

Safety Action Description	Action	Owner	Date Implemented or Planned	Reporting and Oversight
standards of behaviour	language they use at work, the way they speak about those in their care and the impact of the words they use.		framework and appraisal framework and just culture panel and process.	
Develop bystander effect awareness and training package	Develop and implement a bystander effect awareness and training package to raise awareness of the bystander apathy, proactive interventions strategies and the importance of speaking up	Chief Corporate Services Officer	September 2025	Trust Executive Committee Patient Safety Board
Review uniform and name badges for staff in the ED so that they are easily identifiable by role	Review current uniforms and name badge/ lanyard conventions in the ED as part of a review of the Uniform and Dress Code Policy	Chief Nurse	September 2025	Trust Executive Committee

Additional Actions Completed:

Nurse-led training in the Emergency Department:

- Common mental health conditions and presentations
- Mental health triage, initial assessment and risk assessment including prompt questions
- Reducing risk and suitable environments
- Mental Capacity Act 2005 - Lack of capacity, assessing capacity, key principles, two stage capacity test
- Other legislation and limitations in department – Mental Health Liaison Team, police, Deprivation of Liberty Safeguards, Mental Health Act 1983, Sections 2 and 3, common law, best interests
- Section 136 - expectations and responsibilities whilst in ED

- Absconding patients - risk, prioritising assessment, what to do when pt absconds and routes to follow before calling police and key words to use for a police response
- MHLT referrals - encouraging side by side working rather than medically fit for assessment / discharge

The weekly nurse handover teaching also covers:

- Restraint and Restrictive Practices - Policy highlighted and what staff should / shouldn't do regarding patients who are restrained
- Acute Behavioural Disturbance - risks, what to look out for and how to manage
- Rapid Tranquilisation - policy, pharmacology treatment, monitoring
- Violence and abuse - what to do

The relevant training courses available at the Trust relating to these topics are:

- Breakaway Training
- Mental Health First Aid Course - Adult, Youth, Armed Forces
- RESPOND training - multi agency simulation training for professionals involved in Mental Health crisis care, increasing collaboration, knowledge and equips staff to respond quickly and appropriately to improve patient experience (eg. ED staff, police, ambulance service, Approved Mental Health Professionals (AMPS), MHLT, social workers, lived experience)

Staff know to complete the mental health triage and observation forms initially on paper and then the mental health triage and capacity and risk assessments on eCare. Observation checks are also recorded on eCare, and staff have been educated as to how to complete these forms and manage red flags. These will be audited.

Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date 1 May 2025

ICB Executive Lead: Maria Wogan, Chief of Strategy and Assurance, and MK Link Director, Bedfordshire, Luton and Milton Keynes (BLMK) ICB

ICB Partner Member: Joe Harrison Chief Executive, Milton Keynes University Hospital NHS Foundation Trust

BLMK Health and Care Partnership Member: Heidi Travis, Acting Chair, Milton Keynes University Hospital NHS Foundation Trust

Report Author: Maria Wogan

Report to the: Board of Directors, Milton Keynes University Hospital NHS Foundation Trust

Bedfordshire, Luton and Milton Keynes Integrated Care Board (ICB) and Health and Care Partnership update

1.0 Executive Summary

1.1 This report summarises key items of business from the Board of the BLMK ICB and the BLMK Health and Care Partnership arising recent meetings.

2.0 Recommendations

2.1 The Board of Directors is asked to **note** this report.

3.0 Key Implications

Resourcing	✓
Equality / Health Inequalities	✓
Engagement	✓
Green Plan Commitments	✓

4.0 Report

4.1 Bedfordshire, Luton and Milton Keynes Integrated Care Board Update

The Board of the ICB met on 21 March 2025 at Priory House, Central Bedfordshire Council Offices, Shefford.

Questions from the public –There were two questions from residents, concerning Artificial Intelligence and funding for pelvic health. Residents Questions

Resident stories - Three Members of the Central Bedfordshire Youth Parliament attended the Board and shared their experience of attending the first System Insight Network on 28 January, and their ideas on the Government's Change NHS conversation. The Board welcomed feedback from the young people and committed to including their views as part of ongoing programmes of work.

Chair and Chief Executive updates – The Chair raised recent HM government announcements on further reductions to ICB running costs, as part of a new financial reset in the NHS, and reflected on the contribution made by the ICB in the past year including increasing GP appointments by 10.4%, providing more dental appointments and preventing 1,800 unnecessary admissions to hospital through the Unscheduled Care Hub. She committed to providing more information on the future of ICBs as details become available.

The Chief Executive welcomed the powerful presentation from the Youth Parliament Members and drew attention to the profound experience of the Oliver McGowan training on autism. Dr Andrew Rochford, Chief Medical Officer, was welcomed to his new role, and the Chief Executive thanked Dr Ian Reckless for his service to the system as Interim ICB CMO. She informed the Board that Anne Brierley would be stepping back from her role as Chief Transformation Officer due to poor health and thanked her for her service. The Board heard that £1.67m capital funding had been indicatively allocated to BLMK ICB under a Primary Care Estate Utilisation and Modernisation Fund for 2025/26, and the Primary Care Commissioning and Assurance Committee will consider how this funding will be utilised. The Chief Executive updated the Board on the recruitment process for the appointment of the permanent ICB Chair and explained that the appointment is with the Secretary of State for approval.

Directors of Public Health Report – The Director of Public Health for Bedford Borough, Central Bedfordshire and Milton Keynes City Councils provided the Board with her annual report, including an overview from the Population Health Intelligence Unit. The population in BLMK is forecast to grow to nearly 1.3m by 2043 – an increase of 250,000 people (25%), with the highest growth expected in Central Bedfordshire (31%) and Bedford Borough (28%). Significant increases are expected in the over 85 population and with an increase in ethnic diversity, the report projected an increase in health conditions common with an ageing population. The Board heard that this was forecast to lead to a 34% increase in primary care activity – meaning 1.55m more primary care consultations per annum would be required. The Board reflected on how continued tackling of frailty in older people would help make the health service more sustainable, and that a 3% increase in vaccination rates nationally could prevent 100,000 hospital admissions each year.

Strategic Priorities – Start Well – children and families – The Board welcomed the follow up report on children and families, and the transformation metrics and data included. The ICB's Chief Nurse provided an update on the positive work being undertaken by Cambridgeshire Community Services in pilot areas and it was agreed that work was needed to further integrate children's mental health and learning disabilities. Members reflected on the positive work to collaborate across this priority area and reinforced the need to continue to look at outcomes as a means of quality improving the process.

Operational and financial planning – Members heard that the ICB was intending to submit a balanced financial plan for 2025/26, but that there remained unmitigated risks within the plan. The Board agreed that a system wide approach to mitigating the risks was essential to maintain grip and deliver a balanced position. Members also agreed that Board approval would be required, together with a robust communications plan, for any de-commissioning decisions that are proposed to mitigate finances in year. The Board ratified the appointment of Board Champions for each of the Transformation areas, and approved the refresh of the Joint Forward Plan.

Health Service Strategy – The Chief Medical Officer provided an update on the Health Service Strategy and the clinical governance being established to take the strategy forward. The Board welcomed the multi professional clinical representation involved and Members acknowledged and welcomed the co-design involved in developing the strategy.

They asked for assurance that this approach would be taken through to co-delivery across the system.

Transformation of Community and Mental Health Case for Change – The Board discussed the Case for Change and timeline for the transformation of Community and Mental Health Services. Members challenged the proposed potential maximum timeline of 3 years and asked for a more ambitious timeline to be considered. Members reflected on transformation in the past 10 years and recognised the need to innovate and include resident voices and lived experiences into the process. The Chief of Strategy and Assurance and Chief Primary Care Officer agreed that they would review the timeline and approach with the aim of delivering the programme earlier and emphasised the need to ensure the ICB continued to deliver on its statutory duty to involve and that the mobilisation process ensured patient safety. The next stage is the production of the Case for Change which will be completed by the end of June 2025.

Board reports – The Chairs of each Committee provided an update:

Audit and Risk Assurance Committee – The Board:
Noted the report and including that an assessment on cyber security provided a moderate rating. Work was underway to respond to recommendations.
Recognised the contribution of the Finance team for their work, which was recognised in the recent internal audit.
Noted and approved the EPRR Annual Report on Core Standards.
Noted and agreed the System Risk and Board Assurance Framework.
Bedfordshire Care Alliance Committee – The Board noted the Chair's update on the review of the form and function of the BCA.
Health and Care Partnership update – The Board noted the report and recognised the work being undertaken to develop a BLMK devolution deal.
Finance and Investment Committee – the Board:
Approved Section 75 Agreements, as recommended by the report.
Heard that there had been an improvement in the financial position of the system at Month 11 – reporting £13.7m adverse position to plan. Members heard that the forecast for year-end remains at breakeven position, because of financial control methods.
Mental Health, Learning Disabilities and Autism Collaborative Committee – The Board noted the report.
Quality and Performance Committee – The Board noted the report and the system performance report.
The Primary Care Commissioning and Assurance Committee – The Board noted the report.
Remuneration Committee – The Board noted the report.

Corporate Governance Report – proposals set out in the report were agreed.

The full set of Board papers can be found on our website here.

The next meeting of the Integrated Care Board will be at **9am on 27 June 2025 at Priory House, Central Bedfordshire Council, Shefford.**

The BLMK Health and Care Partnership met on 14 February 2025.

Mt Vernon Cancer Centre Review - Partners learned that the public consultation for the Mount Vernon Cancer Centre review would begin following local government elections in May 2025 and discussed the importance of both resident and ICB/ICP involvement in the consultation. The Partnership considered that a position statement on the matter from both the ICB and from the Partnership would be appropriate, and the matter will be discussed at the ICB/ICP joint seminar on 23 May 2025.

BLMK Health and Care Strategy - The Partnership considered progress made on strategic priorities in 2024/25 against the objectives in the Health and Care Strategy published in 2023. Many positive changes and good progress have been made by the ICB and partners over the past two years, with particularly notable examples being the work carried out to reduce unnecessary emergency hospital admissions in Bedfordshire and Milton Keynes, and the development of Diagnostic Centres. The Partnership will be working on the refresh of the Health and Care Strategy in 2025/26 and discussed the need for aims and performance monitoring to take on board advances in health data collation and analysis provided by the Public Health Information Unit. A data driven strategy, with partner led transformation of health and care is required. The next three years will see the population of BLMK grow in an environment of financial restraint, but the area has a strong underlying economic base and opportunities from East-West Rail and Luton Airport development amongst others provide cause for optimism for the future.

English Devolution White Paper - The Partnership heard that local authority partners were working together to maximise the opportunities outlined by HM Government in the recent white paper, and that the local elections in May 2027 were a possible date for the creation of a Strategic Authority covering our area. Two potential options are on the table, one for a Strategic Authority covering the existing BLMK area, and the other for a BLMK plus Northants Strategic Authority. The Partnership offered its support to the local authorities as they sought to firm up the options and their case for BLMK as the year progressed.

BLMK ICS Green Plan - Following the successful joint ICB/ICP Seminar last November the Partnership considered the draft Green Plan. Good progress has been made, with significant reductions in emissions in key areas including the elimination of the use of the anaesthetic gas Desflurane and a reduction in inhaler emissions (both very damaging climate change gases), and reductions in waste and increases of renewables in acute trusts. The new Green Plan seeks to embed a sustainable approach in decision-making, and increase awareness and understanding of the links between our environment and wider determinants of health across our workforce and our residents. The draft had been prepared with input from partners, the VCSE sector and residents, and the ICB Board will consider the final version later in the year.

Health and Care Partnership Terms of Reference: The past three years have seen significant change in the way our system works and following a review of the ToR the Partnership has approved a revised version for the ICB Board's approval. The main alterations are a change and an increase in representation from the VCSE sector with the Co-Chairs of the VCSE Strategy Group becoming members of the partnership, reflecting the importance of the sector in the delivery of health and care in BLMK, and a change to quoracy requirements from 50% to one third of members, to bring us into line with other ICBs in the area and improve the efficient working of the Partnership going forward.

Members welcomed the development of the two key strategic matters discussed at the meeting, i.e. the Health and Care Strategy and the Green Plan. Work has commenced in good time on both of these, and collaboration with partners has been built in from the start. Early work indicates that both of these initiatives will set out clear, measurable plans and targets and provide a strong base for the system to work to over coming years. They are also demonstrative of the value and strength of partnership working in BLMK, which has come a long way in three years, and set a blueprint for future plans and strategies to follow.

The published papers for the meeting can be found at Integrated Care Partnership Joint Committee - Bedfordshire, Luton and Milton Keynes Integrated Care System

Please contact the Governance Team at blmkicb.corporatesec@nhs.net if you have any queries.

Members of the public and partner organisations are welcome to join meetings of the Board in person or on-line. We ask that questions to the Board from members of the public are submitted three days in advance by 23 June 2025. Questions should be emailed to blmkicb.corporatesec@nhs.net.

Board papers and a link to join the meeting is available here a week before the meeting.

If you have any queries regarding this summary, then please contact blmkicb.corporatesec@nhs.net

4.2 Next Steps

None

List of appendices

None

Background reading

None

Meeting Title	**Trust Board Meeting in Public**	**Date: 1 May 2025**
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 Anna Costello, Patient Safety Specialist, Patient Safety Doctor	
Introduction	This paper provides an overview of patient safety activity between 01 February and 31 March 2025. The paper seeks to familiarise the board members with the new incident review systems and processes in place whilst also providing oversight on the number and nature of the safety incidents reports, and the responses to them.	
Key Messages to Note	1. The patient safety incident response framework (PSIRF) was launched Trustwide on 01 May 2024: a variety of new systems and processes are now in place and embedding. 2. The incident reporting rate is on an upward trajectory (an increase being a positive finding). 3. In PSIRF, the role of Trustwide triage (daily) and local patient safety huddles (typically at directorate level, weekly) is pivotal. 4. New significant emerging patient safety themes are described within this paper. 5. 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 at Trust Board on 6 March 2025.	
Next Steps		

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 February 2025 to 31 March 2025**. Much of this information has been shared in other forums within the Trust and is shared today for information and feedback from the members of the board.

Key points:

1. PSIRF at MKUH reaches its first-year milestone on 1st May. A special report will be shared in May in addition to the next bimonthly report in June. The purpose of this report is to provide a review of the implementation of PSIRF in terms of key findings, challenges, achievements, and recommendations for the upcoming year.
2. One incident reported in the time frame has been allocated a level 1 local patient safety incident investigation (PSII) having met the threshold for the 'deteriorating surgical inpatients' local safety priority.
3. Approximately 529 incidents (since PSIRF launch) have 'overdue workflows' associated with them. This is remaining consistent for the past few months. Whilst recognising that timelines for these workflows are internally set, the nature and distribution of these delays is described in this paper. The Radar dashboards are providing good visibility of delays and helping to drive completion.
4. The monthly patient safety learning forums continue with good multi-professional attendance and positive feedback and learning outcomes.

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.

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

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 representatives 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.)

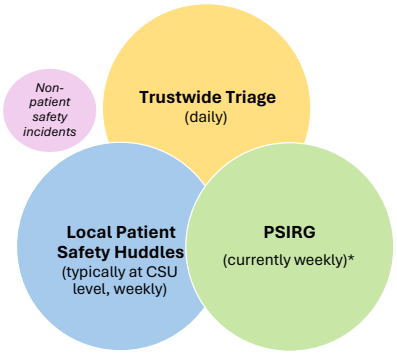
iii. likelihood of recurrence (including scale, scope and spread)

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 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.

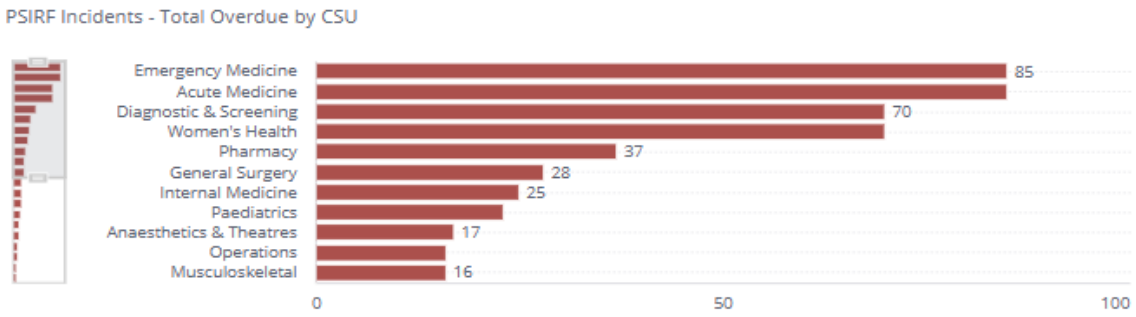
Outcomes (learning and actions) from learning events are shared in several different forums including local safety huddles, team newsletters, in 'Spotlight on Safety' in the CEO newsletter as well as at the Trust wide learning forums such as PSIRG. Additional forums for sharing learning such as podcasts, drop-in learning forums and simulation are being developed and introduced.

Reporting Period (01 February 2025 – 31 March 2025)

Key Data

The total number of incidents reported[2] between 01 February 2025 and 31 March 2025 was 2184. This is marginally lower than figures during December 2024 and January 2025 and is reflected in the number of patient safety incidents (see graph below) reported. Despite this, both sets of data remain significantly above pre-PSIRF levels, suggestive of a positive reporting culture.

The number of incidents with overdue workflows is currently 529, having remained stable over the past few months. **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. The overdue incidents are discussed at PSIRG each week and the patient safety team are continuing to support divisions to clear their backlogs. Women's Health having had the largest proportion of number of overdue incidents previously, has made progress over the past few months. The largest number of overdue incidents sits with acute medicine but the largest proportion of overdue incidents currently sits with the emergency department, which is not surprising given the size and acuity of these departments.



[2] Incidents reported through the RADAR system include both patient safety (typically two thirds) and non-patient safety (typically a third) events.

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 261 rapid reviews 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 local triage backlog of 275.

3. It has been recognised that there is no local safety huddle for patient safety incidents sitting within the corporate division, Examples include patient discharge unit, patient access and the discharge team. A proposal has been made to have a fortnightly huddle with rostered representation from estates, patient access and operations, supported by the patient safety team.

Level 1 Patient Safety Incident Investigations (including local PSIIs)

Since 01 February 2025, there has been one local level 1 investigation identified. Four PSIIs have been completed, quality assured and approved at PSIRG. See table below for details.

INC No.	Date declared at PSIRG	Level 1 investigation type	Safety Priority (National & Local)	Description	Progress update
25330/ 25342	05-Aug-24	PSII	Local Priority: Deteriorating Surgical Patient	Delay in escalation of deteriorating patient on Ward 20.	Completed
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.	Completed

24659	18-Jun-24	PSII	None	30+5 neonatal death. Intrauterine rupture – Coronial case.	Completed - Inquest expected May 2025.
25503	05-Aug-24	PSII	Local Priority: Delayed Diagnosis	Delay in diagnosis of rectal cancer due to error in listing for surgery	Completed
27576	19-Sep-24	PSII	Local Priority: Delayed Diagnosis	Delay in booking for endocrine clinic resulting in undesirable health issues.	
28226	24-Oct-24	PSII	Local Priority: Delayed Diagnosis	Delay in diagnosis of head and neck cancer due to booking error.	
34808	20-Mar-25	PSII	Local Priority: Deteriorating Surgical Patient	Urology patient. Unexpected cardiac arrest associated with abnormal electrolytes and and drug complications.	Learning response lead and engagement lead allocated. Initial engagement commenced.

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. The table below describes themes which are continuing or newly emerging since 01 February 2025.

Category	Source	Plan / next steps
Deterioration of Surgical Inpatients	Incidents	A further PSII declared (total now of 4 PSIIs). Simulation based learning event planned May 2025. Full MDT and patient/family engagement in investigations.
Discharge medications	Incidents	Initial data analysis completed of 149 incidents relating to discharge medications. 3 QIPs identified to address the 3 key workstreams (prescribing, dispensing, administration). Leads and QI coach allocated to 2 of the QIPs. Lead still required for the prescribing QIP. To be linked to discharge summary QIP.
Management of Controlled Drugs (CDs)	Incidents	A benchmarking exercise and gap analysis of regulatory responsibilities and clinical management of opioids is being finalised, with recommendations for the Prescribing & Medicines Governance Committee. The medication safety team is prioritising training and CD audits, with ward-based audits to be rolled out soon.
Violence and aggression towards staff	Incidents	Being managed under Health & Safety.
Emergency Department – poor patient experience, care delays, poor staff experience leading to incivility, delays in documentation of speciality reviews impacting patient flow, violence and aggression towards staff.	Incidents	• Escalated to triumvirate • MDT Level 2 learning event completed January 2025 re documentation delays. Awaiting actions to be agreed. • ED and SCAS regular meeting for sharing incident themes • Plenary session held on 12/2/25 on incivility • Sepsis observation work and tabletop exercise completed Jan 2025 to support sepsis QIP and care delays

Collaborative working with the clinical skills and simulation team

The patient safety team and the clinical skills and simulation team have started working together on a new approach to learning through simulation. This is a two-pronged approach working both reactively and pro-actively in response to patient safety events and optimising how learning is shared:

- A new clinical simulation learning outcome form has been introduced to capture the rationale for the simulation session, the learning generated and any quality improvement ideas. There are a variety of prompts for clinical simulation including team training requests, post clinical events and awareness days. Up until now, the learning and ideas generated during these sessions the sharing is often limited to the attendees. The hope with the new form is that learning can be shared beyond the session and become part of the patient safety learning platforms.
- Recreation of patient safety incidents using simulation in either the area that the incident occurred or recreated in the simulation wards/suite. The teams held their first planned event in December 2024 based on an incident involving a patient with a new hip replacement who sustained a hip dislocation after a controlled slide to the floor and subsequent hoisting off the floor.
- 2 further incidents are planned to have a simulation based learning event in May. Both are related to the recognition and escalation of deteriorating surgical inpatients.

Learning from Patient Safety Incidents

Learning is identified at all stages of the PSIRF process:

1. Daily triage meeting when all patient safety incidents are discussed by experts representing each hospital department.
2. Locally at weekly safety huddles (local triage).
3. Weekly PSIRG meeting where learning is identified and shared.
4. Level 1 & 2 learning events.
5. Mortality and Morbidity (M&M) meetings.
6. Monthly Learning Forums.

Key learning is recorded on Radar and together with case studies, are shared via the 'Spotlight On Safety' (SOS) message each week, published on the patient safety intranet page and shared on the 'MKUH Patient Safety Hub' MS Teams site.

The monthly patient safety learning forums are continuing - drop-in face-to-face sessions for staff to come and hear about patient safety themes, share their experiences and learn from topic experts. The topics chosen for each forum is based on current safety themes, Trust safety priorities and recent learning from PSIIs. The plan from April 2025 is to triangulate intelligence and learning from other sources including complaints, litigation, inquests and safeguarding. The most recent forum was held on 24 March with a focus on 'Point of Care Testing' following a PSII last year (see ***Appendix 5*** for a summary). Upcoming forums will focus on:

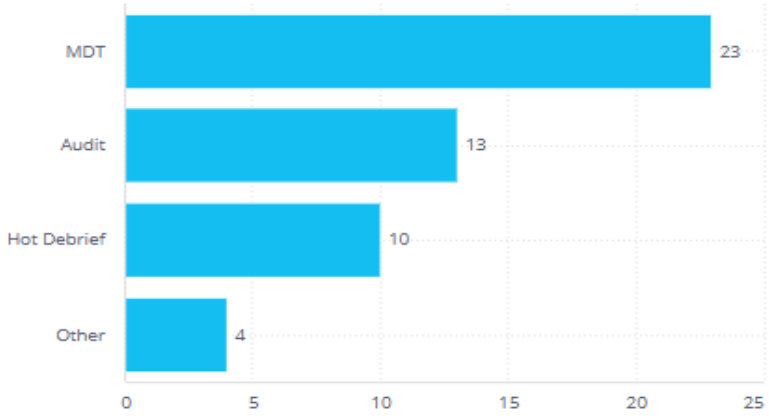
- Sepsis and Antimicrobials (April)
- Patient Identification & Checklists (May)
- Hot Debriefs (June)
- Diagnostic Delays (July)

The patient safety team continues to capture learning using the 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. An outcome summary is developed monthly and shared across all CSUs and learning platforms for Trust wide learning. See ***Appendix 6*** for the latest summary of outcomes.

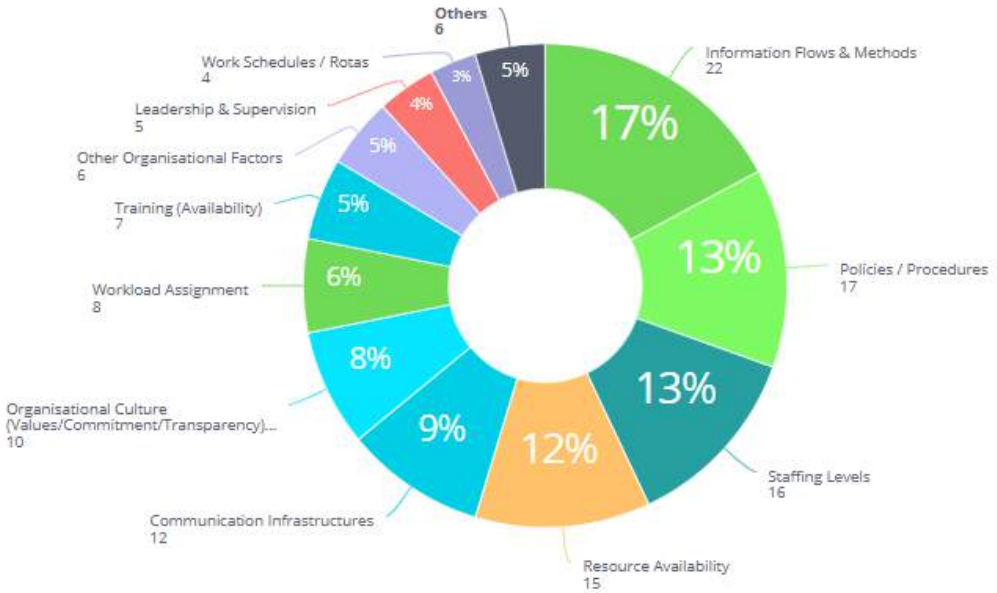
Level 2 Learning Events

Data

Between 01 February and 31 March 2025, 50 level 2 learning events have been completed and the dashboard screenshot below illustrates the type of learning responses held.



The chart below shows the key system factors contributing to our incidents and errors since the PSIRF launch in May 2024 with 'Information flows & methods' remaining the largest contributing factor; themes include the documentation of care handovers and escalation, IT system interactions both within MKUH and across the region and ambiguous processes for the transfer of patients and patient information between departments.



As can be seen from the contributory factors chart above, we need to improve the recording of 'contributory factors' following completion of learning events (these were only provided for about a third of those completed since May 2024). This lack of recording limits our understanding of what is causing our incidents and our ability to make systemic change. Upon further exploration, this disparity between number of learning events held and contributory factors listed can be accounted for by:

- Many MDT learning events are thematic in nature and explore multiple incidents during one event. This means that whilst several incidents were reviewed, the contributory factors are only added once onto Radar.
- Other level 2 learning event types don't currently have specific templates on Radar and therefore the systemic factors are not being captured. This is a piece of work is planned for this year, with specialist departments such as maternity and infection, prevent and control (IPC) to design specific learning outcome forms on Radar where needed. Conversations with the IPC team have already commenced.
- Not all level 2 learning response types currently include a SEIPS analysis, such as audits and M&M reviews.

A further 91 learning events are planned over the coming 2 months. 58 are currently overdue in accordance with the local KPI of within 60 days. 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.

Staff feedback

Learning event feedback forms have been developed with a variety of feedback methods including satisfaction scales and open questions. These are to collate initial feedback from staff following a learning event and then 3 months post learning event.

1. **Initial feedback form** (0-7 days post learning event)

   Visual inquiry images (***Appendix 7***) 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 initial feedback 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 and what they felt was good about the session:

“It's like helping everyone and supporting each other”

"Feels like things are getting better"

“The ladder symbolises growth, progress, and a step-by-step journey in learning. It somehow reflects how the event helped me advance my knowledge and skills in diabetes care, moving toward a higher level of understanding and competence.”

“Steps to take to make a difference to practice”

“Everyone was given the opportunity to speak without prejudice and we were encouraged to speak freely. It was a relaxed and informative session”

2. **3-month post learning event** feedback form

This has been developed to evaluate the impact of learning events. Questions have been designed to explore how people are feeling about the incident now, whether any positive change has occurred, both personally and in terms of safety culture within their area and whether any safety actions have been completed. Below are some examples of feedback gained so far from attendees 3 months post learning event:

"I am pleased that this was reported and that actions identified at the learning event and taken since appears to have reduced the incidences of torn theatre wraps."

"While it was a difficult incident and caused a lot of reflection, I am much more comfortable with my actions and reassured once I heard the experiences and opinions of my colleagues"

"It's a learning experience, am now always on the lookout on how to avoid such circumstances and it has helped me to guide my juniors."

"The learning event was useful in gaining insight into what happened and why. It allowed me to identify learning opportunities and to think about what should happen differently going forward"

How true are these statements?

More

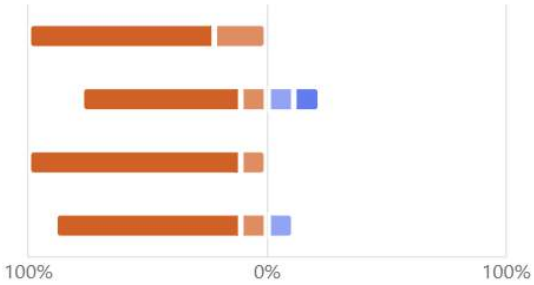
Yes, and I have seen a positive difference in patient safety as a result | Not yet, but I expect to in the near future | No | I'm not sure

I have applied concepts and/or strategies discussed during the learning event in my daily practice.

Have you observed any changes in your own behaviour or practice since the learning event?

Have you seen any positive outcomes or actions taken as a result of the learning from the event?

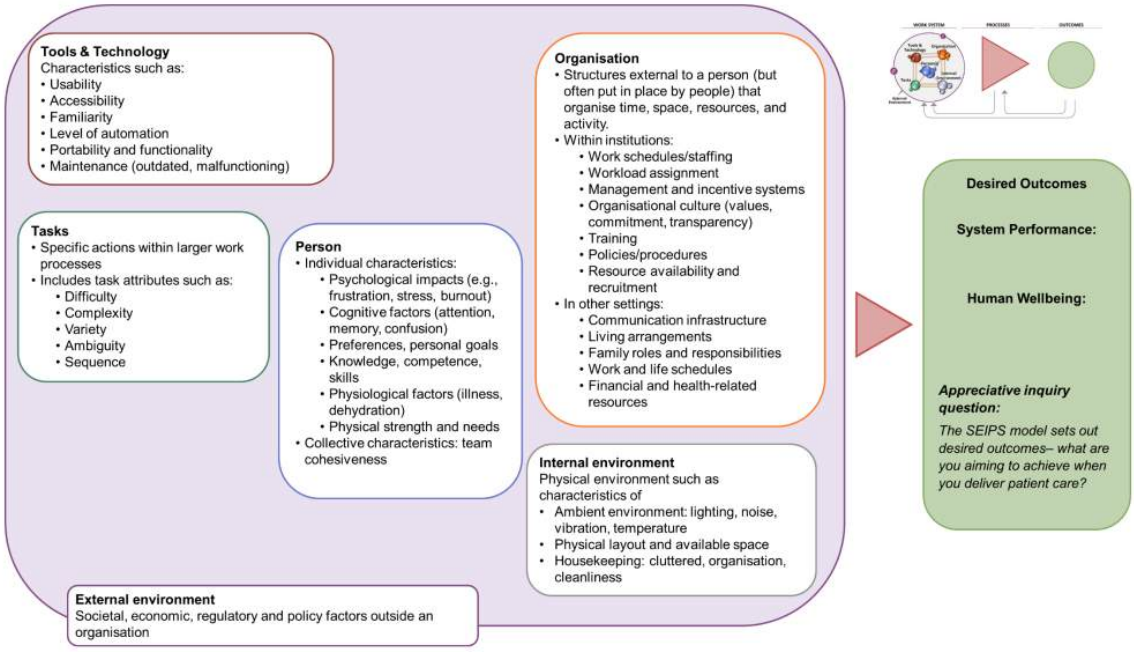
Do you believe the learning event has contributed to a culture of safety or improvement within the Trust?



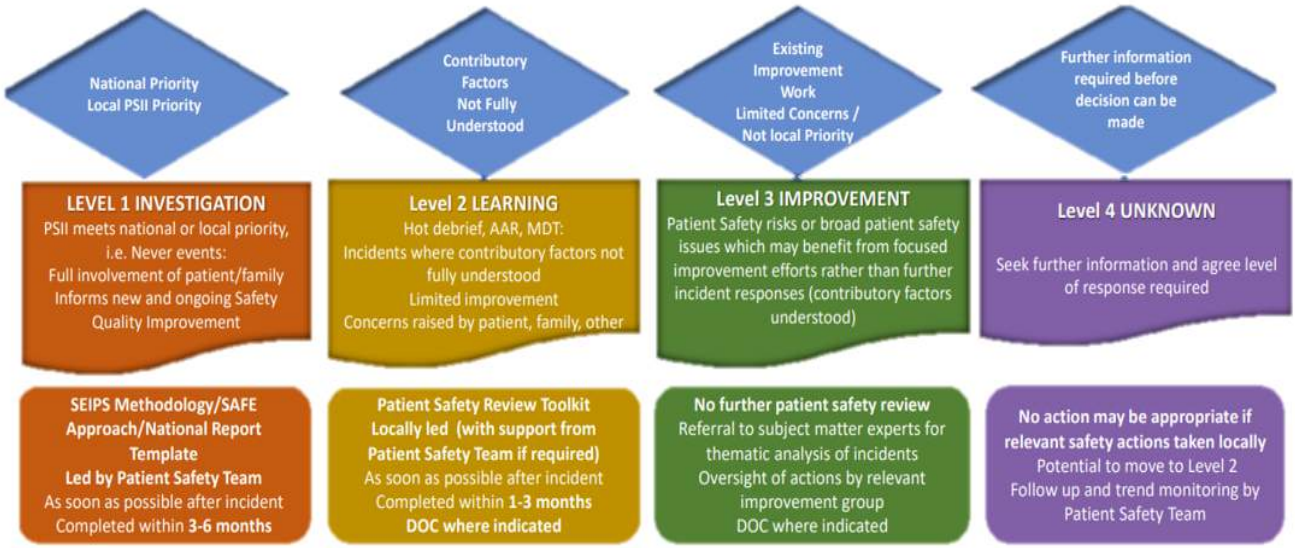
Appendices

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 – Patient Safety learning Forum March 2025 (Point of Care Testing)

LEARNING FORUM
POINT OF CARE DEVICES

ATTENDEES

- Four members of the Patient Safety Team
- Three members of the Point of Care Team
- Nurses from Ward 3, Ward 8 and Ward 24
- Three Practice Development Nurses
- One Practice Education Facilitator
- Two members of the Children's Community Team
- One ED Nurse
- One Student Nurse
- One Consultant Anaesthetist

WHY WE'RE HERE?

Patient Safety | Equipment Awareness | Better Care

A safe space to talk about real incidents and how we can improve our use of Point of Care (POC) devices. Small faults can have big impacts.

WHAT WENT WRONG?

- Unexpected high HbA1c results in well-managed diabetic patients.
- Discrepancies between lab and device readings.
- Device was outdated and not properly maintained.

Impact: Stress, unnecessary visits, misdiagnosis, and damaged trust.

WHAT WE FOUND?

- Unclear ownership of devices and maintenance.
- Training gaps and confusion over interpreting results.
- Invisible equipment lifespan tracking.

WHAT'S CHANGED?

- Faulty devices removed.
- New SOPs and governance.
- Training improvements and device replacements underway.

KEY LEARNING: EMPOWERING STAFF

Staff should feel confident to question readings and escalate concerns. It's not just about using a device-it's about understanding what the results mean.

"You don't know what you don't know-so let's make it easy to ask questions."

IDEAS FOR IMPROVEMENT

- Have clear governance: Make sure there's a named person or team responsible for each device.
- Link barcodes to training: Staff can only use machines if they're trained and scanned in.
- Do yearly refreshers or equipment days for departments.
- Use discretionary spend forms as a checkpoint to flag maintenance needs.
- Make it easier to find SOPs—especially during night shifts!
- Create a device inventory per ward to track what's in use and what needs servicing.
- Make maintenance status visible on the device—like a MOT sticker.

WHAT'S NEXT?

- Building a new linked pathology system (target: 2026) to help reduce transcription errors and improve visibility.
- Encouraging more wards to assign POC 'super users' to lead training and checks.

FINAL THOUGHTS - WHAT YOU CAN DO?

Ask: Who manages our devices?
Check: Is this machine up-to-date?
Speak up: Do the results make sense?

Be curious, not complacent: If a device feels off, question it.
Don't assume someone else is checking – ask your ward manager or point of care team.
Proper maintenance and training could prevent stress, misdiagnosis, and serious harm.
A machine might look fine but still give wrong results if it's past its life expectancy or hasn't been tested.

Staff Feedback

Appendix 6 – M&M outcomes summary March/April 2025

KEY LEARNING

ECG REVIEW:
ENSURE ECGS TAKEN IN THE ED ARE UPLOADED AND REVIEWED DURING POST-TAKE WARD ROUNDS TO AVOID MISSING CRITICAL INFORMATION.

ESCALATION OF ABNORMAL FINDINGS:
PROMPTLY ESCALATE ABNORMAL SKIN OR PRESSURE AREA FINDINGS (E.G., FUNGATING BREAST CANCER) TO AVOID DELAYS IN DIAGNOSIS AND TREATMENT.

NEUROLOGY AND SEIZURES:
ESCALATE CARE FOR PATIENTS WITH FREQUENT SEIZURES IN ED OR ACUTE SERVICES TO ENSURE PROPER FOLLOW-UP AND MANAGEMENT.

ENDOCARDITIS SUSPICION:
MAINTAIN A HIGH SUSPICION FOR ENDOCARDITIS, PARTICULARLY IN PATIENTS WITH RECENT PACEMAKER IMPLANTATION, IF THEY DON'T IMPROVE AFTER ANTIBIOTICS.

RETROSPECTIVE REVIEW:
REVIEW PAST CLINICAL DETAILS (E.G., INFLAMMATORY MARKERS) TO GAIN A COMPLETE UNDERSTANDING OF THE PATIENT'S CONDITION AND GUIDE MANAGEMENT.

POST-SURGICAL COMPLICATIONS:
DISCUSS PATIENTS PRESENTING WITH SURGICAL COMPLICATIONS FROM OTHER HOSPITALS WITH THE TERTIARY FACILITY BEFORE TRANSFER, ESPECIALLY IF IT LACKS AN ED DEPARTMENT (E.G., HAREFIELD HOPSITAL).

CLINICAL DECISION-MAKING:
CONSULT THE EMERGENCY PHYSICIAN IN CHARGE (EPIC) OR REGISTRAR FOR GUIDANCE ON PATIENT MANAGEMENT AND REFERRALS TO SPECIALTY TEAMS.

TERTIARY REFERRAL PATHWAYS:
FOLLOW LOCAL REFERRAL PATHWAYS FOR PATIENTS REQUIRING TERTIARY CARE, REGARDLESS OF WHERE THEY WERE INITIALLY TREATED.

VBG REVIEW:
CAREFULLY REVIEW VBG RESULTS BEFORE SIGNING OFF, INVESTIGATING MISSING VALUES AND SEEKING SENIOR ADVICE WHEN UNCERTAIN.

MDT AND ICU SUPPORT:
EFFECTIVE USE OF MULTIDISCIPLINARY TEAMS AND RAPID ICU SUPPORT ENSURES TIMELY AND COORDINATED CARE.

M&M OUTCOME FORM

Appendix 7 – 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

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Perinatal mortality and morbidity :
Advise: Following the cluster in December 2024 there has been no further events. The PMRT report for Q4 had no reportable cases.
Alert: 1 of the 5 cases in December has requested no MNSI investigation.
Assure: The review of the 5 cases and learning being monitored though CSU / Divisional and MAG as well as ICB/ LMNS forums.

Maternity Incentive Scheme:
Advise : Year 7 MIS guidance released – Gap analysis completed awaiting MIS year meeting 27/04/2025 for further guidance on aspects where possible risk has been identified. Safety action 7 and 9 areas for review and further scoping following information session.

SBLv3 : Q4 SBL actions planned reviewed and signed off by LMNS / ICB. Improvements in key areas such as CO monitoring and Fetal monitoring following implementation of risk assessments.

ANNB screening programme : 2 screening incidents reported to SQAS . One relating to T21 undiagnosed in the antenatal period and 1 incident relating to failure to sent 15 sets of screening bloods from the laboratory. 2 SIAF sent to SQAS for review and decision. SQAS not modelling incidents on PSRIF.

Maternity Dashboard :
Birthrate for 2024/2025 3801. Booking remain at higher level with bookings for 2024/ 2025 4810 highest level since 2019. OOA booking now at 722 upward trend from 2020 /2021. Additional OOA from 2023/2024 by 144. MOH remains an areas of monitoring and improvement and changes in active management.

Midwifery staffing:
Advise: Fill rate remains are now over 90% in acute areas (LW / WARD 9/ 10 / Triage AND ADAU).
Midwife to birth rate decreased to 1:28.
First draft Birth Rate plus report in Trust and under review – first report recommending 7.86 wte. Further draft and recommendations requested from BR+ team.

Risk Register
There are 15 maternity risks and 1 gynae registered within the division no change. RSK-451 relating to USS capacity and compliance with SLBv3 requirements changes in pathway to commence 28.04.2025 to increase capacity to meet demand. On going monitoring via SBL audits required for MIS and MDT with COO.

ATAIN : Term admission to NNU @4.6% for March 2025. Soft launch of TC on the 31.03.2025 to support families remaining together. Pressures with bed capacity having impact on further launch of stages.

Score Card and litigation : Informed of One new claim relating to December 2025 cluster. 1 litigation case closed. Further planned meetings with NHSR re maternity score card.

Complaints:
Advise: In March 4 formal complaints.
Alert : Top Three Themes: remain Communication, clinical care & compassion and empathy. .**Assure :** There has been a decrease in complaints relating to induction of labour and delays. Quality Improvement programmes in place for the other key areas. Monitoring of servier users expernce via Teanable and MNVP feedback

PREM 7, (Preterm Optimisation):
Advise: No births in the wrong place since October 2024. Improvement in commencing IV antibiotics and steroids. The QIP for the antenatal aspect remain in progress

Meeting Title	**Trust Board (Public)**	**Date: 1 May 2025**
Report Title	**Trust-wide Report – Annual Patient and Family Experience Report 2024/2025**	**Agenda Item Number: 10**
Lead Director	Kate Jarman, Chief Corporate Services Officer	
Report Author	Julie Goodman, Head of Patient and Family Experience	

Introduction	Assurance Report		
Key Messages to Note	*This report provides an overview of patient experience, engagement and feedback across the Trust and actions taken to improve patient and family experience.*		
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Review** [ ]

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	*1. Keeping you safe in our hospital* *2. Improving your experience of care* *3. Ensuring you get the most effective treatment* *4. Giving you access to timely care* *10. Innovating and investing in the future of your hospital*

Report History	Patient and Family Experience Board
Next Steps	Quality and Risk Committee and Trust Executive Committee
Appendices/Attachments	Report

1. Introduction and purpose

This report details the Trust's overall position regarding patient and family experience feedback, engagement activity and the achievements of the Patient and Family Experience team for 2024/25.

2. Achievements of the Patient and Family Experience team in 2024/25

Patient Experience Platform (PEP) Health

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

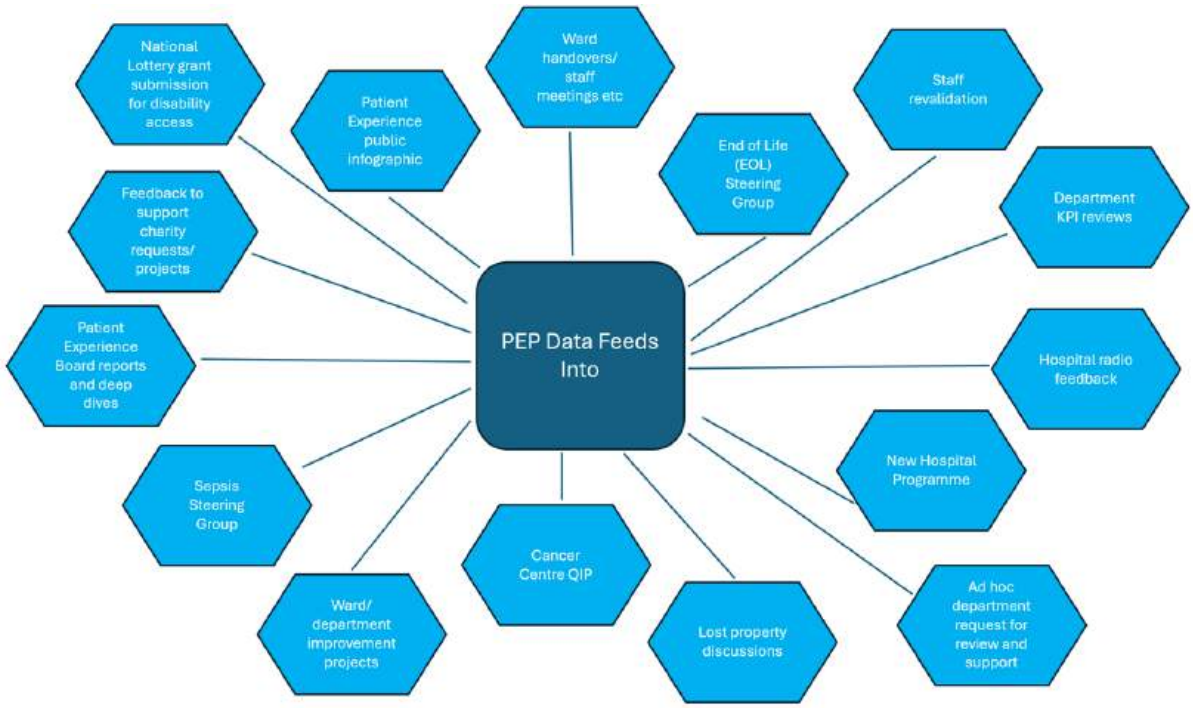
PEP Health collect all free text comments from patient feedback received through the FFT route, and online review sites such as the NHS website and Google reviews, and the hospital's social media accounts and more recently from compliments received by the Trust.

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

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

The team continue to promote the use of PEP to ensure staff are engaging with the platform. This includes supporting the staff on wards, and ensuring staff are triangulating the data on PEP along with other feedback mechanisms available for any reports they are writing or projects they are undertaking.

Some examples of where PEP data is feeding into can be seen below.



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

The team have been collecting feedback from staff to showcase the vast benefits of the dashboard and the various ways the data is used. Examples of this include:

'PEP is integral to our department being able to accurately monitor, report, and act upon feedback from patients and their families. This data is presented in our departmental and divisional meetings.

If we no longer had access to PEP or a similar digital platform that allowed the tracking of patient experience data, then we would be unable to report and act upon the themes that our patients and their families identify across FFT, social media, etc. This would have a negative impact upon the experience of our patients and their families.' **Administrator in Children's Services**

'Been regularly pulling data from it. We've found the patient feedback resource to be incredibly valuable for gathering qualitative insights. The ability to search for keywords has been particularly helpful, making this data indispensable for the following purposes:

- Building an Evidence Base: Patient feedback has supported changes to processes, business cases, floor plans, environmental adjustments, transformation projects, service reviews, and equipment purchases (e.g., Wayfinding).
- Post-Project Evaluations: Reviewing patient feedback has been vital for assessing outcomes. For example, it was used after completing the Maple Centre to gather insights for both SDEC and Ward 1.
- Theme and Trend Analysis: It's straightforward to search for recurring themes or keywords, even across several years of data and multiple services.

- Creating Patient Stories: Feedback has been instrumental in developing compelling patient stories and capturing their experiences.
- Comprehensive Insights: The inclusion of feedback from multiple platforms (e.g., FFT, Google) ensures a well-rounded perspective.

Currently, we're utilising PEP data as part of the New Hospital Programme, beginning with Maternity.' **Workforce Lead – New Hospital Programme**

'I have personally found the access you've provided for PEP to be completely transformative. I have incorporated a lot of patients' experiences into training sessions and also include positive feedback from patients being treated across the trust with sepsis/severe infection in the trust and ED's sepsis newsletters (attached). The feedback from patient experiences also helps identify some real key themes in limitations of staff knowledge and practices that has allowed me to reorganise sepsis training to alleviate knowledge gaps whilst maintaining more of a focus on sepsis and infection management in the context of the patient experience.' **Practice Development Nurse, Lead for Sepsis and Deteriorating Patients**

Please see below executive summary for 1st April 2025. The annual executive report from PEP for 2024/25 is currently being produced and is not available at the date of writing this report (23rd April 2025). The annual report for 2023/24 has therefore been included to allow a comparison.

Monthly report for 1st April 2025

Patient experience report:

Milton Keynes University Hospital NHS Foundation Trust

PEP Health
Patient Experience Platform

Report for: **1 April 2025**

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

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

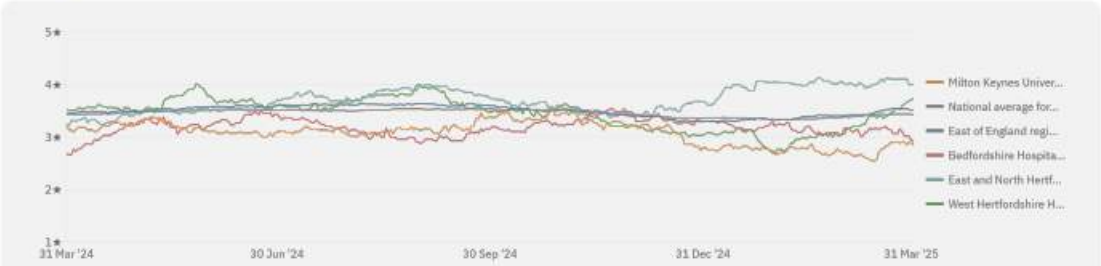
External data

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

Overall moving averages

Milton Keynes University Hospital NHS Fo...	National average for England	East of England region
2.9 ★ ↑0.1 over the last 90 days	**3.4** ★ ↑0.1 over the last 90 days	**3.5** ★ ↑0.2 over the last 90 days
Bedfordshire Hospitals NHS Foundation Tr...	East and North Hertfordshire NHS Trust	West Hertfordshire Hospitals NHS Trust
2.9 ★ ↓0.4 over the last 90 days	**4.0** ★ ↑0.3 over the last 90 days	**3.7** ★ ↑0.7 over the last 90 days

Averages over the last 12 months:

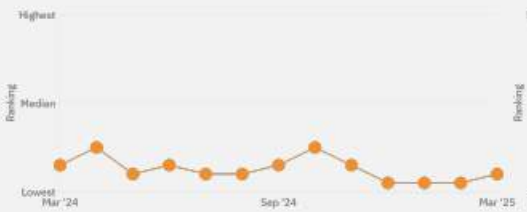


Rankings

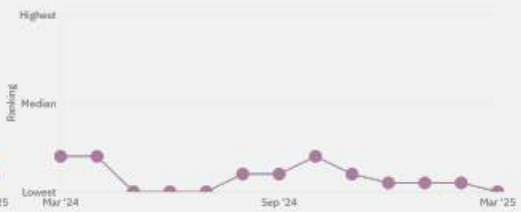
Current national ranking	Current regional ranking
In the top 90%	**In the top 100%**

Rankings over the last 12 months:

Nationally:



East of England region:



Internal data

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

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

Care domain averages for trust

- Fast access: **3.5** ★ ↑0.1 over the last 90 days
- Effective treatment: **4.2** ★ →NC over the last 90 days
- Continuity of care: **3.0** ★ ↑0.1 over the last 90 days
- Communication & involvement: **3.8** ★ →NC over the last 90 days
- Emotional support: **4.2** ★ →NC over the last 90 days
- Physical needs: **2.9** ★ ↓0.2 over the last 90 days

Overall moving averages by division

- Core Clinical & Support Services: **4.7** ★ ↓0.1 over the last 90 days
- Surgery: **4.6** ★ →NC over the last 90 days
- Women's & Children's Health: **4.5** ★ →NC over the last 90 days
- Medicine: **4.6** ★ →NC over the last 90 days

Overall moving averages by ward/team

Highest rated wards & teams:

Infectious Diseases	5.0 ★ ↑0.1
Stoma Clinic	5.0 ★ →NC
Pals	5.0 ★ →NC
Blakelands Hospital	5.0 ★ ↑0.1
Ophthalmology	5.0 ★ ↑0.5

Lowest rated wards & teams:

Pharmacy	3.8 ★ ↓0.4
Emergency Department - Adult	4.0 ★ ↑0.1
Ward 2B	4.1 ★ ↓0.3
Treatment Centre	4.2 ★ ↓0.3
Ward 19 (Medicine)	4.3 ★ ↓0.2

Largest positive change:

IBD	4.8 ★ ↑0.8
Bowel Screening	4.9 ★ ↑0.7
Ophthalmology	5.0 ★ ↑0.5
Dietician	4.8 ★ ↑0.4
Physiotherapy – Childrens	4.9 ★ ↑0.3

Largest negative change:

Pharmacy	3.8 ★ ↓0.4
Same Day Assessment Unit (SDAU)	4.5 ★ ↓0.3
Treatment Centre	4.2 ★ ↓0.3
General Medicine	4.5 ★ ↓0.3
Ward 12	4.7 ★ ↓0.3

Changes shown are over the last 90 days

Annual report for 1st April 2024 to 31st March 2025

External data

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

Overall moving averages

Milton Keynes University Hospital NHS Fo...
3.0 ★ ↓0.4 over the last year

National average for England
3.5 ★ ↓0.1 over the last year

East of England region
3.5 ★ ↓0.2 over the last year

Bedfordshire Hospitals NHS Foundation Tr...
2.8 ★ ↓0.6 over the last year

East and North Hertfordshire NHS Trust
3.1 ★ ↓0.6 over the last year

West Hertfordshire Hospitals NHS Trust
3.5 ★ ↓0.4 over the last year

Averages over the last 12 months:

Rankings

Current national ranking
In the top 90%

Current regional ranking
In the top 90%

Rankings over the last 12 months:

Nationally:

East of England region:

Internal data

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

Current **overall** moving average: **4.6** ★ ↓0.1 over the last year

Care domain averages for trust

Fast access
3.5 ★ →NC over the last year

Effective treatment
4.2 ★ ↓0.1 over the last year

Continuity of care
3.3 ★ ↑0.6 over the last year

Communication & involvement
3.8 ★ ↓0.1 over the last year

Emotional support
4.3 ★ →NC

Physical needs
3.2 ★ ↓0.1 over the last year

Overall moving averages by division

Core Clinical & Support Services
4.8 ★ →NC over the last year

Surgery
4.6 ★ →NC over the last year

Women's & Children's Health
4.6 ★ →NC over the last year

Medicine
4.5 ★ ↓0.1 over the last year

Overall moving averages by ward/team

Highest rated wards & teams:

IBD	**5.0** ★ ↑0.1
Physiotherapy	**5.0** ★ ↑0.1
VTE Clinic	**5.0** ★ ↑0.3
Pals	**5.0** ★
Angio	**5.0** ★ ↑0.1

Lowest rated wards & teams:

Ward 12	**3.2** ★ ↓1.2
Emergency Department - Adult	**3.9** ★ ↓0.2
Ward 19 (Medicine)	**4.1** ★ ↓0.7
Ward 2B	**4.2** ★ ↓0.1
Ward 9	**4.3** ★ ↓0.2

Largest positive change:

Ward 18	**4.4** ★ ↑0.6
Infectious Diseases	**4.9** ★ ↑0.5
Bridging Clinic	**5.0** ★ ↑0.5
Dietician	**4.8** ★ ↑0.4
Ward 2A	**4.6** ★ ↑0.3

Largest negative change:

Ward 12	**3.2** ★ ↓1.2
Ward 19 (Medicine)	**4.1** ★ ↓0.7
Urgent Care Centre	**4.3** ★ ↓0.7
Maple Unit	**4.3** ★ ↓0.5
Colonoscopy	**4.5** ★ ↓0.4

Changes shown are over the last year

The contract with PEP Health was renewed for two years in 2023 and a business case will be submitted later this year to extend the contract further.

Patient Experience Week – week commencing 29th April 2024

The team organised a host of events to celebrate this year's national Patient Experience Week.

Their theme this year was Patient Experience Team 'Goes on Tour'. The team felt it was important to leave the hospital and go to the patients/families in the community to listen to their experiences and share how they can feedback to the hospital and how they can get involved in the hospital with our community engagement work.

The team visited the MS Society Support Group, MK College and Shenley Wood Village. There were lots of conversations and lots of constructive feedback which gave a valuable insight into the experiences of our patients.

The week ended with the Band in the Van coming to the marquee to entertain our patients. This is the start of further work with the Charity to think outside the box on how we can make the experience of inpatients more meaningful. There have been meetings with MK College to look at involving students in some possible health and beauty treatments, courtyard maintenance and music/drama leading up to College in the Community Day in April 2025.

Engagement

The Patient Experience team and the Membership and Engagement Manager have worked collaboratively exploring opportunities to engage with the community. The Trust is taking positive steps to ensure engagement takes place with patients, families, and community support groups to ensure the voice of all groups in the community is heard when changes and improvements to services are being planned. The views of our patients and families should be considered from the onset to the completion of any improvement or service design work.

A few examples of the engagement work are detailed below:

- **Endoscopy Patient Focus Group**

The team supported the Endoscopy team with their annual patient satisfaction audit, which asks patients to share their experiences through their entire journey in the Endoscopy Department. An event was also held one evening with the Endoscopy team and members of the local Crohns and Colitis support group. This involved a walkthrough of the department, review of the survey, and ended with a focus group to give the group an opportunity to share their experiences to date and for staff to reflect on this.

- **Cancer Centre Quality Improvement Project (QIP)**

The purpose of this QIP is to enhance the patient experience within the Cancer Centre.

The group includes a patient representative to ensure the patient voice is heard.

At present the group is focussed on the initial part of the patient's journey into the Cancer Centre, including the arrangement of appointments and the waiting area in the centre. Initial comments from the PEP dashboard were gathered to review feedback from patients. A patient survey was undertaken, along with a survey for the medical staff to look at delays in clinics. The results will be analysed to inform the improvements needed.

- **MK Mosques**

The team attended a meeting with Trust staff and representatives from three of the city's mosques. There was an excellent exchange of views, ideas and suggestions for future engagement. Engagement between local mosques and the hospital supports:

- The health of the Muslim communities which includes information provision around the services provided by the hospital and the opportunities available for improving and maintaining health in areas such as screening, organ donation and research and development. Accessing these services for the Muslim population is lower than other populations, and the team would like to explore why this is and understand how access can be supported.
- The patient experience of Muslim patients and visitors at the hospital to ensure that the needs of individuals are met either as patients or at home waiting for appointments, receiving letters and updates, using the hospital website, prayer facilities, diet availability at the hospital, how general information is provided, and bereavement guidance.
- Establishing channels for Muslim voices in our communities to ensure the hospital is listening to the views of the Muslim communities in a way that is comfortable.
- Promoting contact and trust with the Muslim communities to ensure the communities are confident that their voices are being heard and are positively influencing services at MKUH.

- **Carers MK**

CarersMK

The team continue to support Carers MK to build links with staff who are working with or supporting an unpaid carer to ensure they are aware of the benefits of a referral to Carers MK, for support. Supportive work will be ongoing with the Patient and Family Experience team working alongside Carers MK to put in place a Carers Strategy and Carers Passport. The Head of Patient and Family Experience is supporting as the Trust's honorary Trust contract with the Adult Carers Support Worker/Hospital Support Worker.

- **Kings Community Centre Food Bank**

As part of the Thank you Roadshow in November 2024 the Patient Experience team spent an afternoon with Andy Forbes, Hospital Governor, at Kings Community Centre Food Bank. They learnt about all the wonderful services they offer and met some really interesting people. This has led to a contact who is now presenting a show for the Hospital Radio and discussions are in progress around a larger event in Wolverton in May 2025 which will showcase the work of a number of hospital teams.

Engagement Group Activity

The team have a group of patient representatives and are working to increase the numbers and diversity of members. It is so important that we listen to what our patients, families and carers think about the services we provide. All NHS organisations have a legal duty to involve and consult the public about the running of local health services. Patients should be listened to, and staff should make changes and improvements relevant to what they hear.

The team also has links with Healthwatch MK, learning disability and autism groups, and other community groups that are happy to provide their expert opinion. Examples of what they have been involved in this year include:

- Annual PLACE audit
- Reviewing a survey to assess the support required by patients waiting for the Pain Management Programme
- Reviewing a 'Different Ways of Dying' video put together by a Consultant in Palliative Care
- Supporting Cancer Centre QIP
- Reviewing various Paediatric PILS

Work with the Hospital Charity

Milton Keynes Hospital Charity

The team continues to work with the Charity on various projects and incentives to improve patient experience. This includes continued support on the purchase of items for the patient experience resource trolley.

Other support/collaborations during this year included:

- The team supported with the implementation of 'My Thank You' initiative.
- Looking at possible grants to financially support patient experience projects.
- Funding for an infant feeding corner in the main entrance following feedback via the PALS team.
- Christmas event planning.
- Provided content for the annual Charity impact report.
- College in Community Day.

SignLive Update

The team continue to work with patients and staff to support SignLive, which provides online British Sign Language (BSL) video interpreting services, available 24/7. This allows deaf and hard of hearing patients to communicate with anyone, at any time using a simple app.

The team attended the staff awards where the SignLive Project won the category for the Best Use of Charitable Funds.

The contract with SignLive, previously supported by the hospital Charity, was renewed with the support of the Trust. A business case will be submitted later this year to ensure this valuable service can continue.

'An absolutely a fantastic piece of equipment without which the patient would not have known the plan and doctors would have struggled to communicate with the patient so 5 stars from Ward 16.'

Patient Clothing Supply Project

As a result of feedback from the team's engagement with Age UK, and discussions at the Patient and Family Experience Board, the team are continuing to work on a project to ensure there is an adequate supply of clothing for patients who may not have suitable clothing to wear in hospital or upon their discharge.

This project is two-fold:

- Making sure patients are suitably dressed whilst in hospital. This is essential for initiatives such as #endpjparalysis and for participating in therapy and functional assessments. Being dressed as they would be in their own home is proven to shorten the length of stay and helps maintain the patient's dignity.

- Making sure patients are suitably dressed to go home. Age UK raised concerns about patients being taken home in just a hospital gown, red socks, and a blanket around their shoulders. This feedback has also been received through complaints received.

There are two linen trolleys and boxes on wards to ensure each area have their own supply.

The Charity has provided valuable contacts in the community and the team have held various clothing sales to ensure the project continues.

PLACE Audit

The team supported Hotel Services with the annual PLACE Audit on the 17th October 2024. The team recruited patient representatives and received some very positive feedback.

One patient representative advised, "Thank you for the opportunity to be involved in the PLACE audit today. I found it very interesting and the food tasting session was amazing.'

Disability Advisory Group (DAG)

A member of the team attends the DAG quarterly meeting. Members of this group feed back issues to stakeholders in Milton Keynes such as Milton Keynes Council, the Park's Trust, transport companies and many more. There is now representation from the hospital to allow members to feedback their experiences of using hospital services. This also allows the hospital to form relationships with members of the group who can then get involved in hospital projects. For example, a member of the DAG attended the hospital to undertake a journey through our MSCP to look at disabled parking. This was also attended by the Patient Experience Lead, Membership and Engagement Manager, and Security and Car Park Manager. It was positive to explore positive solutions which are being looked at further.

Ward Assurance Support

The team have supported the Lead Nurse for Quality and Ward Assurance with the ward rounds. This involves visiting various wards and completing the patient experience audit on Tendable. It gives an opportunity for discussion with patients and staff to provide assurance that patients are having a positive experience and staff feel supported and are aware of feedback mechanisms in the Trust and how to access their feedback and direct their patients accordingly.

New Hospital Programme

The team were contacted by the Communications and Engagement Lead for the programme to ask for support in obtaining the views of as many patients as possible to the following question:

'At MKUH we are developing our hospital site to ensure we can meet the future healthcare needs of the Milton Keynes community. Thinking about your most recent hospital experience, what is the one thing you think we should consider as part of these developments that would improve your hospital care? '

The majority of feedback for FFT comes through our SMS text option. It was therefore agreed to add the above question to the text messages sent. This is an optional question for patients. A large amount of feedback has been received, and this is shared with the Project team monthly.

Sexual Safety

In January 2024, Milton Keynes Hospital signed up to NHS England's 'Sexual Safety in Healthcare – Organisational Charter'. NHS England » Sexual safety in healthcare – organisational charter.

As signatories to this charter, the Trust have committed to a zero-tolerance approached to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce in particular, but also patients.

This project is split into a variety of workstreams. The Patient Experience Lead is leading the patient safety workstream. This workstream will look at information provided to patients, how incidents can be reported, how patients can be supported, and setting a sexual safety charter.

It is vital that the patient's voice is involved throughout this process, and this is being supported by a Patient Safety Partner.

Thank You Roadshow

As part of our commitment to ensure the patient voice is centre, the team held a 3-day 'Thank You Roadshow' in November 2024. This was to gather feedback around what is most important to patients and families when they attend hospital, and also to highlight some of the changes that the team and other staff have made as a result of patient feedback.

The team spoke to many patients in outpatients, inpatients, and the community. The data is being analysed and will help form the Patient Experience and Engagement strategy.

Compliment Project

All written compliments are acknowledged and shared with individual staff and their managers. During this year, as above, the PEP Health dashboard has been developed to capture the comments from compliments and these are themed in the same way as the Friends and Family Test comments.

Each month a 'compliment of the month' regarding an individual and a team is chosen by the Patient and Family Experience team. The individual receives either a personal card or a team certificate from the Chief Nurse thanking them for their contribution.

The theme of the 'compliment of the month' project is stars and consequently the card and certificate are star based. The card/certificate is presented to the winners by a member of staff from the Patient and Family Experience team who dresses as a gold star, pictures are then shared in the CEO newsletter. The members of staff and teams receiving 'compliment of the month' are detailed in the Patient and Family Experience quarterly reports.



The winners this year were:

Month	Winner 1	Winner 2
April 2024	Kevin Kibuuka, Learning Disabilities Nurse	Ward 3
May 2024	Emily Howard, HCA Ward 7	Dermatology
June 2024	Debbie Bitmead, Outpatient Receptionist and Scheduler	Ward 7
July 2024	Charlotte Charles, Ward 9	Bereavement Team
August 2024	Georgie Orr, Information Governance	Angiogram

September 2024	Samantha Alder, HCA Ward 1	EPAU
October 2024	Raana Bibi, Speciality Doctor in Gynaecology and Obstetrics	Aimee Monicon, Consultant Anaesthetist
November 2024	Lesley Willis, ED Receptionist	Paediatric ED
December 2024	Dr Sani Magaji, Locum Doctor in Orthopaedics	IBD
January 2025	Sorrell Dickson, Paediatric Play Assistant	Switchboard
February 2025	Jose Gomez-Lopez, ED Doctor	Recovery Team
March 2025	Neil Trew-Smith, Pharmacy	Haematology

3. Patient Experience data

Friends and Family Test (FFT)

The table below details a comparison of the number of FFT responses received across the Trust for each quarter 2023/24.

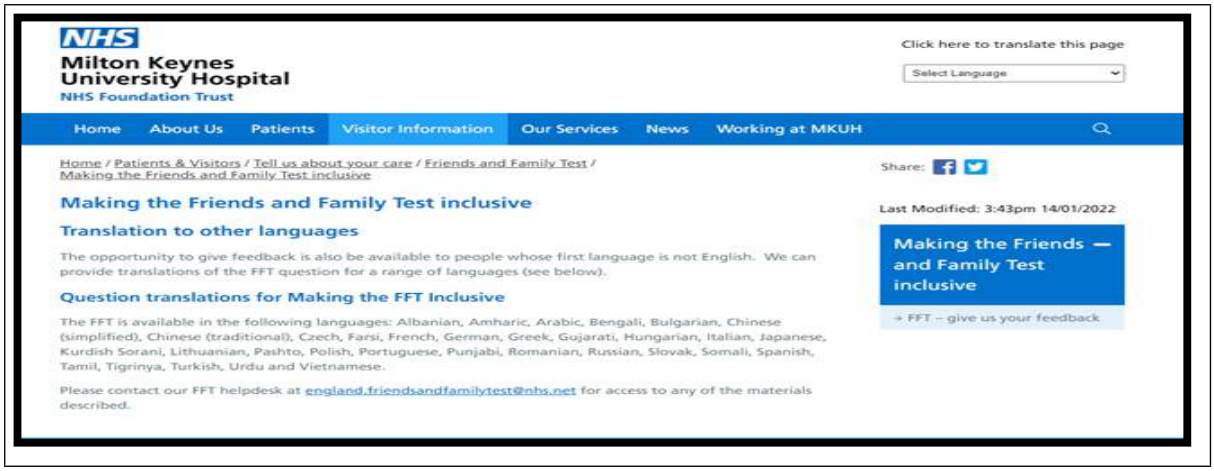
Q1 2023/24	**Q2 2023/24**	**Q3 2023/24**	**Q4 2023/24**	**TOTAL NUMBER RESPONSES FOR 2023/24**
14784	14926	16926	22387	**69023**
Q1 2024/25	**Q2 2024/25**	**Q3 2024/25**	**Q4 2024/25**	**TOTAL NUMBER RESPONSES FOR 2024/25**
22720	20093	19851	21872	**84536**

During 2024/25, 91.6% of patients on average rated the Trust's services as very good or good.

FFT- Ethnicity

From the 84536 respondees to the FFT,and where an ethnic origin was stated, 80% of respondees described themselves as being White British. This is compared to 77.7% for the previous year.

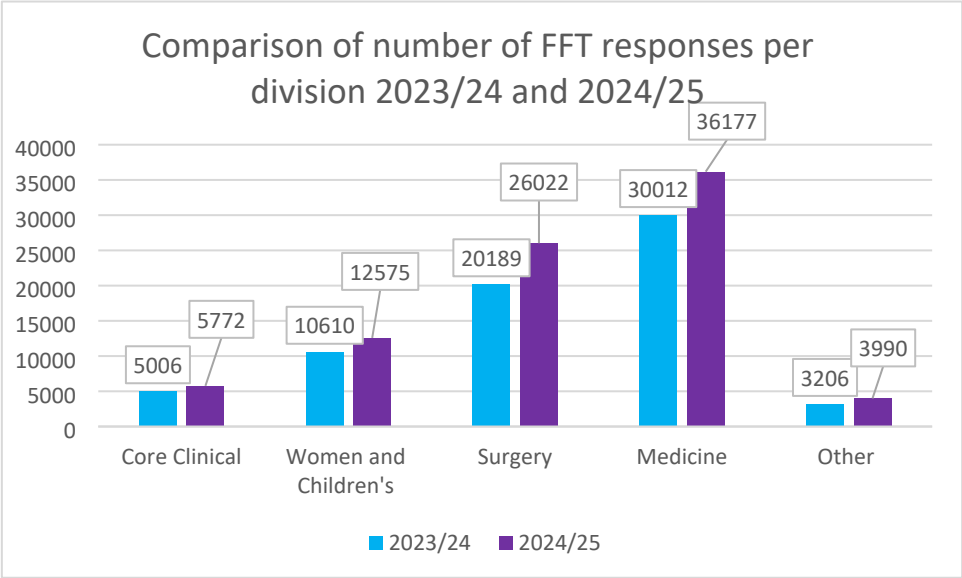
The 'Tell Us About Your Care' website pages have been improved with regard to providing information on how to get the FFT form in a different language, if required.



The Patient Experience team have also been engaging with various community groups to ensure all patients are able to provide feedback in a way that is suitable for them.

Divisonal FFT responses

The chart below details the number of FFT responses per divison for 2023/24 when compared to 2024/25.

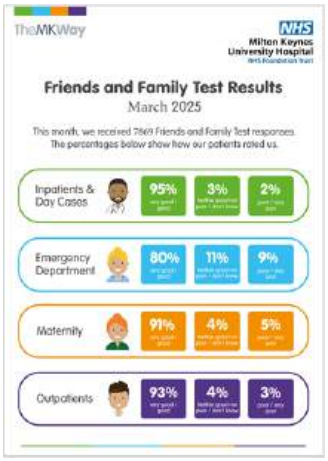


Communication of FFT results

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

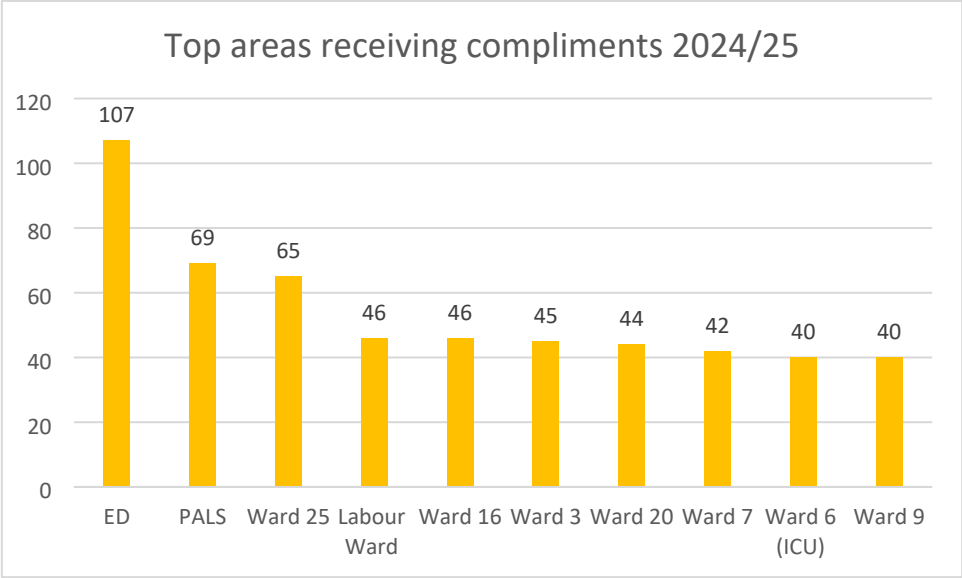
'*Very Good, Good, Neither Good nor Poor, Poor and Very Poor*'

Posters are displayed on all ward areas and some other departments, as below:



Compliments

During 2024/25, the Trust received 1298 compliments, compared to 1272 during 2023/24. The top areas receiving compliments are detailed in the graph below.



4. National Surveys

Maternity 2024

This survey was sent to women who gave birth in February/March 2024. The fieldwork took place between April and June 2024. The final CQC published results in November 2024. Maternity Services have an action plan in place in response to findings, this is monitored through the Patient and Family Experience Board.

Maternity 2025

This survey will be sent to women who gave birth in February/March 2025. Fieldwork is currently being undertaken and there is a robust communication plan in place to work to increase engagement.

Adult inpatient 2024

The survey will be sent to patients who have at least a one-night stay in November 2024. The fieldwork will take place between January and April 2025 with the CQC published results expected in August 2025. There is a communication plan in place to work to increase engagement.

Urgent and Emergency Care 2024

This survey was sent to those adults attending the Emergency Department in February 2024. The final CQC published results were made available in November 2024.

Children and Young People 2024

This survey was sent to the parents/guardians of children and young people during the spring of 2024. The fieldwork took place between July and October 2024 and the final CQC results were published in March 2025. Work is being undertaken to ensure a robust action plan is in place.

5.Governance and learning

Patient and Family Experience Board

The Patient and Family Experience Board meet bimonthly with key staff from across the organisation and patient representation. The Board focuses on improving patient experience by considering all feedback, learning, and governance in relation to patient experience.

The Patient and Family Experience Board has been established to provide oversight and scrutiny of the Trust's patient experience objectives.

The structure of the Board changed in February 2023 and a set agenda is now in place. The divisions and departments complete standard templates to report their current activity, planned activity, and risks in relation to patient experience and how patient feedback is being used to improve patient experience. All divisions present a deep dive report every quarter.

6.Conclusion

There is much to celebrate during this year with the improvements that have been made regarding the amount of valuable feedback gained from our patients and their families and the different pathways our patients can use to provide their feedback. The information on the PEP Health platform has helped enhance learning and outcome from feedback across the Trust. Staff are now able to see their area's feedback on an almost 'live' basis and take action/share learning accordingly in as near to real time as possible.

The projects as referenced in the body of this report have been highly successful and have heled to improve the experience of our patients and their families across the Trust.

Meeting Title	Trust Board (Public)	Date: 1 May 2025
Report Title	2024-25 Executive Summary M12	Agenda Item Number: 11
Lead Director	John Blakesley, Chief Strategic Development Officer	
Report Author	Information Team	

Introduction	Purpose of the report: Standing Agenda Item
Key Messages to Note	**Emergency Department:** - There were 8,944 ED attendances in March 2025, an increase of 880 attendances compared to February 2025. - The percentage of attendances admitted, transferred, or discharged within 4 hours was 74.5%, an improvement in performance compared to 73.5% in February 2025. - 90.3% of ambulance handovers took less than 30 minutes in March 2025 and 99.5% took less than 60 minutes. **Outpatient Transformation:** - There were 39,024 outpatient attendances in March 2025. - 12.0% of these appointments were attended virtually and 5.8% of patients did not attend. **Elective Recovery:** - There were 2,605 elective spells in March 2025. - At the end of March 2025, 31,450 patients were on an open RTT pathway: 44 patients were waiting more than 65 weeks. 7 patients were waiting over 78 weeks. - At the end of March 2025, 7,730 patients were waiting for a diagnostic test. Of these, 68.7% were waiting less than 6 weeks. **Inpatients:** - Overnight bed occupancy in adult G&A beds was 88.6% in March 2025. - A considerable proportion of beds were unavailable due to: o 122 patients not meeting the criteria to reside. o 122 super stranded patients (length of stay 21 days or more). **Human Resources:** - In March 2025: o Substantive staff turnover was 12.6%. o Agency expenditure remained well below the threshold of 5%, at 2.3%. o Appraisals achieved 92% and mandatory training 94%. **Patient Safety:** - In March 2025, the following infections were reported: o E-Coli: 5 o C.Diff: 2 o MSSA: 2 o Klebsiella Spp bacteraemia: 1 o P.aeruginosa bacteraemia: 1

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

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	*1. Keeping you safe in our hospital* *2. Improving your experience of care* *3. Ensuring you get the most effective treatment* *4. Giving you access to timely care* *5. Working with partners in MK to improve everyone's health and care* *6. Increasing access to clinical research and trials* *7. Spending money well on the care you receive* *8. Employ the best people to care for you* *9. Expanding and improving your environment* *10. Innovating and investing in the future of your hospital*

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

TheMKWay

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Trust Performance Summary: M12 (March 2025)

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)	78.2%	95%
RTT Incomplete Pathways <18 weeks	92%	92%
RTT Patients waiting over 65 weeks	0	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

March 2025 performance against transitional targets and recovery trajectories:

OBJECTIVE 4 - KEY TARGETS								
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%	78.2%	73.2%	74.5%	✗	▲	✗	
RTT Incomplete Pathways <18 weeks	92.0%	92.0%		47.8%	✗	▲		
Diagnostic Waits <6 weeks	95.0%	95.0%		68.7%	✗	▲		
62 day standard (Quarterly)	70.3%	70.3%		59.1%	✗	▲		

The percentage of ED attendances that were admitted, transferred, or discharged within four hours was 74.5%, an improvement in performance compared to 73.5% in February 2025. This was in-line with the national performance of 75% and in the top five of the MKUH peer group (see Appendix 1).

The volume of open RTT pathways was 31,450; a reduction of 403 compared to February 2025. Of this total, 44 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 Q3 2024/25, the 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) was 59.1% against a national target of 85%, an improvement from 52.8% in the previous quarter. The percentage of patients to begin cancer treatment within 31 days of a decision to treat increased from 95.2% to 96.2%, which was above the national target of 96%. The 28 Day Faster Diagnosis performance was 75.1%, up from 72.9% in the previous quarter.

3.0 Urgent and Emergency Care

None of these indicators showed any month-on-month improvement in March 2025.

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%	0.64%	1.12%	x	▼	✓	
Ward Discharges by Midday	25%	25%	17.6%	18.0%	x	▼	x	
Patients not meeting Criteria to Reside	50			122	x	▼		
Number of Super Stranded Patients (LOS>=21 Days)	50			122	x	▼		
Ambulance Handovers <60 mins (%)	100%	100%	97.4%	99.5%	x	▼	x	

Cancelled Operations on the Day

In March 2025, 15 operations were cancelled on the day for non-clinical reasons. The majority were due to equipment issues and insufficient time.

Patients not Meeting Criteria to Reside

The number of inpatients not meeting the criteria to reside at the end of March 2025 was 122 against a threshold of 50. This was an increase to the figure of 91 reported at the end of February 2025.

Length of Stay (Stranded and Super Stranded Patients)

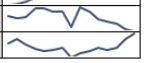
The number of super stranded patients (e.g. length of stay of 21 days or more) at the end of the month was 122, a deterioration compared to 106 in February 2025.

Ambulance Handovers

In March 2025, the percentage of ambulance handovers to the Emergency Department taking less than 30 minutes was 90.3%. This was an improvement in performance compared to 89.1% in the previous month. This was the sixth consecutive month of improved performance for this metric and the highest percentage reported this financial year.

The percentage of ambulance handovers to the Emergency Department taking less than 60 minutes was 99.5%, a slight deterioration on 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%	92.0%	88.6%	✓	▲	✓	
RTT Incomplete Pathways <18 weeks	92.0%	92.0%		47.8%	✗	▲		
RTT Total Open Pathways (inluding ASIs)	32,549	32,549		31,450	✓	▲		
Diagnostic Waits <6 weeks	95.0%	95.0%		68.7%	✗	▲		

Overnight Bed Occupancy

Overnight bed occupancy was 88.6% in March 2025, below the threshold of 95.4%.

RTT Incomplete Pathways

The Trust's RTT 18 week performance at the end of March 2025 was 47.8% and the number of patients waiting over 65 weeks was 44. Total RTT open pathways was 31,450.

Diagnostic Waits <6 weeks

At the end of March 2025, performance was 68.7%, an improvement from 64.3% last month and the highest performance this financial year.

5.0 Patient Safety

Infection Control

In March 2025 the following infections were reported:

Infection	Number of Infections
E-Coli	5
C.Diff	2
MSSA	2
Klebsiella Spp bacteraemia	1
P. aeruginosa bacteraemia	1
MRSA bacteraemia	0

ENDS

Appendix 1: ED Performance - Peer Group Comparison

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

Jan 2025 to March 2025 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	Jan-25	Feb-25	Mar-25
Homerton Healthcare NHS Foundation Trust	78.3%	79.3%	82.8%
Barnsley Hospital NHS Foundation Trust	60.2%	54.7%	80.2%
Buckinghamshire Healthcare NHS Trust	76.6%	78.2%	78.9%
The Hillingdon Hospitals NHS Foundation Trust	70.6%	71.6%	75.8%
Milton Keynes University Hospital NHS Foundation Trust	72.4%	73.5%	74.5%
Mersey and West Lancashire Teaching Hospital (Formerly Southport and Ormskirk)	73.1%	74.3%	74.3%
The Princess Alexandra Hospital NHS Trust	56.8%	62.0%	69.4%
Oxford University Hospitals NHS Foundation Trust	72.7%	70.8%	68.4%
Northampton General Hospital NHS Trust	67.8%	66.4%	65.8%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	60.6%	58.8%	60.1%
Mid Cheshire Hospitals NHS Foundation Trust	56.7%	59.1%	59.8%
North Middlesex University Hospital NHS Trust	NA	NA	NA

Board Performance Report 2024/25
March 2025 (M12)

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) ★		0.0	0.0		Not Available				
Mortality - (SHMI)		100.0	100.0		100.4	✗	▲		
Never Events		0	0	2	0	✓	▭	✗	
Clostridium Difficile		47	47	28	2	✓	▼	✓	
MRSA bacteraemia (avoidable)		0	0	4	0	✓	▲	✗	
Falls with harm (per 1,000 bed days)		0.12	0.12	0.15	0.20	✗	▼	✗	
Incident Rate (per 1,000 bed days)		60	60	56.46	54.59	✗	▼	✗	
Duty of Candour Breaches (Quarterly)		0	0	3	0	✓	▲	✗	
E-Coli		57	57	22	5	✗	▼	✓	
MSSA		17	17	10	2	✗	▼	✓	
VTE Assessment		95%	95%	97.4%	97.5%	✓	▲	✓	
Klebsiella Spp bacteraemia		17	17	18	1	✓	▲	✗	
P.aeruginosa bacteraemia		10	10	4	1	✗	▼	✓	

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	✓	▭	✓	
Cancelled Ops - On Day		1%	1%	0.64%	1.12%	✗	▼	✓	
Over 75s Ward Moves at Night		1,500	1,500	1,628	98	✓	▲	✗	

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%	92.0%	88.6%	✓	▲	✓	
Ward Discharges by Midday		25%	25%	17.6%	18.0%	✗	▼	✗	
Weekend Discharges		63%	63%	62.4%	70.3%	✓	▼	✗	
Patients not meeting Criteria to Reside		50			122	✗	▼		
Number of Stranded Patients (LOS>=7 Days)		184			266	✗	▼		
Number of Super Stranded Patients (LOS>=21 Days)		50			122	✗	▼		
Discharges from PDU (%)		12.5%	12.5%	11.8%	19.0%	✓	▼	✗	
Ambulance Handovers <30 mins (%)		95%	95%	81.1%	90.3%	✗	▲	✗	
Ambulance Handovers <60 mins (%)		100%	100%	97.4%	99.5%	✗	▼	✗	

OBJECTIVE 4 - KEY TARGETS									
Indicator	DQ Assurance	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
ED 4 hour target (includes UCS)		78.2%	78.2%	73.2%	74.5%	✗	▲	✗	
Total time in ED no more than 12 hours		95%	95%	93.9%	93.0%	✗	▼	✗	
Triage within 15 Minutes		90%	90%	67.6%	67.6%	✗	▼	✗	
RTT Incomplete Pathways <18 weeks		92.0%	92.0%		47.8%	✗	▲		
RTT Total Open Pathways (inluding ASIs)		32,549	32,549		31,450	✓	▲		
RTT Patients waiting over 65 weeks (Total)		0	0		44	✗	▲		
Diagnostic Waits <6 weeks		95.0%	95.0%		68.7%	✗	▲		
31 days Diagnosis to Treatment (Quarterly)		96.0%	96.0%		96.2%	✓	▲		
62 day standard (Quarterly)		70.3%	70.3%		59.1%	✗	▲		
28 Day Faster Diagnosis (Quarterly)		78.0%	78.0%		75.1%	✗	▲		

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		217,086	15,906	Not Available	▼	Not Available	
Total ASIs		0	0		848	✗	▼		
Total RTT Non-Admitted Open Pathways					26,923		▲		
Total RTT Admitted Open Pathways					4,527		▲		
A&E Attendances		101,918	101,918	105,028	8,944	✗	▼	✓	
Elective Spells		26,032	26,032	30,693	2,605	✗	▲	✓	
Non-Elective Spells		28,831	28,831	31,267	2,700	✗	▼	✗	
OP Attendances / Procs (Total)		443,414	443,414	491,528	39,024	✓	▲	✓	
Outpatient DNA Rate		5%	5%	6.7%	5.8%	✗	▲	✗	
Virtual Outpatient Activity		25%	25%	13.8%	12.0%	✗	▼	✗	

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	393,248	438,233	57,526	✓	▲	✓	
Pay £'000		(246,892)	(246,892)	(279,187)	(38,009)	✗	▼	✗	
Non-pay £'000		(115,359)	(115,359)	(135,762)	(13,735)	✗	▼	✗	
Non-operating costs £'000		(30,997)	(30,997)	(23,145)	(1,381)	✓	▲	✓	
I&E Total £'000		0	0	140	4,401	✓	▲	✗	
Cash Balance £'000			14,717		28,650	✓	▲		
Savings Delivered £'000		23,822	23,822	23,822	3,510	✓	▲	✓	
Capital Expenditure £'000		(28,670)	(28,670)	(52,344)	(14,449)	✗	▼	✗	
Elective Spells (% of 2019/20 performance)		130%	130%	123.2%	153.0%	✓	▲	✗	
OP Attendances (% of 2019/20 performance)		130%	130%	120.9%	141.1%	✓	▲	✗	

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%		5.0%	✓	▲		
Agency Expenditure %		5.0%	5.0%	3.3%	2.3%	✓	▲	✓	
Staff Sickness % - Days Lost (Rolling 12 months)		5.0%	5.0%		5.0%	✓	▼		
Appraisals (excluding doctors)		90%	90%		92.0%	✓	▭		
Statutory Mandatory training		90%	90%		94.0%	✓	▼		
Substantive Staff Turnover		12.5%	12.5%		12.6%	✗	▭		

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		14	✗	▼		
Rebooked cancelled OPs - 28 day rule		90%	90%	86.4%	96.0%	✓	▲	✗	
Patient Safety Incidents (Reported)		9876	9876	9960	824	✓	▼	✓	
Patient Safety Incidents which resulted in moderate harm or above		1716	1716	1969	181	✗	▲	✗	

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.

Confidential
- For Internal Circulation Only

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Public Board**	**Date: 1 May 2025**
Report Title	**Finance Paper Month 12 2024-25**	**Agenda Item Number: 12**
Lead Director	**Jonathan Dunk**	**Chief Finance Officer**
Report Authors	**Sue Fox** **Cheryl Williams**	**Head of Financial Management** **Head of Financial Control and Capital**

Introduction	This report provides an update on the financial position of the Trust at Month 12 (Mar 2025).		
Key Messages to Note	➢ The Trust is reporting a surplus position of £136k (on a Control Total basis) to the end of March, which is on plan. ➢ Elective Recovery Fund (ERF) performance is 141% above pre-Covid levels, which is above the 106% national target and our internal budget target of 124%. As a result, ERF income is £25.5m above the 2024/25 national target giving rise to a favourable variance to internal plan of £12.5m, accompanied by a prior year benefit of £2m. ➢ The Trust financial plan includes a savings target of 6% (£23.8m). This has been achieved in full. The key issues are as follows: • Throughout the year, the deficit position was driven by £1.2m of pay award pressure (costs outstripping income uplifts) and unfunded support for RTT premium costs • The final reported position has benefited from non-recurrent elements (most notably prior year's ERF income settlement) • Unfunded escalation capacity costs were incurred because of discharge challenges and winter pressures • Further risks remain (now into future accounting periods) regarding any impact of counting and coding changes for SDEC on ERF.		
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	Supplementary Shelf

FINANCE REPORT FOR THE MONTH TO 31st MARCH 2025

PUBLIC BOARD

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	30,700	40,614	9,914	367,434	396,195	28,761	367,434	396,195	28,761	
2	Other Revenue	2,120	18,201	16,081	31,856	48,340	16,484	31,856	48,340	16,484	
3	Pay	(21,064)	(38,009)	(16,945)	(251,560)	(279,188)	(27,628)	(251,560)	(279,188)	(27,628)	
4	Non Pay	(10,131)	(13,735)	(3,604)	(117,213)	(135,762)	(18,548)	(117,213)	(135,762)	(18,548)	
5	Financing & Non-Ops	(2,106)	(13,210)	(11,104)	(24,931)	(35,555)	(10,624)	(24,931)	(35,555)	(10,624)	
6	Surplus/(Deficit)	(481)	(6,140)	(5,658)	5,586	(5,970)	(11,556)	5,586	(5,970)	(11,556)	
7	Control Total Surplus/(Deficit)	(419)	4,400	4,820	0	137	137	0	137	137	
	Memos										
8	IA Cost	-	-	-	-	(153)	(153)	-	(153)	(153)	
9	High Cost Drugs	(2,118)	(2,400)	(282)	(25,096)	(29,281)	(4,185)	(25,096)	(29,281)	(4,185)	
10	Financial Efficiency	1,985	3,510	1,525	23,822	23,822	-	23,822	23,822	-	
11	Cash	14,717	28,650	13,933	14,717	28,650	13,933	14,717	28,650	13,933	
12	Capital Plan - CDEL (excluding donated)	(7,371)	(8,140)	(769)	(35,287)	(46,035)	(10,748)	(35,287)	(46,035)	(10,748)	

Key messages

The Trust is reporting a breakeven position (on a Control Total basis) to the end of March 2025.

The Trust achieved its efficiency target in full (£23.8m).

ERF performance is above the 106% target, with estimated income showing £25.5m above the national target as at M12, which is £12.5m above plan.

The capital expenditure programme is £10.8m above plan due to the approval of an additional £8.7 million in national scheme funding and a further £5.7 million in ICS CDEL, offset by £3.6m agreed ICS underspend.

(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), high-cost drugs (HCD) over performance and unbudgeted income from CDC and SDF (offset by delivery costs). Other revenue is above plan due principally to donated income received.

(3. & 4.) Operating expenses – Pay costs are higher than plan due to the wage award funding gap (£1.2m), cost of temporary staff in escalation wards and additional hours carried out to reduce elective backlogs. Bank and Agency expenditure increased in March. The cost of clinicians pensions was also included in the M12 position (£15.6m) but this was offset by additional income. Non-pay is overspent with an overspend on drugs (partly offset by income for high-cost drugs), outsourcing, clinical supplies and services and utilities.

(7.) Control Total Deficit - The Trust is reporting a breakeven position to the end of March. As is required this excludes donated income, impairments and associated depreciation, hence the difference to overall surplus/deficit figures.

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

(10.) Financial Efficiency – £23.8m delivered in full.

(11.) Cash – Cash balance is £28.7m, equivalent to 25 days cash to cover operating expenses.

(12.) Capital – Capital expenditure is above the year-to-date plan due to the approval of an additional £8.7m in national scheme funding and a further £5.7m in ICS CDEL, offset by £3.6m agreed ICS underspend.

CASH

1. Summary of Cash Flow

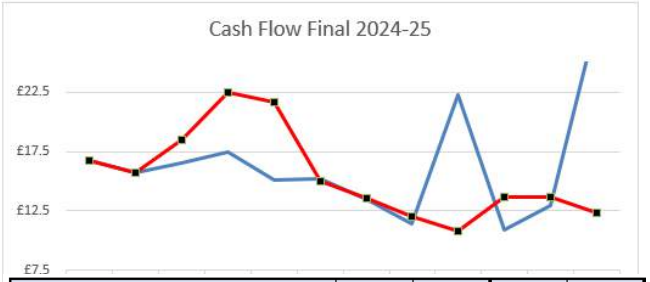
The cash balance at the end of March was £28.7m, £16.3m ahead of the planned figure of £12.4m. It is an £15.7m increase on last month's figure of £13.0m (see opposite).

2. Cash arrangements 2025/26

The Trust will continue to receive block funding for FY26 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.

3. 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 timing on approvals. This metric will continue to be monitored in accordance with national guidance and best practice.



Better payment practice code	Actual M12 YTD Number	Actual M12 YTD £'000	Actual M11 YTD Number	Actual M11 YTD £'000
Non NHS				
Total bills paid in the year	63,976	235,478	57,305	207,678
Total bills paid within target	44,111	198,254	39,270	173,645
Percentage of bills paid within target	**68.9%**	**84.2%**	**68.5%**	**83.6%**
NHS				
Total bills paid in the year	2,204	11,680	2,031	10,858
Total bills paid within target	1,945	8,409	1,805	7,746
Percentage of bills paid within target	**88.2%**	**72.0%**	**88.9%**	**71.3%**
Total				
Total bills paid in the year	**66,180**	**247,157**	**59,336**	**218,536**
Total bills paid within target	**46,056**	**206,663**	**41,075**	**181,391**
Percentage of bills paid within target	**69.6%**	**83.6%**	**69.2%**	**83.0%**

Key message

Cash at the end of March was £16.3m ahead of plan. There was a month-on-month increase of £15.7m from February, due to an in-month working capital surplus (mainly due to a £3.6m ICB system bonus, plus £8.7m ERF received early).

BPPC performance has improved in March but is still below the national 95% target.

BALANCE SHEET

4. Statement of Financial Position

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

- Non-Current Assets have decreased from March 24 by £9.2m; this is driven by a £6.9m decrease in tangible assets, a £2.2m decrease in intangible assets (both mainly due to a £37.3m downwards year-end asset revaluation, offset by additions in the year) and a £0.5m decrease in the Right of Use assets.
- Current assets have increased by £3.7m; this includes increases in other receivables of £5.1m (mostly due to a £5.1m increase in prepayments) and cash of £1.5m, offset by a decrease in NHS receivables of £3.1m.
- Current liabilities have increased by £1.6m; this is due to a £9.6m increase in trade payables, offset by decreases of £5.8m for provisions and £2.3m for deferred income.
- Non-Current Liabilities have increased from March 24 by £1.0m; due to a £1.6m increase in the Right of Use assets, related to IFRS 16; offset by a £0.5m decrease in deferred income.

5. Aged debt

- The debtors position as of March 25 is £5.3m, which is a decrease of £0.8m from the prior month. Of this total £0.8m is over 121 days old.

6. Creditors

- The creditors position as of March 25 is £13.6m, which is an increase of £5.5m from the prior month. £0.7m is over 30 days of ageing with £0.3m approved for payment.

Key message

Main movements in year on the statement of financial position are the £9.2m decrease in non-current assets (driven by a £37.3m downwards asset revaluation) and increase in supplier payables £9.6m; offset by increases in other receivables of £5.1m and reductions in provisions of £5.8m and deferred income £2.3m.

RECOMMENDATIONS TO BOARD OF DIRECTORS

7. The Board is asked to note the financial position of the Trust as of 31st March 2025 and the proposed actions and risks therein.

Meeting Title	**Trust Board (Public)**	**Date: 1 May 2025**
Report Title	People and Culture Committee Report	**Agenda Item Number: 13**
Lead Director	*Catherine Wills, Chief People Officer*	
Report Author	*Louise Clayton, Deputy Chief People Officer*	

Introduction	*Standing Agenda Item* *This report provides a summary of workforce Key Performance Indicators for the previous 12 months up to 31 March (M12) 2024/25 and relevant People and Culture updates*		
Key Messages to Note	*Points to note in the report for the members of the Board:* • *Temporary Staffing spend and usage has reduced over the last 12 months from 12.2% of the pay bill to 11%. This remains an area of focus as we continue to seek to reduce temporary solutions and work towards a more sustainable and stable workforce, balanced against operational need.* • *Absence is at 5% for the 12 month period and in-month for M12 is 4.7% which is a significant improvement since M10.* • *Appointments to key roles have been carried out in Q4 and the new Freedom to Speak Up Guardian as well as the Inclusion Lead, will be starting in post in Q1 and Q2.*		
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)*	*8. Employ and retain the best people to care for you*

Report History	*This is the first version of this report*
Next Steps	*This report will be presented at Trust Executive Committee*
Appendices/Attachments	*None*

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators as at 31 March 2025 (Month 12), covering the preceding 13 months.

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

Indicator	Measure	Target	03/2024	04/2024	05/2024	06/2024	07/2024	08/2024	09/2024	10/2024	11/2024	12/2024	01/2025	02/2025	03/2025
Staff in post *(as at report date)*	Actual WTE		3869.1	3861.1	3880.6	3879.2	3913.0	3873.3	3875.2	3885.2	3909.6	3924.3	3935.0	3950.0	**4002.4**
	Headcount		4402	4392	4415	4412	4449	4408	4406	4414	4439	4454	4466	4478	**4528**
Establishment *(as per ESR)*	WTE		4018.1	4109.9	4144.0	4156.7	4162.7	4159.1	4170.8	4187.0	4196.1	4199.2	4207.9	4209.4	**4212.5**
	%, Vacancy Rate - Trust Total	**10.0%**	3.7%	6.1%	6.4%	6.7%	6.0%	6.9%	7.1%	7.2%	6.8%	6.5%	6.5%	6.2%	**5.0%**
	%, Vacancy Rate - Add Prof Scientific and Technical		16.1%	19.9%	21.4%	22.2%	23.0%	23.8%	23.8%	23.9%	23.5%	25.6%	23.0%	20.8%	**17.1%**
	%, Vacancy Rate - Additional Clinical Services *(Includes **HCAs**)*		15.3%	16.3%	15.5%	14.7%	14.4%	16.7%	19.1%	18.8%	18.4%	16.6%	16.6%	16.1%	**13.0%**
	%, Vacancy Rate - Administrative and Clerical		1.4%	2.9%	2.9%	3.1%	2.8%	4.5%	3.9%	3.3%	3.6%	4.2%	4.5%	4.7%	**3.7%**
	%, Vacancy Rate - Allied Health Professionals		12.1%	11.6%	17.0%	18.6%	18.0%	16.0%	14.9%	16.5%	15.0%	14.0%	13.6%	13.2%	**10.8%**
	%, Vacancy Rate - Estates and Ancillary		4.3%	9.2%	8.7%	8.2%	7.7%	6.6%	7.0%	7.9%	8.2%	8.5%	7.5%	7.5%	**6.8%**
	%, Vacancy Rate - Healthcare Scientists		-0.9%	4.1%	5.2%	5.0%	2.6%	1.9%	1.6%	0.0%	1.1%	0.0%	0.0%	0.0%	**0.0%**
	%, Vacancy Rate - Medical and Dental		-1.3%	1.4%	2.1%	3.0%	-0.5%	1.2%	1.6%	0.9%	0.3%	0.2%	0.4%	0.0%	**0.1%**
	%, Vacancy Rate - Nursing and Midwifery Registered		-2.2%	0.9%	0.8%	1.5%	1.5%	2.0%	1.7%	2.4%	1.6%	1.5%	1.6%	1.5%	**0.9%**
Staff Costs (12 months) *(as per finance data)*	%, Temp Staff Cost (%, £)		12.2%	11.9%	11.7%	11.7%	11.7%	11.8%	11.8%	11.6%	11.5%	11.4%	11.3%	11.1%	**11.0%**
	%, Temp Staff Usage (%, WTE)		12.2%	12.2%	12.0%	11.9%	11.9%	11.8%	11.8%	11.7%	11.6%	11.5%	11.4%	11.4%	**11.2%**
Absence (12 months)	%, 12 month Absence Rate	**5.0%**	4.7%	4.8%	4.8%	4.8%	4.8%	4.9%	4.9%	4.9%	4.9%	4.9%	4.9%	**5.0%**	*5.0%*
	- %, 12 month Absence Rate - Long Term		*2.6%*	*2.6%*	*2.6%*	*2.6%*	*2.6%*	*2.6%*	*2.7%*	*2.6%*	*2.6%*	*2.6%*	*2.6%*	**2.6%**	*2.7%*
	- %, 12 month Absence Rate - Short Term		*2.1%*	*2.2%*	*2.2%*	*2.2%*	*2.3%*	*2.3%*	*2.2%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	**2.3%**	*2.3%*
	%,In month Absence Rate - Total		4.5%	4.8%	4.4%	4.3%	4.9%	4.9%	4.8%	5.1%	5.2%	5.6%	5.6%	**5.3%**	*4.7%*
	- %, In month Absence Rate - Long Term		*2.7%*	*2.4%*	*2.4%*	*2.4%*	*2.7%*	*2.8%*	*2.7%*	*2.5%*	*2.9%*	*2.8%*	*3.0%*	**2.9%**	*2.8%*
	- %, In month Absence Rate - Short Term		*1.8%*	*2.4%*	*2.0%*	*2.0%*	*2.2%*	*2.1%*	*2.1%*	*2.6%*	*2.3%*	*2.8%*	*2.6%*	**2.4%**	*1.9%*
Starters, Leavers and T/O rate (12 months)	WTE, Starters (In-month)		40.4	31.8	43.8	43.0	36.1	25.4	26.5	31.8	46.3	36.3	37.0	27.4	**70.6**
	Headcount, Starters (In-month)		47	36	51	49	45	28	29	37	50	40	45	32	**77**
	WTE, Leavers (In-month)		31.1	43.2	34.5	39.3	36.0	55.1	39.5	29.9	27.5	24.0	34.7	21.8	**30.1**
	Headcount, Leavers (In-month)		39	52	39	49	41	64	51	35	32	32	43	29	**40**
	%, Leaver Turnover Rate (12 months)	**12.5%**	12.6%	13.2%	13.1%	13.1%	12.5%	13.3%	13.1%	13.3%	13.1%	12.9%	12.7%	12.6%	**12.6%**
Statutory/Mandatory Training	%, Compliance	**90.0%**	94%	95%	96%	95%	94%	95%	95%	95%	95%	95%	95%	95%	**94%**
	Moving and Handling - Level 1 - 3 Years		[illegible]	94.0%	94.0%	94.0%	93.0%	93.0%	93.0%	93.0%	93.0%	92.0%	92.0%	92.0%	**92.0%**
	Moving and Handling - Level 2 - 3 Years		[illegible]	94.0%	94.0%	94.0%	94.0%	94.0%	93.0%	92.0%	92.0%	93.0%	92.0%	92.0%	**90.0%**
Appraisals	%, Compliance	**90%**	92%	92%	92%	91%	91%	90%	93%	93%	94%	92%	92%	92%	**91%**
Time to Hire (days)	General Recruitment	**35**	43	49	54	48	44	51	51	42	43	46	51	48	**44**
	Medical Recruitment (excl Deanery)	**35**	52	79	76	51	54	68	86	65	40	36	56	75	**46**
Employee relations	Number of open disciplinary cases		19	16	20	12	18	12	17	18	18	15	18	17	**26**
Number of payroll payments to all staff *(inc. Doctors in Training)* **for all payrolls processed**	*Number of Overpayments in monthly period*		[illegible]			10	19	27	30	11	41	39	33	45	**17**
	Number of Underpayments in monthly period		[illegible]			177	181	70	81	23	37	144	58	93	**85**
	Percentage of Payroll errors		[illegible]			4.2%	4.4%	2.1%	2.4%	0.7%	1.7%	4.1%	2.0%	3.0%	2.2%

2.1. **Temporary staffing usage** and cost has **reduced** slightly and is now the lowest it has been for 13 months. Areas with high bank usage remain under review.

2.2. The Trust's **headcount has increased in month** and there are now 4528 employees in post. The **vacancy rate** has further decreased and is at 5% with notable improvements across all professional groups.

2.3. **Staff absence is at 5%** for the 12-month period and **has reduced by nearly 1%** in 2 months, now reporting at 4.7% in month. Additional temporary Occupational Health resource has resulted in the support of more management referrals and the Employee Relations Team and HRBPs have been working with managers to provide increased education around absence management.

2.4. **Staff turnover remains at 12.6%.** Retention projects in areas of high turnover continue and the HRBPs are carrying out bespoke pieces of work where turnover is high.

2.5. **Time to hire has reduced to 44 days.** The recruiters are longlisting candidates to save managers' time in the shortlisting process. The manageable delays in processes are being reviewed to close the timeline where possible.

2.6. The number of **open disciplinary cases** is now at 26. A detailed Employee Relations case report is produced monthly to JCNC.

2.7. **Statutory and mandatory training** compliance is at 94% and **appraisal** compliance is at 91%.

2.8. **Pay impacting errors in M12 have improved** now that the majority of HCA re-bandings have completed. Work is ongoing to explore automation solutions to improve pay impacting errors.

3. Continuous Improvement, Transformation and Innovation

3.1. The **Resourcing Group** has made significant improvements in refining policies to ensure bank and agency are only used when it is safety critical or related to a particular performance/activity. Changes to rostering practices to include unpaid breaks for all shifts over 6 hours, a mandated unpaid break for bank medics for 30 minutes, reversion to TOIL for extra time worked up to an hour per day for admin staff, and greater oversight and scrutiny of approving shifts to send to bank, have all had a positive impact on this. Governance arrangements for embedding these changes to practice are underway with a move of the responsibility to deliver improvements to the Divisions.

3.2. The new **Occupational Health Management Referral System** was launched in M12. This allows managers to do a direct referral for their staff to Occupational Health and to track progress for their referral, download outcome letters, and have ongoing access to their letters and referrals for their direct reports.

4. Culture and Staff Engagement

4.1. The new **Freedom to Speak Up Guardian** commences in post in M2 and will continue to deliver against the refreshed FTSU strategy, with a focus on increasing our number of Guardians and Champions across the Trust.

4.2. The Trust is currently recruiting to the **Inclusion Lead** role and will be appointed in M1 with an anticipated start date of late Q1/early Q2.

4.3. There are now close to 200 recruiting managers/leads trained on **Values Based Recruitment** and each panel should now have a member with a licence to hire. This is a significant step towards the cultural improvement work and ensures we are recruiting staff who exhibit our Trust Values.

4.4. All requests for non-clinical training and development will need to be submitted through a template **Training Needs Analysis** form which is currently being piloted. The form guides the manager to consider what is available in the Trust through alternative development tools such as an apprenticeship or shadowing/mentoring and ensures a fair process for professional development. This is planned to be rolled out fully by the end of M2.

5. Current Affairs & Hot Topics

5.1. The **Loop App** has been launched with nearly half of the organisation having downloaded the app. This will enable staff to book and cancel bank shifts, book and request leave, view the availability of their team, and see their rosters on their phone. Additional functionality is possible within the app, with the option to send push notifications and communicate key information directly to staff and this will be explored further once roll-out is complete.

5.2. The Trust has now been issued with its **Certificates of Sponsorship** for the next 12 months and the number is less than the previous year. This appears to be a similar picture across the wider NHS. The Trust is committed to sponsoring those in professionally qualified roles that we have already made a commitment to continue to. An assessment is currently being made on the number of certificates needed each year for the next few years to model the number of sponsorships we can allocate for overseas candidates (which are uncapped) and in-country candidates (capped).

6. Recommendations

6.1. The Board is asked to note the report.

Meeting Title	**Trust Board Public**	**Date: 1 May 2025**
Report Title	**Nursing Workforce Update**	**Agenda Item Number: 14**
Lead Director	*Fiona Hoskins, Chief Nursing Officer*	
Report Author	*Emma Thorne, Safe Staffing Matron*	

Introduction	This report provides an overview of the Nursing and Midwifery staffing for February 2025. The report contains a new safer staffing dashboard that details Fill Rates, Care Hours Per Patient Day alongside patient outcomes for triangulation.		
Key Messages to Note	1. Band 5 Registered Nurses vacancies continue to reduce to -0.7% (-3.49wte), and Healthcare Support Worker vacancies have also decreased from 21.8% to 17% (78wte). 2. In conjunction with the nursing establishment reviews work is being undertaken to ensure that establishments align and correlate with finance and ESR. 3. Fill rates (against establishment) for Registered Nurse was 96% during the day and 105% at night. The HCA fill rate for the day was 84% and 101% at night which suggests there are occasions where staffing levels did not meet the acuity and needs of patients. 4. 173 Red Flags were raised in February. 117 were unable to be mitigated. 5. SafeCare workforce utilisation suggests that there are 9 areas exceeding 110% to meet patients care needs. 6. Commitment remains to reducing temporary staff usage by optimising rota efficiency. There was however an increase in agency usage for registered staff in February by 63 shifts. There were 1172 registered duties left unfilled by bank.		
Recommendation	**For Information** [x]	**For Approval** [ ]	**For Review** [ ]

Strategic Objectives Links	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	*Standing agenda item*
Next Steps	*Standing agenda item*
Appendices/Attachments	*Report follows.*

Glossary

	Acronyms	
	CHPPD	Care Hours Per Patient Day
	HCA	Healthcare Assistant
	MCA	Maternity Care Assistant
	RN	Registered Nurse

Milton Keynes University Hospital NHS Foundation Trust

Safer Staffing Report

Reporting Period: February 2025 Data **Author: Emma Thorne, Matron for Safer Staffing**

Environment		Day Fill Rates						Night Fill Rates						Care Hours Per Patient Day			Workforce Utilisation		Reported Concerns				Nurse Sensitive Outcome Indicators				
Directorate	Ward	Average fill rate registered nurses/midwives (%)	Average fill rate registered nurses/midwives (%) including additional duties	% of which are Bank / Agency	Average fill rate - care staff (%)	Average fill rate - care staff (%) including additional duties inc	% of which are Bank / Agency	Average fill rate - registered nurses/ midwives (%)	Average fill rate - registered nurses/ midwives (%) including additional duties	% of which are Bank / Agency	Average fill rate care staff (%)	Average fill rate - care staff (%) including additional duties inc.	% of which are Bank / Agency	RN/RM	HCA	Overall	SafeCare Average Utilisation % February 2025	SafeCare Average Utilisation trend	No. of Red Flags raised	No of Red Flags that were unable to be mitigated	Total Number of Radars for January 2025	No.of Radars completed associated to staffing	Hospital Acquired Pressure Ulcers G2 and above	Falls with no harm/ Falls resulting in harm	Medication errors	Patient Expereince Rating	Friends and Family Test Response Rate
Medicine	Ward 1	92%	90%	7%	99%	75%	28%	100%	98%	5%	117%	88%	45%	5.2	3.4	8.6	114%	1%↓	15	10	75	1	2	7/0	3	4.61	48.9
Medicine	Ward 2	95%	95%	12%	80%	74%	19%	95%	95%	17%	102%	95%	34%	4.0	2.8	6.8	108%	3%↑	18	9	65	1	1	1/0	4	4.38	118.5
Medicine	Ward 3	95%	80%	39%	98%	89%	13%	123%	99%	32%	113%	98%	30%	4.3	2.3	6.6	104%	15%↓	8	7	21	2	1	7/0	3	4.54	76.2
Medicine	Ward 7	89%	89%	8%	88%	83%	21%	98%	98%	5%	105%	97%	37%	3.8	3.1	8.8	111%	0%	2	1	13	0	1	3/0	0	4.68	107.1
Medicine	Ward 8	92%	87%	16%	89%	80%	24%	106%	99%	23%	120%	100%	58%	4.3	2.5	6.8	111%	2%↓	2	2	14	0	6	2/0	2	4.59	40.9
Medicine	Ward 14	104%	104%	8%	85%	85%	39%	102%	102%	11%	100%	99%	53%	2.0	4.2	6.2	108%	5%↓	12	10	18	0	2	3/0	0	4.61	72
Medicine	Ward 15	105%	85%	22%	87%	85%	3%	109%	93%	25%	109%	100%	13%	3.5	2.2	5.7	112%	0%	6	4	26	0	3	3/0	1	4.58	60.5
Medicine	Ward 16	98%	94%	23%	97%	80%	28%	101%	98%	24%	129%	97%	58%	3.2	2.4	5.6	123%	0%	25	14	43	2	5	3/0	8	4.37	23.8
Medicine	Ward 17	97%	89%	17%	90%	87%	12%	108%	99%	29%	109%	100%	31%	4.0	2.2	6.2	116%	2%↓	9	8	19	2	3	0/0	2	4.68	29.3
Medicine	Ward 18	96%	96%	9%	89%	74%	31%	127%	95%	28%	126%	98%	39%	3.2	3.2	6.4	121%	3%↓	15	10	46	0	4	6/0	3	4.3	47.4
Medicine	Ward 19	113%	98%	26%	88%	76%	57%	151%	97%	48%	113%	95%	31%	4.1	3.5	7.6	100%	15%↓	5	5	33	0	1	2/0	1	4.3	46.3
Medicine	Ward 22	82%	82%	29%	90%	90%	31%	100%	100%	36%	100%	100%	58%	3.6	3.2	6.8	98%	0%	0	0	11	0	0	4/0	4	4.6	102.2
Medicine	Ward 25	97%	92%	17%	95%	80%	31%	101%	99%	30%	136%	96%	72%	4.7	3.0	7.7	95%	1%↑	8	7	14	3	0	1/0	2	4.78	63.3
Medicine	ED	95%	94%	23%	108%	107%	55%	102%	101%	33%	121%	121%	53%	N/A	N/A	N/A	N/A	N/A	1	1	150	2	1	2/0	9	3.92	6.2
Surgery	Ward 20	89%	89%	16%	78%	78%	25%	97%	97%	26%	104%	98%	38%	3.7	2.0	5.7	98%	1%↓	7	7	22	2	1	2/0	4	4.45	54.5
Surgery	Ward 21	88%	88%	8%	84%	84%	8%	92%	91%	13%	77%	77%	30%	4.9	2.3	7.2	84%	1%↓	13	5	14	0	1	1/0	5	4.64/4.52	31/21.8
Surgery	Ward 23	91%	90%	19%	108%	94%	11%	99%	99%	17%	114%	99%	18%	3.3	3.0	6.3	106%	2%↓	16	6	51	1	6	6/0	2	4.43	32.5
Surgery	Ward 24	110%	97%	19%	82%	82%	33%	108%	99%	28%	90%	90%	66%	4.5	2.5	7.0	82%	1%↓	0	0	4	0	0	0/0	1	4.66	50.5
Surgery	ITU	96%	96%	11%	0%	0%	0%	98%	98%	13%	0%	0%	0%	21.7	0.0	21.7	75%	21%↓	0	0	21	0	0	0/0	4	4.81	40
Paediatrics	Ward 5	94%	94%	12%	77%	77%	54%	101%	97%	27%	93%	93%	77%	6.9	1.1	8.0	123%	2%↓	15	10	21	0	0	0	6	4.55	26.1
Paediatrics	NNU	93%	92%	16%	57%	57%	2%	98%	98%	18%	48%	48%	0%	15.5	3.0	18.5	112%	9%↑	2	1	15	0	0	0/0	2	4.83	16.1
	Total	**96%**	**92%**	**17%**	**84%**	**78%**	**25%**	**105%**	**98%**	**23%**	**101%**	**90%**	**40%**	5.1	3.0	8.1	105%	3%↓	179	117	696	16	38		66		

Areas of concern

Area	Concern
Ward 15	High workforce utilisation, low CHPPD, Red patient outcomes.
Ward 16	Highest workforce utilisation in the Trust, low CHPPD, high number of Red Flags. high number of care hours short on SafeCare due to increased acuity. Red patient outcomes.
Ward 18	High workforce utilisation, low fill rates for HCAs against additional requirements/enhanced care requirements. High number of Red flags raised. Red patient outcome.
Ward 8	High workforce utilisation, low fill rates. Red patient outcomes.
Ward 20	Low CHPPD, Low fill rates and red patient outcomes.
Ward 5	High workforce utilisation in the trust. Low fill rates due to staff deployment to support paediatric escalation. High number of red flags. High number of care hours short on SafeCare due to patient acuity and dependency. Red patient outcomes.

Narrative and mitigation

All wards are reviewed on a daily basis by a Matron.

Safer Staffing meetings review SafeCare data, including red flags, fill rates patient acuity and staffing available. Matrons redeploy staff to mitigate risk where possible. RN Staffing increased on Ward 18 at Night in response to increased acuity.

Safe Staffing Report

Milton Keynes University Hospital NHS Foundation Trust

Data

- In February, the Trust wide fill rates (planned vs Actual) against establishment for Registered Nurse was 96% during the day and 105% at night. The HCA fill rate for the day was 84% and 101% at night.
- Trust wide fill rates against additional requirement details that RN fill rates decreased to 92% Day and 98% at night. Where HCA fill rates decrease to 78% in the day and 90% at night.
- Trust wide CHPPD 8.1. Latest CHPPD data published by Model Hospital (Nov 2024) details 8.6 to be the median CHPPD provided by peer organisations. Areas of concern, Ward 15, 16 and 20
- Agency use for Registered Nurse/Midwives increased from 277 shifts in January to 340 in February 2025.
- Bank RN usage decreased from 2678 shifts (January) to 2543 shifts in February 2025.
  1172 shifts remained unfilled.
- 189 Red Flags were raised in February in comparison to 228 Red Flags In January. Ward 16 (x25), Ward 2 (x18), Ward 23 (x16) are the highest areas for reporting red flags for this reporting period.
- Trust wide workforce utilisation in February was 105 % which is a decrease of 3% from January 2025.
  9 areas working above 110% (RED), in comparison to 11 last month.
- 23 staffing incidents were raised across the Trust pertaining to Nursing and Midwifery staffing (38 January 2025).

Escalations

High workforce utilisation (above 110%) in 9 areas.
Unable to mitigate all red flags.
Noted reduction in fill rates due to additional requirements and further escalation beds.
This group are asked to review the patient outcome data for falls, medication incidents and pressure ulcers.

Exceptions

- Fill rates continue to vary from planned levels due to changes in patient acuity, dependency, enhanced care requirements and additional beds.
- During this reporting period registered nurse staffing was increased for both Ward 18 & 19 at night due to the acuity and dependency of patients.
- It is important to note that Ward 2b (escalation area) was opened during this reporting period and the workforce has been mobilised to support this area.

Actions

To continue with the three times daily safer staffing meetings, to review red flags, staffing levels and implement mitigation and deployment, where possible.
To continue to work in line with the Trusts Safer Staffing and Escalation Policy.
To focus on the onboarding of the 29 HCA/MCA's offered employment during the Trusts HCA open day.
Divisions to encourage radar reporting relating to insufficient staffing and to also record the impact on care provision.

Meeting Title	**Trust Board (Public)**	**Date: 1 May 2025**
Report Title	**Declaration of Interest Annual Report – 2024/25**	**Agenda Item Number: 15**
Lead Director	Kate Jarman, Director of Corporate Affairs	
Report Author	Kemi Olayiwola, Trust Secretary	

Introduction	This is to provide the Board with an update on the returns submitted for 2024/25 FY ending in line with trust's policy. The report was reviewed at the Audit & Risk Committee on 14 April 2025 and recommended for Board approval for publication on the Trust's website.		
Key Messages to Note	The Board is invited to APPROVE.		
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [x]	**For Review** [ ]

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

Report History	Audit & Risk Committee 14 April 2025
Next Steps	Publication on the Trust's website
Appendices/Attachments	a. A summary of Trust Board members' current register of interests for 2024/25 (**Appendix 1**). b. A summary of the register of interests of Consultants **(Appendix 2)** c. A summary of the register of interests of Managers and decision-making staff for 2024/25 (**Appendix 3**). d. A summary of the Hospitality and Gifts register for 2024/25 (**Appendix 4**).

DECLARATIONS OF INTERESTS REPORT

1. Introduction

In compliance with the guidelines for managing conflicts of Interest in the NHS and the Counter Fraud framework, the Trust is required to maintain and publish a register of gifts, hospitality and conflicts of interest. This is to ensure that there is greater transparency, accountability and ethical conduct in place at the Trust.

Pursuant to the above provisions:

- MKUH has a Conflicts of Interest, Hospitality, Gifts, Donations and Sponsorship Policy that includes reference to gifts, hospitality and sponsorship with reference to fraud, bribery and corruption under the Bribery Act 2010.
- The policy is published on the Trust website and assessable to all staff at all levels. The Staff are also aware of the requirements of the policy, and the need to update the register as soon as an actual or a potential conflict of interest arises.
- The Trust also schedules and circulates a request to update the register to board members, consultants and other decision-making managers on an annual basis at the least, in compliance with the annual governance declaration which is an annual report requirement for publishing on the Trust website subject to Board approval of the effectiveness of the process.

The Audit & Risk Committee reviewed the report on 14 April and were assured that the improvements made to the process with the move to RADAR systems is anticipated to increase reach and response level of decision-making staff and consultants during the next financial year, outcome of which will be reported in April 2026.

The purpose of this report is for the Board to NOTE and APPROVE the register of Interest for publication on the Trust' website.

2. Background

In line with the Trust's Conflicts of Interest, Hospitality, Gifts, Donations and Sponsorship Policy, all 'decision making staff' (defined as AfC band 8A and above, staff involved in contracting and procurement, and all consultant medical staff), Executives and Non-Executive Directors and members of the Council of Governors were asked in April 2024 to submit their declarations of interests for 2024/25FY ending. The process continued throughout the year as the secretariat team routinely created awareness of the policy, distributed reminders to eligible colleagues, highlighting the need for compliance.

For this declarations exercise, an online solution was utilised with a view to improving the rate of returns for the Trust's Consultants and decision-making managers especially. This is to ensure that an improvement is sustained from previous years

and over the next couple of years, subject to continuous improvement of the solutions questionnaire.

3. Update on 2024/25 Returns

At the close of the financial year, the following figures were achieved and benchmarked against previous returns:

Categories	Current Returns 2024/25	Previous Returns 2023/24	Previous Returns 2022/23
Trust Board	All Board members submitted their declarations (100%)	All Board members submitted their declarations (100%)	All Board members submitted their declarations (100%)
Trust Consultants	125 (54%) out of 229	121 (56%) out of 215	152 (71%) out of 215
Band 8A+ (Managers)	166 (69%) out of 240	163 (77.9%) out of 209	138 (65%) out of 214
Procurement Staff	14 submitted	16 submitted	17 submitted

4. Action Plans for 2025/26

The Trust has continued to improve the process towards ensuring that all relevant staff submit their declarations of interests, and that they provide the full details in line with best practice requirements and national guidance.

To ensure that colleagues are better informed on the statutory requirement to declare any potential conflicts of interest, the Trust had taken steps to simplify the Trust's policy into PowerPoint slide decks '*Declaration of interest at a glance'* and circulated to staff. The Trust also continues to work with the local counter fraud team to ensure full compliance with the national standard.

In anticipation of better compliance rates for the 2025-26FY, further steps have been taken to ensure that all colleagues are well-informed on how to report offers of gifts and hospitality, whether accepted or not, as well as any secondary jobs undertaken. These improvements include:

- Rolling banner on the Trust's intranet to sensitise colleagues about the Declaration of interest exercise, with a link to redirect to the online form
- Awareness of the Trust's policy
- Weekly notification in the Trust's weekly newsletter

The Trust has recently automated the process by transferring the declaration process to RADAR healthcare systems for broader accessibility.

A formal update on progress was presented to the Audit & Risk Committee on 14 April 2025 and the committee discussed the trend over the last few years. The committee were assured that the automation of the process with the move to RADAR systems was anticipated to increase reach and response level of decision-making staff and consultants during the next financial year, outcome of which will be reported in April 2026.

5. Recommendation

The Board is asked to:

- **Note** the report and the appended registers and approve for publication on the Trust's website in compliance with the requirement for 2024/25 Annual Report.

TheMKWay

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Appendix 1: BOARD OF DIRECTORS – DECLARATIONS OF INTERESTS 2024/25

Director	Role	Do you, your spouse, partner of family member hold or have any of the following: • A directorship of a company? • Any interest or position in any firm, company, business or organisation (including charitable or voluntary) which does or might have a trading or commercial relationship with the Foundation Trust? • Any interest in an organisation providing health and social care to the NHS?	Do you or your spouse, partner or family member have a position of authority in a charity or voluntary organisation in the field of health and social care?	Do you, your spouse, partner or family member have any connection with an organisation, entity or company considering entering into a financial arrangement with the Foundation Trust, including but not limited to lenders or banks?	Dates during which the interests were held	Action taken to manage any potential conflict *[Board and Committee agendas are proactively and continuously scrutinised to ensure that Board members are not exposed to potential conflicts and at every Board and Committee meeting, members are asked to declare any conflicts that they may have]*
Heidi Travis	Acting Trust Chair	Yes – CEO Sue Ryder Charity	No	No	2011 to June 2024	No direct conflict with MKUH
Haider Husain	Non-Executive Director	Yes- Director & CEO of Paracat Ltd	No	No	Feb 2018 to date	If any perceived conflict of interest

		Director & COO of Healthinnova Limited British Standards Institute (BSI) Committee member – Healthcare Organisation Management Associate Non-Executive Director, Medicines and Healthcare products Regulatory Agency Board Bucks. Oxfordshire & Berkshire West ICB Dementia Carers Count			March 2019 to date Apr 2019 to date September 2020 to date July 2022 to date June 2021 to date	arises between my roles I would declare this straight away and excuse myself from the discussion
Ganesh Baliah	Non-Executive Director	Yes – Deputy Chief CNO/Chief AHP at Kettering General Hospital (University Hospitals Northamptonshire) UHN and my role at Suffolk & North East Essex ICB	No	No	To date	
Gary Marven	Non-Executive Director	Non-Executive Director, MLL Telecom	No	No	April 2022 to date	I am not involved in any procurement process
Precious Zumbika	Non-Executive Director	Yes – Carus Advisory Services Ltd Milton Keynes Community Foundation Worktree	No	No	To date	Declare where required - Currently no conflict
Sarah Whiteman	Non-Executive Director	Yes – Director of AKESO Coaching a Community Interest Company	GP, Stonedean Practice, Milton Keynes	No	To date	Exemption from any relevant decisions and open declaration at

		Bedfordshire Hospitals Foundation Trust - Medical Examiner James Paget University Hospital Non-Executive Director Lincolnshire Partnership Trust Non-Executive Director			March 2024 to date October 2023 to date October 2023 to date	meetings where needed
Mark Versallion	Non-Executive Director	Yes – Lesnewth Estates Ltd Central Bedfordshire Councillor for Heath and Reach, Hockliffe, Eggington, Stanbridge, Tilsworth, Tebworth and Wingfield	No	No	To date	There are no conflicts
Piers Ricketts	Non-Executive Director	Yes – Chief Executive and a Board Director of Eastern AHSN (Academic Health Science Network), a non-profit making Company Limited by Guarantee, trading as Health Innovation East. Position held since April 2018.	No	No	April 2018 to date	Eastern AHSN is licenced and funded by NHS England and the Office for Life Sciences to support the adoption and spread of innovative medicines and healthcare technologies by the NHS in the East of England. MKUH is part of this region. The mitigations to this potential conflict are: (i) services under the Health Innovation

						Network licence have traditionally been provided to MKUH by Oxford AHSN (now trading as Health Innovation Oxford and Thames Valley), and not by Eastern AHSN. (ii) the services provided under the licence are generally free of charge to the receiving organisation. If Health Innovation East were to provide services to MKUH under the licence, I as a director of Health Innovation East would therefore not have an interest (financial or non - financial) in the service provision. (iii) In the unlikely event that Health Innovation East were requested to provide paid -for

						services either to MKUH directly or (for example) to support a third party undertaking an academic study at MKUH, I would absent myself from any decisions concerning the project. None of these situations has ever arisen in my 6+ years in the role but I have provided a description here in the interests of full disclosure.
Joe Harrison	Chief Executive Officer	National Director for Digital Channels, NHSE Chair, NHS Employers Policy Board Keele University Lecturer Council Member, National Association of Primary Care Chair, CRN Thames Valley & South Midlands Partnership Group Member, Oxford AHSN Member, TenX Advisory Board Advisor to Stepcare, Silverlight, M3 Global Research, Alphasights	No	No	To date Jan 23 - Current	Always declared

		Spouse, Samantha Harrison, Non-Executive Director DHSC – Current Spouse, Samantha Harrison, Various Management Consultancies - March 2023 to present. Spouse, Samantha Jones , Chair of Keys – Current Spouse, Samantha Jones, Board Member, Accurx – Current Spouse, Samantha Jones, Director, Samantha Jones Ltd - Current Sister, Ruth Harrison, Director of Durrow Ltd – Current				
Ian Reckless	Chief Medical Officer	Yes – Director, JTER Trading Ltd (retail and property services) Director, ADMK (wholly owned subsidiary of MKUH NHS Foundation Trust) Spouse is employed as a Consultant Anaesthetist in the NHS in the region Non-Executive Director, Royal Orthopaedic Hospital NHS Foundation Trust CMO, BLMK Integrated Care Board	No	No	July 2019 to date November 2022 to date April 2024 to March 2025	Always declared

John Blakesley	Chief Strategic Development Officer	Yes – Director of ADMK Limited, wholly owned subsidiary of the Trust	No	No	July 2019 to date	
Kate Jarman	Chief Corporate Services Officer	Yes – Faculty Member of the Good Governance Institute Board Member – Milton Keynes Urgent Care Centre Member of the Labour Party Member of Women's Equality Party Trustee – Milton Keynes Arts for Health Trustee	No	No	Nov 2020 to date	Always declared
Jonathan Dunk	Chief Finance Officer	Spouse, Emma Dunk, Head of Legal Services, Cambridge University Hospitals NHS Foundation Trust	No	No	To date	Declared
Helen Beck	Chief Operating Officer, Planned Care	Yes- Non – Executive Director, Healthsense Solutions Director, SL Beck Non-clinical consulting Spouse, Director, SL Beck Non-clinical consulting	No	No	 Current Current	Declared Declared Declared
Catherine Wills	Chief People Officer	No	No	No		
Fay Gordon	Chief Operating Officer -	No	No	No		

	Unplanned Care					
Fiona Hoskins	Chief Nursing Officer	No	No	No		
Alison Davis	Trust Chair (Till 30 April 2024)	Nil	No	No		
Devdeep Ahuja	Non-Executive Director (Till November 2024)	Yes – RTW Plus Limited - Director - Appointed 12 June 2018 DPA Equity Ltd - Director - Appointed 22 March 2021 Urgent Locum Ltd - Director - Appointed 4 February 2023 Normedica International Ltd - Director - Appointed 14 April 2023 Bucks Consultants Limited - Director - Appointed 6 February 2024	No	No	To date	- Update declarations regularly - Declare interests to the specific topics in meetings - If applicable, not be involved in discussions or decisions around the specific topics.
Jason Sinclair	Associate Non-Executive Director (Till August 2024)	No	No	No		
Emma Livesley	Chief Operating Officer, Unplanned Care	Nil	No	No	To date	

	(Till July 2024)					
Yvonne Christley	Chief Nursing Officer (Till 30 April 2024)	No	No	No		
Danielle Petch	Chief People Officer (Till September 2024)	Yes – Husband is Director of S4 Software Solutions Ltd.	No	No	To date	There is no conflict - company not associated with MKUH.
Steven Beaumont	Interim Chief Nursing Officer (Till July 2024)	Yes – Wife is an NHS Health Visitor in Kent	No	No		

Meeting Title	**Trust Board (Public)**	**Date: 1 May 2025**
Report Title	**Risk Management Report**	**Agenda Item Number: 16**
Lead Director	*Kate Jarman, Chief Corporate Services Officer*	
Report Author	*Paul Ewers, Senior Risk Manager*	

Introduction	The report provides an analysis of all risks on the Risk Register, as of 2 April 2025.
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.

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.

Recommendation	**For Information**	☐	**For Approval**	☐	**For Review** ☑

Strategic Objectives Links	*Objective 1: Keeping you safe in our hospital* *Objective 2: Improving your experience of care* *Objective 3: Ensuring you get the most effective treatment* *Objective 4: Giving you access to timely care* *Objective 7: Spending money well on the care you receive* *Objective 8: Employ the best people to care for you* *Objective 10: Innovating and investing in the future of your hospital*

Report History	The Risk Report is an ongoing agenda item
Next Steps	
Appendices/Attachments	The following items can be found under item 17 in the supplementary shelf: • Appendix 1: Corporate Risk Register • Appendix 2: Significant Risk Register

Exception Reporting:

The report 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. There has been a slight increase in the total number of risks (n=273).

2. Just over a quarter of the risk identified (69) are currently graded as significant. 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 51 risks (19%) that are overdue their review date. This is **an increase of 16** from the previous report.

4. 19 of the overdue risks are more than 1 month overdue

Reference	Risk Owner	CSU	Days Overdue
RSK-427	Mike Pashler	Imaging	61
RSK-457	Mike Pashler	Imaging	61
RSK-459	Mike Pashler	Imaging	61
RSK-131	Paula Robinson	Imaging	54
RSK-591	Katy Philpot	Women's Health	50
RSK-105	Elaine Gilbert	Women's Health	47
RSK-111	Elaine Gilbert	Women's Health	47
RSK-418	Elaine Gilbert	Women's Health	47
RSK-439	Elaine Gilbert	Women's Health	47
RSK-513	Katy Philpott	Women's Health	47
RSK-523	Anja Johansen-Bibby	Women's Health	47
RSK-450	Elaine Gilbert	Women's Health	46
RSK-487	Natalie Lucas	Women's Health	43
RSK-488	Roxanne Vidal	Women's Health	43
RSK-085	Amanda Taylor	General Surgery	40
RSK-226	Antoanela Colda	Research & Development	40
RSK-475	Julian Robins	Head & Neck	39
RSK-451	Faryal Nizami	Women's Health	33
RSK-012	Liz Winter	Acute Medicine	32

5. There are 322 controls that have been identified and are in progress. This shows that when risks are identified, controls are being identified to mitigate the risk. However, of these 167 are past their expected implementation date. This is **an increase of 32**.

Risks on Risk Register > 5 years and not at Target/Tolerable Level:

It was identified that there were a number of 18 risks that had been on the Risk Register more than 5 years ago, and had not been mitigated down to the Target / Tolerable level (as at 31st January 2025).

Unmitigated risks can result in the Trust being unnecessarily exposed to risks that could have been prevented and/or reduced the impact if they do occur. Therefore, this leaves the Trust potentially vulnerable. Mitigation of risk also increases the likelihood of the Trust achieving its goals and objectives including reducing harm to patients / staff / members of the public, providing high quality care, having efficient and effective processes and managing resources/finances effectively

A review of these risks has commenced. Below is a summary of the progress to date:

Ref	Title	Risk Owner	Progress	Status
RSK-019	Violence & Abuse in ED	Kirsty McKenzie	V&A QI project is taking place. This risk is to be updated and kept aligned with the progress of the project.	Treat – Further controls required
RSK-080	Head Injury Pathway	Arosha Hettiarachchige	Meeting scheduled with multi-disciplinary team on Tuesday 8th April	Treat – To be reviewed after meeting
RSK-020	ED Ligature Points	Kirsty McKenzie	Meeting held. Ligature Policy to be updated. Recommended that a Target Risk Score of 8 is more appropriate for this risk – therefore risk to be tolerated once policy has been updated	Treat – To be changes to Tolerate once policy has been updated.
RSK-042	Medical Equipment Training records in Theatres	Arabelle Casey	Risk updated. Current Risk Score reduced to Target Level and changed to Tolerate. No further controls required	Changed to Tolerate
RSK-039	Diathermy Machines in Theatres	Arabelle Casey	Risk requires the purchase of additional diathermy machines. No further controls available. Decision required whether to tolerate the current risk (12) or to purchase diathermy machines to reduce risk to Target level.	Treat / Tolerable dependent on decision
RSK-059	Increased demand for Medical Retina follow-up service	Ben Nichols	Risk updated. Current Risk Score reduced to Target Level and changed to Tolerate. No further controls required	Changed to Tolerate
RSK-016	Lack of patient flow	Kirsty McKenzie	Ongoing risk, to be reviewed	Treat
RSK-183	CRIS Radiology Information System	Andrew Scott	Risk no longer reflects the issue. Risk closed and replaced with two link risks	Closed
RSK-043	Deterioration of anaesthetics rooms in Phase 1	Arabelle Casey	Risk requires the refurbishment of Phase 1 Theatres. No further controls available. Decision required whether to tolerate the current risk (6) or to refurbish Phase 1 Theatres to reduce risk to Target level.	Treat / Tolerable dependent on decision
RSK-158	Escalation beds - Inpatient Therapy and Dietetics capacity	Laura Sturgeon	To be reviewed. Awaiting response from Laura.	

RSK-159	Capacity within OT and Physio Inpatients	Laura Sturgeon	To be reviewed	
RSK-035	High turnover of staff in Pharmacy	Helen Smith	To be reviewed	
RSK012	Violence & Abuse within Acute Medicine	Liz Winter	V&A QI project is taking place. This risk is to be updated and kept aligned with the progress of the project.	Treat – Further controls required
RSK-135	Pathology LIMS system	Rebecca Potter	Risk to be closed when LIMS system is implemented (May 2025).	Treat – to be closed
RSK-018	ED Diabetes Patients not being assessed promptly	Liz Winter	To be Reviewed	

Risks Escalated by Division/Corporate Department:

There are 2 risks that have been identified as requiring escalation onto the Corporate Risk Register this month.

Ref	Title	Risk Owner	Rationale for escalation to Corporate Risk Register
RSK-638	POCT Poccellerator informatics system	Phillip Dickson	This risk impacts multiple clinical areas, as the POCT devices described in the Risk Assessment are used throughout the trust. The mitigation of the risk is reliant on IT capacity and resource which falls outside of Pathology
RSK-645	CPAP Service	Alexandra Peers	Rapid increase in service demand (50 per year 2013 to 50 per month 2025) Patient Safety impact - Due to delays in offering treatments and the inability of the team to provide adequate follow up care, the effectiveness of their treatment cannot be properly assessed Departmental budget has not been increased for over five years ~ and at £155k is insufficient We are putting Respiratory Physiology's DM01 at risk if we do not invest in this service

Recommendations / Decisions to be considered:

1. It is recommended that the Divisions/Corporate Departments put plans in place to ensure that all overdue risks to be updated by 30 April 2025.

2. Divisions/Corporate Departments to ensure that controls are reviewed and updated as part of reviewing each risk. It is recommended that all controls are updated and either closed or their due dates extended by 30th April 2025.

3. For the Board to discuss the way forward for the following long-standing risks:

    a. RSK-039 - Decision needs to be made on whether to tolerate the current risk (12) or to purchase diathermy machines to reduce risk to Target level.

    b. RSK-043 - Decision required whether to tolerate the current risk (6) or to refurbish Phase 1 Theatres to reduce risk to Target level.

4. The Board is asked to approve the escalation of the following risks onto the Corporate Risk Register:

    a. RSK-638 – POCT Poccellerator Informatics System
    b. RSK-645 – CPAP Service

Meeting Title	**Trust Board (Public)**	**Date: 1 May 2025**
Report Title	**Board Assurance Framework**	**Agenda Item Number: 17**
Lead Director	*Kate Jarman, Chief Corporate Services Officer*	
Report Author	*Paul Ewers, Senior Risk Manager*	

Introduction	This report is to provide assurance that the Board Assurance Framework (BAF) is being effectively managed.		
Key Messages to Note	• BLMK System Risk information updated (page 7 of full BAF in supplementary pack) • SR1 – Current Risk Score reduced from 20 to 15 • SR12 – Vulnerability to Cyber Security breach has been added • Template of full BAF (in supplementary pack) updated to include 'Summary narrative of progress'. This will support easy identification of where risks have been mitigated as much as possible, remain above tolerance and are out of the control of the Trust.		
Recommendation	**For Information** ☐	**For Approval** ☐	**For Assurance** [x]

Strategic Objectives Links	*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	Regular Committee cycle
Next Steps	*N/A*
Appendices/Attachments	*The full Board Assurance Framework can be found under item 18 in the Supplementary Shelf.*

BAF Dashboard:

Strategic Risk		Executive Lead	Inherent Risk (level of risk without controls)	Current Risk												Target Risk (level of risk deemed tolerable)	Risk Appetite	Treatment Strategy	Assurance Rating
				May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr				
2	Insufficient capital funding to meet the needs of population we serve	Chief Financial Officer	25	20	20	20	20	20	20	20	20	20	20	20	15	10	Avoid	Treat	Negative Assurance
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.	Chief Financial Officer	20	20	20	20	20	20	20	20	20	20	20	20	20	8	Cautious	Treat	Negative Assurance
4	Patients experience poor care or avoidable harm due to delays in planned care	Chief Operating Officer – Planned Care	25	20	20	20	20	20	20	20	20	20	20	20	20	10	Avoid	Treat	Inconclusive Assurance
5	Patients experience poor care or avoidable harm due to inability to manage emergency demand.	Chief Operating Officer – Unplanned Care	25	20	20	20	20	20	20	20	20	20	20	20	20	10	Avoid	Treat	Positive Assurance
6	System inability to provide adequate social care and mental health capacity.	Chief Operating Officer – Unplanned Care	20	20	20	20	20	20	20	20	20	20	20	20	20	8	Avoid	Treat	Inconclusive Assurance
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	Chief Medical Officer	25	15	15	15	15	15	15	15	15	15	15	15	15	10	Avoid	Treat	Inconclusive Assurance
10	Insufficient staffing levels to maintain safety - Inability to recruit 'hard to recruit' roles	Chief People Officer	15	10	10	10	10	10	10	10	10	10	10	10	10	5	Avoid	Treat	Positive Assurance
11	Insufficient staffing levels to maintain safety - Inability to retain staff	Chief People Officer	15	10	10	10	10	10	10	10	10	10	10	10	10	5	Avoid	Treat	Positive Assurance

12	Vulnerability of Cyber Security breach	Chief Strategic Development Officer	20										16	16	8	Cautious	Treat	Inconclusive Assurance

Longer-term Risks: Nine 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 Appetite Statement:

Following discussions at the BAF Board Seminar in February 2025, the following new Risk Appetite scores were proposed.

Finance:	Cautious
Compliance/Reg:	Cautious
Strategic:	Seek
Operational:	Cautious
Reputational:	Open
Hazard/Pt Safety:	Minimal (ALARP)

It was agreed that the Risk Appetite statement and its implementation would be discussed further at a future Board seminar.

Potential New BAF Risks:

1. New strategic risk in relation to poor data quality is being assessed and will be added to the BAF once this work has been completed.

2. The following risk was discussed at Quality & Clinical Risk Committee, and it was recognised that the risk would need to be appropriate worded so that it reflects what MKUH can influence/control. The Committee decided that this needs further discussion at Board:

    - Widening health inequalities

Recommendations:

1. The Board are asked to review and discuss the Board Assurance Framework and have an awareness of the potential new risks being added to the BAF and those still under discussion.
2. The Board are asked to approve that the Risk Appetite statement.

TheMKWay

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Meeting Title	**TRUST BOARD (PUBLIC)**	**Date: 1 May 2025**
Report Title	Audit & Risk Committee Assurance Report	**Agenda Item Number: 18**
Committee Chair	**Mark Versallion**, Non- Executive Director & Chair of the Committee	
Report Author	**Timi Achom**, Assistant Trust Secretary	

Introduction	The purpose of the report is to provide an update to the Trust Board on the activities of the Audit & Risk Committee since the Trust Board held in public on 6 March 2025. The committee had met on two occasions since the last update to the Board: 17 March 2025 and 14 April 2025		
Key Messages to Note	The Trust Board is invited to NOTE the report.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Assurance** [x]

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	*1. Keeping you safe in our hospital* *2. Improving your experience of care* *3. Ensuring you get the most effective treatment* *4. Giving you access to timely care* *5. Working with partners in MK to improve everyone's health and care* *6. Increasing access to clinical research and trials* *7. Spending money well on the care you receive* *8. Employ the best people to care for you* *9. Expanding and improving your environment* *10. Innovating and investing in the future of your hospital*

1. Committee Discussion and Decision

Key points to note:

- The committee had met on two occasions since the last update to the Board: 17 March 2025 and 14 April 2025

The following decisions were made at the Audit and Risk Committee held on **17 March 2025**

The meeting was quorate and chaired by Mark Versallion - NED

Agenda Item	Decision Made	Comments
Annual Report, Annual Accounts &	The committee **noted** the Annual Accounts Timetable and **agreed**	The committee received the Annual Accounts Timetable which highlighted key dates including the draft accounts submission on 25 April, draft annual report submission on 6 May, Audit Committee

Quality Report Timetable	with the submission timeline.	review on 16 June, and final audited accounts submission on 30 June.
Audit Plan 2024/25	The committee **noted** the Audit Plan 2024/25	No fundamental changes in risks identified compared to previous years. Monitoring the Trust's financial position as part of Value For Money, particularly in light of potential impacts from the NHSE abolition.
External Audit Findings Improvement Action Plan	The committee **noted** the External Audit Findings Improvement Action Plan	The committee received an update on the audit action plan findings for both the main finance and value-for-money audits. It was reported that 14 out of 15 actions from the main finance audit were either completed or on track. The remaining action, concerning asset verification, was pending and may not be finalised by the end of the financial year.
Accounting Policies for Completion of Annual Accounts	The committee **noted** the Accounting Policies for Completion of Annual Accounts and **approved** the changes and update to the Accounting Policies	The committee noted the minor changes in pension disclosures and the implementation of IFRS 17
MK Urgent Care Service (MKUCS)	The committee **noted** and **approved** the decision to include the Milton Keynes Urgent Care Services Ltd (MKUCS) investment income in the Trust 2024/25 annual accounts	The Trust's approach to the Urgent Care Centre, a Community Interest Company (CIC), and its minimal financial impact due to CIC rules was outlined.
Draft Going Concern Review	The committee **noted** the Draft Going Concern Review	The committee noted that the Trust could be deemed a Going Concern. This conclusion was supported by the Trust's inclusion in the BLMK Health and Care Strategy and the New Hospital Programme, with the Department of Health and Social Care (DHSC) confirming that the Trust would be part of "Wave 1" of the New Hospital Programme starting in 2025-26
Internal Audit Progress Report	The committee **noted** the report.	Key Financial Controls report provided reasonable assurance; Discharge Management report provided partial assurance.

Internal Audit - Audit Plan 2025/26	The committee **noted** the Internal Audit - Audit Plan 2025/26 Update	The committee received an update on the audit plan for 2025/26 noting that while the formal document would be presented at the next committee meeting, the Executive team had reviewed the plan's content to ensure comprehensive coverage.
Draft Head of Internal Audit Opinion	The committee **noted** the report	Draft Head of Internal Audit Opinion was borderline amber-green rating. This positive rating reflected the Trust's good progress in implementing actions and addressing risks.
Counter Fraud Progress Report	The committee **noted** the report	Two proactive reviews were conducted on reporting culture and secondary employment, neither of which identified major concerns. Over the past year, 11 new referrals were received and subsequently closed, with one referral carried over from the previous year.
Financial Controller's Report	The committee **approved** reported write offs and **noted** report	The committee reviewed the financial controller's report, covering write-offs, credit notes, special payments, and salary overpayments.
Waiver Report	The committee **noted** the report	The committee noted the Q4 Waiver trends, noting a total of 17 waivers, with Estates being the highest user. The procurement team was actively working to reduce waiver use through education and monitoring.
Conflicts of Interest, Hospitality, Gifts, Donations & Sponsorship Policy	The committee **noted** the Conflicts of Interest, Hospitality, Gifts, Donations & Sponsorship Policy and **approved** the proposed modifications	The committee noted the updated Conflicts of Interest Policy, which had been reviewed in accordance with policy governance requirements. The policy was reviewed every three years and had already been approved by the Trust Executive Committee.
Health and Safety Report	The committee **noted** the report.	Key highlights included key developments within the Health and Safety team and ongoing operational priorities.
Board Assurance Framework (BAF)	The committee **noted** the report	The recent inclusion of cyber security as a risk, along with ongoing efforts to address poor data quality, was noted. The committee acknowledged that updates to the risk appetite statements were underway and would be presented to the committee for approval.

Risk Management Report	The committee **noted** the report	The report emphasised the need for divisions to proactively update their risks and ongoing efforts to maintain the register.
The following decisions were made at the Audit and Risk Committee held on 14 April 2025		
Early Significant Judgements Paper	The committee **noted** the report	Key areas of focus included Elective Recovery Funds, Chemotherapy discrepancies, and Clinical Negligence Premium.
Valuation Outturn	The committee **noted** the report	The Trust has changed the company that provides its site valuation for 2024/25 which has resulted in a more accurate reflection of the site valuation through a change in methodology and better information for the external team. The impact of this is a reduction in the Trust's site value. There is a financial benefit to the Trust as it reduces the Public Dividend Capital payable and there is also a lower depreciation charges. No concerns were raised by the committee members of this valuation.
IFRS 17 Review Findings	The Audit and Risk Committee **noted** the IFRS 17 Review Findings	The review assessed over 30 contract types, with minimal financial significance. No concerns were raised by the committee members
Discharge Management Audit	The committee **noted** the Discharge Management Audit	Six key actions were outlined to improve patient discharge processes, including policy updates, system enhancements, and performance reporting
Risk Management Framework	The committee **noted** the report	The framework outlined how the Trust managed risk, including risk appetite, committee functions, and responsibilities
Declaration of Interest Annual Report	The committee **noted** the report	Improvements were made to the process, including the transition to an automated system hosted on Radar, which resulted in over 70% of staff completing their declarations

2. Assurance

As noted in comments

3. Areas for escalation to the Board for further discussion or decision from the agenda items
There was no escalation items noted for the Board

Recommendation
• The Board are invited to NOTE the report.

Meeting Title	**TRUST BOARD (PUBLIC)**	**Date: 1 May 2025**
Report Title	Charitable Funds Committee Report	**Agenda Item Number: 18**
Committee Chair	**Haider Husain**, Non- Executive Director & Chair of the Committee	
Report Author	**Timi Achom**, Assistant Trust Secretary	

Introduction	The purpose of the report is to provide an update to the Trust Board on the activities of the Charitable Funds Committee since the Trust Board held in public on 6 March 2025 The committee had met on one occasion since the last update to the Board: 22 January 2025		
Key Messages to Note	The Trust Board is invited to NOTE the report.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Assurance** [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. Working with partners in MK to improve everyone's health and care* *5. Increasing access to clinical research and trials* *6. Spending money well on the care you receive* *7. Employ the best people to care for you* *8. Expanding and improving your environment* *9. Innovating and investing in the future of your hospital*

1. Committee Discussion and Decision

The committee had met on one occasion since the last update to the Board: 22 January 2025

The following decisions were made at the Charitable Funds Committee held on **22 January 2025**

The meeting was quorate and chaired by Haider Husain - NED

Agenda Item	Decision Made	Comments
Charitable Funds Report	The committee **noted** the report.	The report highlighted fundraising activities, including significant contributions from schools, corporate entities, and MKUH staff. The charity's website and social media presence saw significant engagement and growth. The departure of the Individual Giving Marketing Lead was discussed,

		and an extra-ordinary meeting was agreed to address future funding, recruitment, and retention
Radiotherapy Wellbeing Appeal Friends of MK – Future Partnership	The committee **noted** the update and **approved** the move to close the Radiotherapy Wellbeing Appeal	The committee agreed to support discussions with key stakeholders to understand the use of funds and gain approval to close the appeal and move to the planning stage
Friends of MK – Future Partnership	The committee **noted** the report.	Ongoing work to formalise a plan for partnership or aligned working with Friends of MK was discussed. The affordability of the retail outlet was to be reviewed. An extra-ordinary meeting was agreed to discuss the potential effects on MK Hospital charity if a partnership or amalgamation were suggested
Arts for Health MK – Funding Position	The committee **noted** the report.	The funding position of Arts for Health MK was updated, reporting that the following two years were to be driven by MK Hospital charity. Figures were to be agreed by the Chief Finance Officer to ensure sustainability and clarity for the proposed provision supplied
Arts for Health MK – 2024/25 Invoice	The committee **noted** the conversation regarding the Arts for Health funding position	The invoice and works undertaken by AfH MK during 2024/25 were presented. The committee highlighted the requirement to review MK Hospital Charity requirements for 2025/26 to ensure alignment to objectives and reduction in costs
Risks Highlighted During the Meeting for Consideration to CRR/BAF	Discussed	The impact on the charity from the removal of the Individual Giving Fundraising Lead role. Friends of MK Hospital

2. Assurance

The Chair and Non-Executive Directors were assured that:

- As noted in comments

3. Areas for escalation to the Board for further discussion or decision from the agenda item

The following were escalated from the committee to the Trust Board:

- The impact on the charity from the removal of the Individual Giving Fundraising Lead role

- Friends of MK Hospital

Recommendation

- The Board are invited to NOTE the report.

TheMKWay

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Meeting Title	**TRUST BOARD (PUBLIC)**	**Date: 1 May 2025**
Report Title	People and Culture Committee	**Agenda Item Number: 18**
Committee Chair	**Precious Zumbika**, Non- Executive Director	
Report Author	**Timi Achom**, Assistant Trust Secretary	

Introduction	The purpose of the report is to provide an update to the Trust Board on the activities of the People and Culture Committee since the Trust Board held in public on 6 March 2025 The committee had met on one occasion on **17 April 2025**		
Key Messages to Note	The Trust Board is invited to NOTE the report.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Assurance** 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. Employ the best people to care for you* *6. Expanding and improving your environment* *7. Innovating and investing in the future of your hospital*

1. Committee Discussion and Decision

The committee had met on 17 April 2025

The following decisions were made at the People and Culture Committee held on **17 April 2025**

The meeting was quorate and chaired by Precious Zumbika - NED

Agenda Item	Decision Made	Comments
Board Assurance Framework and Risk Register	Discussed	The committee discussed the controls for the risks highlighted and the level of assurance. There was a discussion about whether the targets were realistic and if the risk appetite needed adjustment. It was suggested that Risk Manager, Paul Ewers should be invited to the next people committee for a deep dive session to triangulate ongoing work through the strategy and discuss potential shifts in targets and risk appetite.

Inclusion Programme	The committee **noted** the report.	The appointment of an inclusion lead role was noted. The inclusion lead would be responsible for developing a dashboard to monitor progress against the inclusion strategy and manage expectations for applicants. Yvonne Coghill report now received and due for launch across the organisation throughout May/June.
Freedom to Speak Up Report	The committee **noted** the report.	The committee discussed the appointment of a new Freedom to Speak Up post starting in May. The role would be moved to the governance structure to ensure open lines of communication. Next meeting to include deep dive on F2SU.
Workforce Strategy	The committee **noted** the Workforce Strategy.	Key highlights included the launch of values-based recruitment training for over 170 managers, the implementation of the Loop app for booking bank shifts and addressing resourcing issues in occupational health functions – over half the Trust now signed up to Loop. The committee also discussed the impact of Home Office changes on Certificate of sponsorship availability for international colleagues and the difficulties and restrictions this has presented.
Safe Staffing Report	The committee **noted** the report	The report highlighted a reduction in vacancies for Band 5 and healthcare support workers but noted challenges in meeting patient acuity needs. The committee discussed the impact of high utilisation levels on staff burnout and the need for further investment to manage these challenges. Overview of the work underway to counter some of the above through a business case for staffing levels assessed against the Safer Nursing Care Tool.

2. Assurance

The Chair and Non-Executive Directors were assured that:

- As noted in comments

Recommendation

- The Board are invited to NOTE the report.

Meeting Title	**Trust Board (Public)**	**Date: 1 May 2025**
Report Title	**Annual Review of Effectiveness**	**Agenda Item Number: 19**
Lead Director	**Kate Jarman, Chief Corporate Services Officer**	
Report Author	**Oluwakemi Olayiwola, Trust Secretary**	

Introduction	Annual Review of Effectiveness 2024/25		
Key Messages to Note	The purpose of this report is to provide an update to the Trust Board on the work of the Audit & Risk Committee ('ARC') and the Quality and Clinical Risk Committee (QCRC) over the past financial year with the aim of providing an assurance that the committee has carried out its roles and responsibilities in accordance with its terms of reference during the financial year 2024/25.		
Recommendation	**For Information** √	**For Approval** ☐	**For Assurance** √

Strategic Objectives Links	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* *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	*N/A*
Next Steps	*N/A*
Appendices/Attachments	Supplementary Shelf

AUDIT & RISK COMMITTEE (FORMERLY AUDIT COMMITTEE)

Annual Review of Effectiveness 2024/25

Mark Versallion

Chair - Audit & Risk Committee

Oluwakemi Olayiwola

Trust Secretary

1. Purpose

1.1 The purpose of this report is to provide an update to the Trust Board on the work of the Audit & Risk Committee ('ARC') over the past financial year with the aim of providing an assurance that the committee has carried out its roles and responsibilities in accordance with its terms of reference during the financial year 2024/25.

2. Background

2.1 Good practice requires that the Trust Board should review the performance of its committees annually to determine if they have been effective, and whether further development work is required. The ARC is a committee of and accountable to the Board of Directors.

2.2 In line with the committee Terms of Reference, the committee is also required to annually review its own effectiveness and report the results of that review in an annual report to the Board.

2.3 This Annual Review of Effectiveness summarises the activities of the Trust's Audit & Risk Committee for the financial year 2024/25, setting out how it has met its Terms of Reference and key priorities.

3. Governance

3.1 The Audit & Risk Committee is a sub-committee of the Trust Board. The committee chair is responsible for escalating matters which the committee considers require highlighting to the Board when presenting the summary report of the committees' activities to the Trust Board.

3.2 The purpose of the committee is contained in its Terms of Reference. 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.

3.3 Gary Marven, Non-Executive Director was chair of the committee until June 2024.

3.4 Mark Versallion was appointed Chair of the Audit & Risk Committee ('ARC') in June 2024 and continues to act till date.

3.5 The ARC Terms of Reference were reviewed and approved at the Trust Board on 14 November 2024 for the 2025/26 financial year. The Terms of Reference is scheduled on the committee's forward agenda plan for a review in September 2025, following which a recommendation will be made to the 6 November 2025 Trust Board for approval.

3.6 On 14 November 2024, the name of the committee changed to '*Audit & Risk Committee'* following the approval by the Trust Board to support the 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, as well as for more effective and regular review of the Trust's risk management assurance processes.

4 Evaluation of Effectiveness of Members & Attendees

4.1 An evaluation of the committee was undertaken in May 2024 in accordance with the committee's Terms of Reference. A self-evaluation tool was used as the survey instrument that was circulated to members and attendees.

4.2 10 members and attendees were asked to provide a rating between 1 to 5 for each question.

(1= strongly disagree, 5 = strongly agree). 6 out of the 10 provided responses and the results were analysed by averaging the scores for each question.

4.3 The overall rating and comments demonstrated a **neutral response (3.4), requires some improvement actions** to the committee's function and performance.

4.4 Feedback showed that the committee would benefit from spending more time on challenging matters of substance. There was the need to focus on key risks to the organisation and from work of other committees. It was also suggested that deep dive sessions be undertaken on a regular basis to allow the committee to assure itself that risk management was working effectively.

4.5 Suggested areas for improvement were discussed at the 15 July Audit Committee meeting and proposed actions were implemented in the course of the financial year.

5 Review of Committee Activities against its Terms of Reference

5.1 Membership

5.1.1 Audit & Risk Committee maintains a record of membership in accordance with its Terms of Reference. As at 31 March 2025, the following persons were members and attendees of the Committee:

Members		**Attendees**	
Mark Versallion	NED - Chair	Karan Hotchkins	Deputy Chief Finance Officer
Sarah Whiteman	NED	Cheryl Williams	Head of Financial Control & Capital
Gary Marven	NED – Chair (till June 2024)	Daphne Thomas	Deputy Chief Finance Officer
Piers Ricketts	NED (from 1 December 2024)		
Kate Jarman	Chief Corporate Services Officer		

Jonathan Dunk	Chief Finance Officer		

5.2 Meetings Attendance & Quorum

5.2.1 The Audit & Risk Committee met formally on **four** occasions between 1 April 2024 and 31 March 2025. **Two** additional meetings were held to support the Annual Report and Accounts governance process.

5.2.2 The record of attendance of members at the committee is as follows:

	Name	Designation	Attendance Status	Number attended /Maximum number
	Mark Versallion	NED - Chair	Member	4/4
	Sarah Whiteman	NED	Member	2/4
	Gary Marven	NED – Chair (till June 2024)	Member	2/2
	Piers Ricketts	NED (from 1 December 2024)	Member	2/4
	Kate Jarman	Chief Corporate Services Officer	Member	3/4
	Jonathan Dunk	Chief Finance Officer	Member	3/4

5.2.3 The Trust Secretary had attended all meetings and was available throughout the financial year to advise and support the committee. Other Directors and staff had attended the committee meetings during the course of the financial year to present reports and to respond to queries from the committee. These have included the Chief Executive Officer, Deputy Chief Executive Officer, Chief Operations Officer, Chief Operations Officer.

5.2.4 In accordance with the Committee's Terms of Reference, the Internal Auditors (RSM), External Auditors (Grant Thornton), Transformation Consultants (PA Consulting), Local Counter Fraud (KPMG) had attended the committee meeting on different occasions during the financial year 2024-25 to present reports on their work and to respond to queries from the committee.

5.3 Assurance

5.3.1 The committee had maintained oversight and undertaken regular reviews of the Board Assurance Framework ('BAF'), Significant Risk Register and Corporate Risk register ('CRR') as appropriate to the purpose of all Board Committees at every meeting.

5.3.2 The committee had maintained oversight of the Trust's Declaration of Interest's register in line with its Terms of Reference

5.3.3 The committee reviewed and signed off the Trust's Risk Management Framework, Standing Financial Instruction (SFI) and Standing Orders (SO), and the Conflicts of Interest, Gifts, Hospitality, Sponsorship and Donations policy in line with its Terms of Reference.

5.3.4 During the 2024/25 financial year, the committee received regular updates at each meeting or regular intervals on the following:

- Internal Audit Progress Report
- Counter Fraud Progress Report
- Financial Controller's Report
- Waiver Report
- Health & Safety Report
- Information Governance & data Security and Protection Toolkit
- Business Continuity audit
- Audit & Risk Committee Terms of Reference
- External Audit Findings Improvement Action Plan

5.3.5 In line with its Terms of Reference, the committee had escalated all matters it considered required the Board attention to the Trust Board in 2024/25.

6 Appendices

6.1 The following are attached to this report:

Appendix 1 – Audit & Risk Committee Terms of Reference.

QUALITY & CLINICAL RISK COMMITTEE

Annual Review of Effectiveness 2024/25

Ganesh Baliah

Chair, Quality & Clinical Risk Committee

Oluwakemi Olayiwola

Trust Secretary

1. Purpose

1.1 The purpose of this report is to provide an update to the Trust Board on the work of the Quality & Clinical Risk Committee ('QCRC') over the past financial year with the aim of providing an assurance that the committee has carried out its roles and responsibilities in accordance with its terms of reference during the financial year 2024/25.

2. Background

2.1 Good practice requires that the Trust Board should review the performance of its committees annually to determine if they have been effective, and whether further development work is required. The QCRC is a committee of and accountable to the Board of Directors.

2.2 In line with the committee Terms of Reference, the committee is also required to annually review its own effectiveness and report the results of that review in an annual report to the Board.

2.3 This Annual Review of Effectiveness summarises the activities of the Trust's Quality & Clinical Risk Committee for the financial year 2024/25, setting out how it has met its Terms of Reference and key priorities.

3. Governance

3.1 The Quality & Clinical Risk Committee is a sub-committee of the Trust Board. The committee chair is responsible for escalating matters which the committee considers require highlighting to the Board when presenting the summary report of the committee's activities to the Trust Board.

3.2 The purpose of the Committee is contained in its Terms of Reference (Appendix 1). In summary, it is to provide assurance to the Board that the Trust is providing safe, effective and high-quality services to patients, supported and informed by effective arrangements for monitoring and continually improving the safety and quality of care, and the patient experience. It will receive information from the CSUs and Divisions via the Trust Executive Committee and will, where necessary, escalate issues to the Board.

3.3 Dev Ahuja was appointed Chair of the Quality & Clinical Risk Committee in June 2023 till November 2024.

3.4 The QCRC Terms of Reference were reviewed and approved at the Trust Board on 14 November 2024 for the 2025/26 financial year. The Terms of Reference is scheduled on the committee's forward agenda plan for a review on 15 September 2025, following which a recommendation will be made to the 6 November 2025 Trust Board for approval.

4 Evaluation of Effectiveness of Members & Attendees

4.1 An evaluation of effectiveness of the committee was undertaken in April 2024 in accordance with the committee's Terms of Reference. A self-evaluation tool was used as the survey instrument that was circulated to members and attendees.

4.2 12 members and attendees were asked to provide a rating between 1 to 5 for each question

(1= strongly disagree, 5 = strongly agree). 5 members and attendees provided responses, and the results were analysed by averaging the scores for each question.

4.3 The overall rating and comments demonstrated a **neutral response (3.5)** to the committee's function and performance.

4.4 Feedback includes that the Trust will benefit from extensive discussions around National quality reports through the committee. It was also highlighted that assurances could be more robust with regards to action plan follow through.

4.5 Suggested areas for improvement were discussed at the QCRC held on 3 June 2024 and proposed actions were implemented in the course of the financial year.

5 Review of Committee Activities against its Terms of Reference

5.1 Membership

5.1.1 QCRC maintains a record of membership in accordance with its Terms of Reference. As of 31 March 2025, the following persons were members and attendees of the Committee:

Members		Attendees	
Dev Ahuja	NED – Chair (Till 30 November 2024)	Vicky Alner	Medical Director - Unplanned Care
Heidi Travis	Trust Chair	Anna O'Neil	Patient safety specialist
Sarah Whiteman	NED	Julie Orr	Associate Chief Nurse
Gary Marven	NED- SID	Tina Worth	Head of risks & Clinical Governance
Ganesh Baliah	NED	Marsha Jones	Deputy Chief Nurse
Piers Ricketts	NED (from 1 December 2024)	Anna Costello	Patient safety specialist
Joe Harrison	Chief Executive Officer		
Ian Reckless	Chief Medical Officer		
Fiona Hoskins	Chief Nursing Officer		
Kate Jarman	Chief Corporate Services Officer		

5.2 Meetings Attendance & Quorum

5.2.1 The QCRC met formally on four occasions between 1 April 2024 and 31 March 2025.

5.2.2 The record of attendance of members at the committee is as follows:

	Name	Designation	Attendance Status	Number attended /Maximum number
1	Dev Ahuja	NED - Chair	Member	2/2
2	Heidi Travis	Trust Chair	Member	4/4
3	Gary Marven	NED -SID	Member	3/4
4	Sarah Whiteman	NED	Member	3/4
5	Ganesh Baliah	NED	Member	1/2
6	Piers Ricketts	NED	Member	2/2
7	Joe Harrison	Chief Executive Officer	Member	3/4
8	Ian Reckless	Chief Medical Officer	Member	4/4
9	Fiona Hotchkins	Chief Nursing Officer	Member	2/3
10	Emma Livesley	Chief Operations Officer	Member (till June 2024)	1/1
11	Kate Jarman	Chief Corporate Services Officer	Member	4/4

5.2.3 Throughout the year in review, the Trust Secretary, along with the Committee Secretary, attended all committee meetings. The Secretary was consistently available to provide advice and support, ensuring the committee performed its responsibilities in accordance with its terms of reference.

5.2.4 Other Directors and staff attended meetings during the course of the financial year to present reports and to respond to queries from the committee. These have included the Chief Finance Officer, Deputy Chief Finance Officer, Deputy Chief Executive Officer, Chief Operations Officer (planned care), Chief Operations Officer (unplanned care) and Head of Quality Improvement.

5.3 Assurance

5.3.1 The committee had maintained oversight and undertaken regular reviews of the Board Assurance Framework ('BAF') and Corporate Risk register ('CRR') as appropriate to the purpose of the Quality & Clinical Risks at every meeting.

5.3.2 The committee reviewed and reported progress against the 2024/25 quality priorities as well as recommended for approval to the Council of Governors and Trust Board, the quality priorities for the 2025/26 Financial year.

5.3.3 During the 2024/25 financial year, the QCRC received regular updates at each meeting or regular intervals on the following:

- Quality Dashboard
- Clinical Quality Updates
- Drafts Minutes from Patient Safety Board, Patient Experience Board and Maternity Assurance Group
- Divisional Presentations
- Quarterly Patient Experience Report

- Quarterly Complaints Report
- Quarterly Mortality Update
- Safeguarding update
- Emergency Preparedness, Resilience & response
- Infection Prevention and Control
- Research and Development

5.3.4 In line with its Terms of Reference, the committee had escalated all matters it considered required the Board attention to the Trust Board in 2024/25.

5.3.4 The committee certifies that it has met its Terms of Reference and key priorities during the financial year in review.

6 Appendices

6.1 The following are attached to this report:

Appendix 1 – Quality & Clinical Risk Terms of Reference.

TheMKWay

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Meeting Title	**TRUST BOARD (PUBLIC)**	**Date: 1 May 2025**
Report Title	Use of Corporate Seal	**Agenda Item Number: 20**
Lead Director	Kate Jarman, Director of Corporate Services	
Report Author	Timi Achom, Assistant Trust Secretary	

Introduction	To update the Trust Board on the use of the Corporate Seal in accordance with the Trust's Constitution		
Key Messages to Note	Trust Board to NOTE.		
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Review** [ ]

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	1. *Spending money well on the care you receive* 2. *Expanding and improving your environment* 3. *Innovating and investing in the future of your hospital*

Report History	*Standing Agenda Item*
Next Steps	*N/A*
Appendices/Attachments	Schedule of Use of Corporate Seal

TheMKWay

NHS
Milton Keynes University Hospital
NHS Foundation Trust

SCHEDULE OF USE OF CORPORATE SEAL 2024/25

	Description	Parties	Purpose	Value	Date	Signatories
1	Professional Services	Milton Keynes University Hospital NHS Foundation Trust and Fiva Landscapes Ltd	Contract for the provision of landscape architects for the New Hospital and refurbished Day Surgery Unit	N/A	28/03/2025	John Blakesley – Chief Strategic Development Officer Kate Jarman – Chief Corporate Services Officer

Milton Keynes University Hospital NHS Foundation Trust

TRUST BOARD MEETING IN PUBLIC

Forward Plan 2025-26

	Agenda Item	Lead	Purpose	Frequency Paper(P)/Verbal (V)	Seminar 03/04/2025	Formal 01/05/2025	Seminar 05/06/2025	Formal 03/07/2025	Formal 04/09/2025	Seminar 02/10/2025	Formal 06/11/2025	Seminar 04/12/2025	Formal 08/01/2025	Seminar 05/02/2026	Formal 05/03/2026
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	Assurance Discuss	Standing Item (V)		■		■	■		■		■		■
8	Patient Story/Staff Story	Chief Nursing Officer	Assurance Discuss	Standing Item (P)		■		■	■		■		■		■
9	Nursing Workforce Update	Chief Nursing Officer	Assurance Discuss	Standing Item (P)		■		■	■		■		■		■
10	Performance Report	Chief Operating Officer	Assurance Discuss	Standing Item (P)		■		■	■		■		■		■
11	Finance Report	Chief Finance Officer	Assurance Discuss	Standing Item (P)		■		■	■		■		■		■
12	Workforce Report (-IPR?)	Chief People Officer	Assurance Discuss	Standing Item (P)		■		■	■		■		■		■
13	Patient Safety Update (-IPR)	Officer/Chief Corporate Services Officer	Assurance Discuss	Standing Item (P)		■		■	■		■		■		■
14	Objectives Update	Chief Executive	Assurance Discuss	(P)									■		
15	Equality, Diversity & inclusion (ED&I) Update	Chief People Officer	Assurance Discuss	(P)					■						
16	and Board Assurance Framework Sign Off	Chief Nursing Officer	Assurance Discuss	(P)									■		
17	Progress update – 2025/26 Quality Priorities	Chief Corporate Services Officer	Assurance 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 Discuss	(P)		■									
20	Annual Claims Report	Chief Medical Officer	Assurance Discuss	Annually (P)		■									
21	Falls Annual Report	Chief Nursing Officer	Assurance Discuss	Annually (P)		■									
22	Freedom to Speak Up Guardian Report	Chief People Officer	Assurance Discuss	(P)				■					■		
23	Pressure Ulcers Annual Report	Chief Nursing Officer	Assurance Discuss	Annually (P)				■							

24	Green Plan Update	Chief Finance Officer	Assurance Discuss	(P)											
25	Green Plan Update (C/F from July 2025)	Chief Finance Officer	Assurance Discuss	(P)											
27	Mortality Update	Chief Medical Officer	Assurance Discuss	(P)											
28	Safeguarding Annual Report	Chief Nursing Officer	Assurance Discuss	Annually (P)											
29	Research & Development Annual Report	Chief Medical Officer	Assurance Note	Annually (P)											
30	Emergency Preparedness, Resilience and Response Annual Report	Chief Operating Officer	Assurance Note	(P)											
31	Annual Complaints Report	Chief Corporate Services Officer	Assurance Discuss	Annually (P)											
32	Annual Patient Experience Report	Chief Corporate Services Officer	Assurance Discuss	Annually (P)											
33	Patient Safety Incident Response Framework, PSIRF – Policy and Plan	Chief Medical Officer	Assurance Discuss	(P)											
34	Antimicrobial Stewardship - Annual Report	Chief Medical Officer	Assurance Discuss	Annually (P)											
35	Infection Prevention and Control Annual Report	Chief Nursing Officer	Assurance Discuss	(P)											
36	Patient Experience Report	Chief Corporate Services Officer	Assurance Discuss	Standing Item (P)											
37	Maternity Assurance Group Update	Chief Nursing Officer	Assurance Discuss	Standing Item (P)											
38	Summary Reports from Board Committees	Chairs of Board Committees	Assurance Information	Standing Item (P)											
39	Update to the Terms of Reference of the Board and its Committees	Chief Corporate Services Officer	Assurance Approve	Annually (P)											
40	Significant Risk Register Report	Chief Corporate Services Officer	Assurance Discuss	Quarterly											
41	Board Assurance Framework	Chief Corporate Services Officer	Assurance Discuss	Standing Item (P)											
42	Trust Seal	Chief Corporate Services Officer	As required	(P)											
43	Forward Agenda Planner	Chair	Administration and Closing Information	Standing Item (P)											
44	Questions from Members of the Public	Chair	Administration and Closing Receive and Respond	Standing Item (V)											
45	Motion To Close The Meeting	Chair	Administration and Closing Receive	Standing Item (V)											
46	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												

	Board Informal meeting & Dinner	All	Informal												
	The Trust's representations on the BLMK ICB and ICP, and the implications thereof	Chief Executive	Assurance												