Bundle Trust Board Meeting in Public 6 July 2023

1.1 Agenda
    1. Agenda Board Meeting in Public - 06.07.23
1.2 Apologies
2 Declarations of Interest
3 Patient Story
Director of Patient Care and Chief Nurse
4 Minutes of the Last Meeting
Chair
    4. Minutes Trust Board Meeting in Public 04.05.23 AD reviewed.docx
5 Matters Arising and Action Log
Chair
    5. Board Action Log 28.06.23.pdf
6 Chair's report
Chair
    6a. coversheet July 2023.docx
    6b. Chair report.docx
7 Chief Executive's Report
Chief Executive - Verbal
7.1 BLMK Health and Care Partnership and Integrated Care Board Update
Chief Executive
    7. ICB Board Meeting - June 2023 - Final_
8 Serious Incident and Learning Report
Director of Corporate Affairs/ Medical Director
    8. SI report Q4 2022 - 2023 June 2023 meeting final with new front sheet.docx
9 Performance Report
Chief Operations Officer
    9a. 2023-24 Executive Summary M02 Coversheet.docx
    9b. 2023-24 Executive Summary M02.docx
    9c. 2023-24 Board Scorecard M02.pdf
10 Finance Report
Director of Finance
    10. Public Finance Report Month 2.docx
Director of Workforce

11. July 23 Workforce Report M2.docx

12 Annual Claims Report
Medical Director
12. Annual Claims Report 2022 - 2023.doc

13 Antimicrobial Stewardship Annual Report
Medical Director
13a. AMS annual report 2022-23_IR - cover sheet.docx
13b. AMS annual report 2022-23_IR 1.docx

14 Falls Annual Report
Director of Patient Care and Chief Nurse
14. Fall Annual Report 2223
14.1 Annual Falls Report 2223.edited

15 Hospital Acquired Pressure Ulcers Annual Report
Director of Patient Care and Chief Nurse
15a. MKUH HAPU Annual Report Cover page May 23.docx
15b. HAPU ANNUAL Report (2223).docx

16 Freedom To Speak Up Annual Review
Director of Workforce
16a. July 23 Board FTSU report and vision.docx
16b. Annual Freedom To Speak Up Report.docx

17 Risk Register Report
Director of Corporate Affairs
17a. Public Board - 6th July 2023 - Risk Register
17b. Corporate Risk Register - as at 29th June 2023.pdf
17c. Significant Risk Register - as at 29th June 2023.pdf

18 Board Assurance Framework
Director of Corporate Affairs
18. Board Assurance Framework July 23.docx

19 Summary Reports
Chairs of Board Committees
19.1 Audit Committee Summary Report 18.04.2023
19.2 Audit Committee Summary Report 25.05.2023
19.3 Audit Committee Summary Report 23.06.2023
19.4 FIC 07.03.2023 Board Committee Summary Report
19.5 FIC 04.04.2023 Board Committee Summary Report
19.6 FIC 02.05.2023 Board Committee Summary Report
19.7 TEC Board Committee Summary Report 08.03.23
19.8 TEC Board Committee Summary Report 10.05.23

19.9 TEC Board Committee Summary Report 14.06.23
19.10 Quality and Clinical Risk Committee Summary Report 12.03.23
19.11 Quality and Clinical Risk Committee Summary Report 05.06.23
19.12 Charitable Funds Committee Summary Report
19.13 Charitable Funds Committee Summary Report
19.14 WDAC 15.05.23 Board Committee Summary Report

20 Use of Trust Seal
Director of Corporate Affairs
20. Use of Trust Seal July 2023.docx

21 Forward Agenda Planner
Chair
21. Trust Board Meeting In Public Forward Agenda Planner v 3.docx

22 Questions from Members of the Public
Chair

23 Motion To Close The Meeting
Chair

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

25 Next Meeting Date
Next Meeting in Public: Thursday, 07 September 2023

Agenda for the Board of Directors' Meeting in Public

Meeting to be held at 10:00 am on Thursday 06 July 2023
in the Conference Room at the Academic Centre and via MS Teams

Item No.	Timing	Title	Purpose	Lead	Paper
Introduction and Administration					
1	10:00	Apologies	Receive	Chair	Verbal
2		Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda • 2022/23 Register of Interests – Board of Directors - Register of Interests - Milton Keynes University Hospital (mkuh.nhs.uk)	Information	Chair	Verbal
3		Patient Story	Receive and Discuss	Director of Patient Care and Chief Nurse	Presentation
4		Minutes of the Trust Board meeting held in public on 04 May 2023	Approve	Chair	Attached
5		Matters Arising and Action Log	Note	Chair	Attached
Chair and Chief Executive Updates					
6	10:30	Chair's Report	Information	Chair	Attached
7	10:35	Chief Executive's Report • BLMK Health and Care Partnership and Integrated Care Board Update	Receive and Discuss	Chief Executive	Verbal Attached

Our Values: We Care-We Communicate-We Collaborate-We Contribute

Board Behaviours: Kindness-Respect-Openness

Patient Safety					
8	10:45	Serious Incident and Learning Report	Receive and Discuss	Director of Corporate Affairs/ Medical Director	Attached
Performance					
9	10:50	Performance Report	Receive and Discuss	Chief Operations Officer	Attached
Finance					
10	11:00	Finance Report	Receive and Discuss	Director of Finance	Attached
Workforce					
11	11:10	Workforce Report	Receive and Discuss	Director of Workforce	Attached
Assurance and Statutory Items					
12	11:15	Annual Claims Report	Receive and Discuss	Medical Director	Attached
13	11:20	Antimicrobial Stewardship Annual Report	Receive and Discuss	Medical Director	Attached
14	11:25	Falls Annual Report	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached
15	11:30	Hospital Acquired Pressure Ulcers Annual Report	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached
16	11:35	Freedom To Speak Up Annual Review	Receive and Discuss	Director of Workforce	Attached
17	11:40	Risk Register Report	Receive and Discuss	Director of Corporate Affairs	Attached
18	11:45	Board Assurance Framework	Receive and Discuss	Director of Corporate Affairs	Attached
19	11:50	(Summary Reports) Board Committees • Audit Committee 18/04/2023, 25/05/2023 and 23/06/2023 • Finance Committee 07/03/2023, 04/04/2023 and 02/05/2023	Assurance and Information	Chairs of Board Committees	Attached

		• Trust Executive Committee 08/03/2023, 10/05/2023 and 14/06/2023 • Quality & Clinical Risk Committee 12/03/2023, and 05/06/2023 • Charitable Funds Committee 16/02/2023 and 17/04/2023 • Workforce and Development Assurance Committee 18/05/2023			
20		Use of Trust Seal	Note	Director of Corporate Affairs	Attached
Administration and Closing					
21		Forward Agenda Planner	Information	Chair	Attached
22		Questions from Members of the Public	Receive and Respond	Chair	Verbal
23		Motion To Close The Meeting	Receive	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	

Our Values: We Care-We Communicate-We Collaborate-We Contribute

Board Behaviours: Kindness-Respect-Openness

12:00	Close
Next Meeting in Public: Thursday, 07 September 2023	

BOARD OF DIRECTORS MEETING

Minutes of the Trust Board of Directors Meeting in Public held on Thursday, 4 May 2023 at 10.00 hours in the Academic Centre, Milton Keynes University Hospital Campus and via Teams

Present:

Alison Davis	Chair	(AD)
Professor Joe Harrison	Chief Executive Officer	(JH)
Heidi Travis	Non-Executive Director / Senior Independent Director	(HT)
Bev Messinger	Non-Executive Director	(BM)
Dr Dev Ahuja	Non-Executive Director	(DA)
Gary Marven	Non-Executive Director	(GM)
John Blakesley	Deputy Chief Executive	(JB)
Dr Ian Reckless	Medical Director & Deputy Chief Executive	(IR)
Danielle Petch	Director of Workforce	(DP)
Yvonne Christley	Director of Patient Care and Chief Nurse	(YC)
Emma Livesley	Director of Operations	(EL)
Terry Whittle	Director of Finance	(TW)

In Attendance:

Kate Jarman	Director of Corporate Affairs	(KJ)
Jason Sinclair	Associate Non-Executive Director	(JS)
Ganesh Baliah	Associate Non-Executive Director	(GB)
Liz Winter (Item 3)	Divisional Chief Nurse for Medicine	(LW)
Sophie Clarke (Item 3)	Haemoglobinopathy Nurse	(SC)
Melissa Davies (Item 9)	Head of Midwifery, Gynaecology & Paediatrics (For Item 12)	(MD)
Kwame Mensa-Bonsu	Trust Secretary	(KMB)
Julia Price	Senior Corporate Governance Officer	(JP)

1 Welcome and Apologies

1.1 AD welcomed all present to the meeting. There were apologies from Mark Versallion (Non-Executive Director), Haider Husain (Non-Executive Director) and Precious Zumbika-Lwanga (Associate Non-Executive Director)

2 Declarations of interest

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

3 Patient Story

3.1 YC introduced LW and SC who presented the journey of a sickle-cell patient through the Emergency Department (ED), being admitted and subsequently discharged. SC explained that sickle cell disease is the name for a group of inherited health conditions that affect the red blood cells. It is a life-long condition and patients attend the ED most frequently suffering from excruciating pain. NICE (National Institute for Health and Care Excellence) guidance indicates treating patients with opiate analgesia within 30 minutes of arrival and SC explained that reducing patients' pain quickly results in a shorter length of stay.

3.2 The patient was born with sickle cell disease and was aware of the treatment she required to avoid becoming very unwell. She attended the ED in extreme pain and was very difficult to cannulate which is often the case for people in sickle cell crisis. The patient was triaged straightaway but had to wait over an hour for morphine to be prescribed, a cannula inserted and medication to be administered. LW explained that part of the reason for the delay was locating a person with the right skills to cannulate, given the known difficulties around this for sickle cell patients in crisis. SC saw the patient within 90 minutes by which time she was feeling more comfortable. However, once the analgesia had worn off, the patient felt that the response to her request for more analgesia was inadequate. She was informed that there was no PCA (patient controlled analgesia) machine available anywhere in the Trust which she accepted but her pain score and medication were not reviewed. The patient was moved to Ward 1 and then to Ward 25 appropriately but by the time a PCA was located, the patient needed to be cannulated again. The clinician did not heed the patient's advice in obtaining an ultrasound machine to assist with this, however. The patient spent four days in hospital and, LW and SC advised could have been reduced to two days had her pain had been brought under control more quickly.

3.3 The patient felt that the Trust's sickle cell protocol was not detailed enough and that patients are best placed to know their requirements for pain control. She was very disheartened with the treatment she received.

3.4 LW explained that under the new complaints process, she made early contact with the patient and was able to avoid the situation becoming a formal complaint. In response to the concerns raised, the following measures were being put in place.

- The triage standard operating procedure was being updated and staff reminded how to escalate when a patient is in extreme pain.
- The sickle cell protocol was being put in place together with various training sessions particularly for ED staff which would be repeated on a rolling basis for new staff.
- 25 PCA machines were ordered in December, however they did not arrive until the beginning of April and staff were being trained to use the new equipment.
- A PCA machine would be made available at all times in the Medical Equipment Library and one would be solely for ED use.

3.5 In response to a question, SC clarified that the patient was not a regular attender and was rarely admitted so did not have a personalised plan. It was explained that there were around 150 sickle cell patients in Milton Keynes. After discussion, a means of alerting clinicians through eCARE when a sickle cell patient came into hospital was proposed. However, IR highlighted the problems for non-Milton Keynes residents.

3.6 Regarding the management of pain relief, YC highlighted the need for a detailed protocol and pathway for staff to work and engage with sickle cell patients, commenting on how the complaint had raised important issues that should be addressed.

3.7 IR commented that the patient's treatment could have been suboptimal due to staff fears of getting it wrong and welcomed the training programme for sickle cell disease. SC added that in addition to staff's fears, patients are often terrified of attending hospital. He asked whether there was any improvement in attitudes towards drug-seeking behaviours here and SC advised that she was working hard to change attitudes.

3.8 GM asked whether the availability of Patient-controlled Analgesia (PCA) machines was known prior to this incident and SC advised that it had been escalated. As Chair of Clinical Board Investment Group (CBIG), IR advised that he would check to see where this had been discussed. It was pointed out that the Medical Equipment Library would be aware of shortages of equipment and a process should be in place for them to escalate.

Action: IR to establish where discussions had taken place around the procurement of PCA machines and why there was a 4-5 month time-lag between order and delivery.

3.9 In response to a question from HT, SC advised that she was responsible for supporting staff in ED as soon as she becomes aware of a sickle cell patient attending. There were also two Band 7 nurses in the ED focusing on practice development and sickle cell disease. LW stated that they were in the process of ensuring that a Band 7 was always on shift fully appraised of the sickle cell protocol.

3.10 On behalf of the Board, AD thanked LW and SC for the presentation.

4 Minutes of the Trust Board Meeting in Public held on 09 March 2023

4.1 The minutes of the Trust Board Meeting in Public held on 9 March 2023 were reviewed and **approved** by the Board.

5 Matters Arising

5.1 With regard to Action 32 (an explanation of error markers to be placed in iBabs for reference) with a completion date of June 2023, JB advised that a graphics bar would be attached to the report as an aide memoire and a longer report would be added to iBabs.

6 Chair's Report

6.1 The report was taken as read and AD added that the topping out ceremony for the radiotherapy centre would be taking place in the afternoon.

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

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

7.1.1 Bedford, Luton and Milton Keynes (BLMK) Health and Care Partnership and Integrated Care Board Update

JH highlighted four aspects from the update:

1. The submission of a balanced operational plan for 2023/24.
2. The forward plan for BLMK and the generic issue of population growth headed by Bedford. JH advised that looking at volume growth, Milton Keynes also stood out significantly. This was a big challenge for all parts of BLMK and a continuing theme of discussions was how to ensure that the right things were being done at both place and integrated care system (ICS) levels.
3. Subsidiarity principles needed embedding in both working and resource allocation across the ICS.
4. JH was pleased to report that partnership working and relationships had never been stronger within Milton Keynes place and work around the MK Deal was going well.

7.1.2 GM asked if there was particularly high growth in over 65s and JH advised that there was a differential between actuals and percentages. He explained that in Milton Keynes the population was aging and additionally, the availability of proportionately reasonably priced housing meant that elderly parents of local residents were moving to Milton Keynes at a rate above the national average.

7.1.3 HT asked whether the Trust was challenged in dealing with the backlog whilst focusing on the Integrated Care Board's (ICB) long term plan and JH advised that the issues with BLMK were no different from the two biggest national challenges. Namely, around how the appropriate workforce manages the changing population and how people could manage their own care better. He explained that the organisation sat comfortably within those two aims. There was a discussion on whether the Trust's strategy should be focused on key services or on technology and workforce. HT felt that the latter underpinned the former.

7.1.4 AD suggested that the BLMK partnership approach referenced within the report could be demonstrated more strongly with more examples from adult social care and the third sector.

7.2 JH highlighted the following as part of his overall report:

1. The Trust had not been impacted by the recent nurses strike as the proportion of those voting for a strike was insufficient to meet the threshold. However, of those who did vote the vast majority of nurses had voted for strike action. He had recently signed off a number of letters to clinicians recognising their contribution during the recent junior doctors' strike.
2. Samantha Penny (Staff Nurse), a champion for deaf people at the hospital, was instrumental in bringing SignLive to the organisation, an on-demand interpreting service, and JH advised that a demonstration could be organised for Board if desired.
3. There was a reduction in the number of attendances to the Emergency Department on the last Bank Holiday Monday followed by a significant increase on the Tuesday, causing operational difficulties.
4. JH thanked TW and his team for submitting the accounts on time adding that it is taken for granted that this occurs every year but it is not always straightforward with timescales getting tighter each year. AD added the Boards thanks for this achievement.
5. FestivALL, replacing the annual Event in the Tent, had begun and would run over four months incorporating many events on a daily and weekly basis. These were being recorded.

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

8 Serious Incident and Learning Report

8.1 IR presented the report and highlighted the five serious incidents that had occurred in March and April and which were currently under investigation. He welcomed the report's focus on trends and learning from previous incidents. Referencing the anticipated Preventing Future Deaths notice from HM Coroner, IR reported that the inquest had been challenging and focused on the management of sepsis and the hospital's electronic patient record system. The good collaboration with the ICB was noted regarding the implementation of the Patient Safety Incident Report Framework (PSIRF) and the loan of an experienced member of staff to help manage that change. Noting the system changes to Radar (the hospital's risk and reporting system) required ahead of the PSIRF implementation, IR reminded the Board that Radar replaced Datix and this was considered more intuitive and user-friendly. At the same time, however, a new national form was introduced within the system: Learning From Patient Safety Events, which had proved cumbersome, taking up to 20 minutes to complete. This was being discussed at a national level and the Trust continued to raise concerns with the national team.

8.3 KJ advised that there was going to be a trust-wide focus on sepsis care with an improvement project specifically aimed at the Emergency Department and she would be reporting back on progress.

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

9 Feedback from Maternity Assurance Group (MAG)

9.1 YC invited MD to provide feedback and advised that going forward the acronyms within the report would be written in full. MD reminded the Board that MAG was a monthly meeting where quality and surveillance data and hotspots were discussed. She highlighted the following from the report.

1. New items had been added to the risk register:
   a. The backlog in scanning CTG (cardiotocography) traces on to the electronic document management (EDM) system mitigated by keeping all CTG traces in paper form.
   b. Obstetric scanning capacity. This was not unique to MKUH. The referral criteria were being reviewed to enable efficient use of capacity.
2. The Perinatal Mortality Review Tool (PMRT) quarterly report had been received. Some of the themes included documentation of routine enquiry for women booking for pregnancy care. Carbon monoxide (CO) monitoring had significantly improved at booking and the 36 week contact but more

work was required to improve monitoring for every woman who is a known smoker at every booking and every subsequent contact.
3. The Did Not Attend (DNA) policy was being rewritten to incorporate different means to inform people of their appointments to accommodate and reflect the diverse needs of our population and reduce missed appointments.
4. The Bereavement Midwife was working on the bereavement checklist to ensure all relevant information is available for teams.
5. The Avoiding Term Admissions Into Neonatal Units (ATAIN) rate was 5.6, below the national average of 6 and the rolling action plan was half complete. Respiratory causes were the main reasons for admission nationally. In addition, the admissions between 35 and 36 +6 weeks for the last quarter were reviewed. The main aim of the review was to understand whether these babies would have needed to go to the neonatal unit if transitional care capacity was in place. The outcome was that the majority of babies were admitted for respiratory causes of which 48% would have required admission to the neonatal unit. A business case was underway for more transitional care capacity.

9.2 Regarding the new risk around CTG traces, JH commented on the challenge of ensuring CTGs were automatically saved electronically, in a bid to remove all paper from the organisation. This would also save midwives' time. JB advised that the capture of CTGs was due to be rolled out at the end of 2024 but could be prioritised if desired at the expense of another area.

The Board **noted** the feedback from the Maternity Assurance Group.

10 Performance Report for Month 12 (March 2023)

10.1 EL presented the report and reminded the Board that the Trust had been consistently reporting a comparatively good emergency performance throughout the year. However, there was significantly high attendance in March and the four hour target had reduced to 76%. From an elective forecast position, the list of 104-week waiters had been cleared and the next challenge was to clear the 78-week waiters. The year ended on the forecast position of 20 patients in Orthopaedics where the challenges within that service had previously been reported. EL highlighted that there were over 2000 2-week wait patients at the end of the year, with a similar position in month, where pre-pandemic, there would not have been any. Diagnostics showed a good recovery in year and the Board were reminded of the significant investment into that area.

The hospital was currently full with escalation capacity open and operationally, the junior doctors strike had been well managed with good decompression beforehand and people heeding advice not to attend the Emergency Department. EL commented on how well the organisation and local partners come together to reduce the number of non-criteria to reside patients on occasions but the position was always unsustainable on a daily basis. Outpatients were badly impacted by the 72 hours of strike action where 800 clinic appointments were cancelled to release clinicians to cover inpatient areas. EL stated that going forward the elective performance needed to improve.

10.2 AD noted that some patients choose to wait for treatment and asked if this had an impact on the backlog figures. EL advised that this was rarely the case.

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

11 Finance Report for Month 12 (March 2023)

11.1 TW reported that the audit of the draft accounts was underway and was expected to complete by mid-June.

11.2 The Trust reported a £5m deficit at year end. This was £5m worse than plan as a result of significant investment at the start of 2022/23 which was not reimbursed from the Elective Recovery Fund due to changes in national policy during the year. The shortfall was mitigated by the Trust throughout 2022-23 with the requirement to break even. There had been ongoing conversations with integrated care system partners and NHS England to progress that position. Agreement with NHS England was

reached in March that the Trust would not be required to offset the shortfall. JH clarified that the £5m deficit reported for 2022/23 was reported in consultation and by agreement with NHS England and the Trust would not be penalised for this in anyway.

11.3 Referencing the adjustments in the Month 12 position, TW explained that costs had been set aside for the national pay negotiations in Month 12 which remained unresolved at that time. In addition, costs for the pension settlement had also been set aside. TW explained the Trust makes a contribution of around 14% for staff with 6% being received centrally from NHS England for the balance.

11.4 The Trust reported just under 70%, at £8.3m, of the financial efficiency target of £12m for the year. The national figures were awaited but comparatively, TW advised that this was a strong performance in aggregate but like every organisation, more work needed to be done around recurrency of those savings and in addressing the shortfall. This would cause an underlying pressure in the position for 2023/24 and more priority and focus would therefore be given to productivity and cost control throughout the year.

11.5 Highlighting what appeared to be a significant overspend on capital, TW explained that the capital spend was just over £30m and the difference between that and the planned figure at the beginning of the year was due to new schemes that had been authorised through central funding released through central programmes from NHS England. At year end, there was an overspend of £600k by prior agreement with system partners, against the agreed capital spending budget for the year, offset by an underspend at Bedford Hospital.

11.6 Currently, the finance team were focusing on a successful audit outcome and with working with the Trust's new auditors, Grant Thornton. The planned position for 2023/24 was agreed last week and the team would now be focusing on delivery.

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

12 Workforce Report for Month 12 (March 2023)

12.1 DP highlighted the following from the report.

1. An anticipated increase in temporary staffing usage for Month 1 (2023-24) due to industrial action.
2. A reduction in vacancy rates at 7.4% with over 4100 staff in post, 240 more than for the same period in 2022-23.
3. Staff absence was 4.2% with more people coming into long term sickness absence and processes were being reviewed to ensure staff were being effectively supported.
4. Turnover, which had grown steadily during the year, was reducing as a result of the huge amount of work going on to support departments. It was noted that turnover would take time to change.
5. A significant amount of work was being done to bring down time to hire from around 90 days to 41 and DP highlighted the importance of this metric within a competitive marketplace with applicants likely to be receiving multiple job offers.
6. Statutory mandatory training and appraisals remained on target.
7. Nursing vacancies had reduced as a result of both domestic and international recruitment but healthcare support worker vacancies remained stubbornly high. The team had been asked to focus on this. DP highlighted the competition in Milton Keynes for this workforce area.
8. WRES (race equality) and WDES (disability equality) data would be shared at Workforce Development and Assurance Committee later in the month before presentation at the next Board meeting.
9. A significant amount of work was undertaken by the apprenticeship team to ensure the best use was being made of the Apprenticeship Levy.

12.2 GM asked what level of confidence there was that the turnover rate would continue to fall and DP responded that there was evidence that the interventions were having an impact with people withdrawing their resignations. She added that some people who had left the organisation a few months ago were reapplying. It was explained that there was no deadline against the 9% target.

12.3 GB asked if there was any data around the patient journey as a result of the high vacancy rate for healthcare science posts and he was advised that pharmacists formed the biggest cohort within this group for which there were national recruitment issues but progress was being made. Every attempt was being made to cover gaps with agency and therefore the impact was more on cost than human resource.

12.4 Regarding time to hire, BM enquired where this was measured from and to, and whether the changes were ongoing. DP explained that this was measured from permission to recruit to an unconditional offer. The process was now more digital which was having a positive impact but any role involving a visa, of which there were currently a great many, took a long time. Other roles could take around 29 days.

12.5 JH advised the Board that the Trust was in the top quartile on sickness rates at 4.9% which was reassuring. However, staff surveys indicated that people still wanted to come to work even when they did not feel well enough, highlighting the dangers of taking a metric in isolation. He added that it would be concerning if the sickness rate and turnover rate were both poor.

The Board **noted** the Workforce Report for Month 12.

13 Risk Register Report

13.1 KJ advised that the report provided a detailed summary of the movement of the risks on the corporate register adding that risks were reviewed and monitored by the central risk team. The new ones were a mixture of HR and clinical risks. Where a risk increases, risk owners were encouraged to capture the reason on Radar and training on the system was ongoing. The risk assessment process had been changed to align with health and safety risk processes.

13.2 AD queried whether there was a standard trigger time for overdue risks and KJ responded that this was detailed in the risk management framework and was monitored. The Risk Manager and KMB regularly met with teams and encouraged them to review their risks. GM added that they were reviewed in Audit Committee but small and low risks would not be a cause for concern.

The Board **noted** Risk Register Report.

14 Board Assurance Framework

14.1 KJ acknowledged that there was more work to be done around individual risks and owners would continue to be met with, to ensure they were kept up to date.

14.2 JH highlighted Risk 5 (Suboptimal head and neck cancer pathway) and reminded the Board of the organisation's desire to become the spoke to the Oxford University Hospitals hub instead of Northampton General Hospital. The lack of a timeframe for this had been escalated at both a regional and national level.

14.3 EL advised that Risks 2 and 3 (patients experiencing poor care or avoidable harm due to delays in planned care and due to inability to manage emergency demand) had been updated since the pack was issued.

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

15 Use of Trust Seal

15.1 The Board **noted** the use of the Trust Seal

16 Forward Agenda Planner

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

17 Questions from Members of the Public

17.1 Miss B Bromige:

"As a patient of Milton Keynes hospital my journey within the hospital has not been the best and aftercare and care at the hospital has been lacking. As a sepsis survivor I have found that my care has been shocking. What is going to be done to change the aftercare and how patients are treated? Staff do not seem to grasp how serious it actually is and I have seen and heard stories of where people have been sent home while septic."

Trust Response:
KJ was in the process of arranging to meet with Miss Bromwich to understand her experience in a bit more detail and to establish what the organisation could do better. YC advised that a new sepsis training programme for the Emergency Department was about to start and was more in depth than for other areas of the hospital. In terms of the deteriorating patient and discharge processes, a new suite of adult metrics designed by clinical teams and patients had just been completed. Additionally, dedicated and detailed audits were being put in place around sepsis management more generally.

17.2 Mr A Hastings:

"How will MKUH check the current medical condition of patients who have had their surgery/treatment delayed by recent industrial disputes, how will such patients be prioritised for receiving their necessary surgery/treatment and what happens to those with current appointments that will almost certainly need to be postponed to fit in the earlier delays?"

Trust Response:
JH advised that as reported previously, a harm review would routinely be carried out by clinicians for patients waiting more than 78 weeks which will reduce to 65 weeks this year. Patients affected by the strike would be reappointed and cancelled operations rescheduled where possible within 28 days. Additional clinics were being run to manage this. JH asked that patients who felt they needed to be prioritised raised this with their GPs. IR reiterated that patients do not go to the bottom of a list when their appointments were cancelled and the Trust would use 'firebreak' clinics for patients affected by the junior doctor strikes. However, it was highlighted that with continued disruptions from industrial action these would fill quickly.

17.3 Ms V Bell:

"Because meat, dairy and fish consumption and production are destroying the planet and people's health, and causing world hunger, the American Medical Association has urged hospitals to drop processed meats and increase plant-based foods, and the American Journal of Cardiology has stressed "the moral imperitive of the medical profession to promote plant-based nutrition".
Also, in an open letter to the NHS, a coalition of doctors in Scotland have urged for a ban on meat in hospitals, comparing the serving of red and processed meat to the distributing of cigarettes.
Therefore I would like to ask - **will the Board consider establishing a plant-based Cafe instead of Costa Cafe, when the contract with Costa Cafe ends?**
I believe that the company *Elior* has about 50 plant-based outlets around the uk, through Eatwell dining rooms, retail shops, coffee shops and vending services."

Trust Response:
The Compass Group is responsible for the outlets in the hospital's main reception with 10 years to run on the contract. All the outlets have to follow NHS guidance on food and drink and JB advised that 50% of the offerings were vegan. AD queried if the company could be approached directly with suggestions and JB advised this would be possible and their contact details could be supplied.

AD commented, for those who may be interested, a search had identified the recent Dublin Declaration and website which provided a different perspective from scientists across the globe.

18 Any Other Business

18.1 There was no other business.

19 The meeting closed at 11:50

Updated : 04/05/23

Trust Board Action Log

Action No.	Date added to log	Agenda Item No.	Subject	Action	Owner	Completion Date	Update	Status Open/ Closed
24	03-Nov-22	18	Significant Risk Register	KJ, KMB and Paul Ewers to review the front sheet of the report to include an overview of the Trust's risk position and appetite	KJ/KMB/PE	06-Jul-23	To be progressed after the Trust's Risk Appetite Statement has been reviewed.	Open
31	09-Mar-23	10.4	CQC Maternity Patient Experience Update	Patient experience presentation on themes across the hospital from Tendable and PEP data	KJ	06-Jul-23		Open
34	04-Mar-23	3.8	Patient Story	IR to establish where discussions had taken place around the procurement of PCA machines and why there was a 4-5 month time-lag between order and delivery.	IR	06-Jul-23		Open

Meeting Title	Trust Board	Date: 05.07.2023
Report Title	Chair's Report	Agenda Item: 5
Lead Director	Name: Alison Davis	Title: Chair
Report Author	Name: Alison Davis	Title: Chair

Key Highlights/ Summary	An update for the Board on activity and points of interest including: • Visit by the Countess Howe, Lord Lieutenant of Buckinghamshire • Annual Staff Awards • 75th Anniversary of the NHS (5th July 2023)			
Recommendation *(Tick the relevant box(es))*	**For Information** ☒	**For Approval** ☐	**For Noting** ☐	**For Review** ☐

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

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

Chair's report: July 2023

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

1. In May I joined Vanessa Holmes when we had a visit from the Countess Howe, His Majesty's Lord Lieutenant of Buckinghamshire. She visited the Cancer Centre and had a tour of the Radiotherapy Centre site. Lady Howe is a great supporter of the hospital and was very interested to see the new facilities and hear how they have improved or will improve patient experience.

2. Work has commenced reviewing the process for appointment of Non-Executive (NED) and Associate Non-Executive Directors (ANED). A Task and Finish Group has been established with Governors to oversee the review, and draft proposals will be presented to the Council of Governors in due course for consideration and sign-off.

3. Our Finance Director, Terry Whittle and members of his team provided a training and refresher session for NED and ANED colleagues on the current financial regime of the NHS. It was well received and very helpful for those attending.

4. In June I attended a session arranged as part of the Thames Valley Deanery 'Education Leaders in Training' programme. This is a medical leadership programme, and I attended to discuss my experience and path into the role as a Non-Executive Director in the NHS.

5. As part of the Armed Forces Week in June, our Medical Director, Ian Reckless and I presented Veteran Aware pins to Armed Forces trained service champions from MKUH. These champions play an important role in spotting signs of mental health issues, offering initial help and guiding people towards support.

6. At the time of writing we are about to hold our annual Staff Awards. Once again, nominations have identified so many areas of excellence in teams and individuals, and it is a great opportunity to celebrate and thank everyone.

7. The 5th July is the 75th Anniversary of the founding of the NHS and we have plans to mark the occasion at MKUH. For detail about national events and priorities for the future, I have provided links below:-

   NHS England » Events and news

   The-NHS-in-England-at-75-priorities-for-the-future.pdf (longtermplan.nhs.uk)

Bedfordshire, Luton and Milton Keynes Integrated Care Board Meeting on 30 June 2023

On 30 June 2023, the Board met in the Council Chamber of Central Bedfordshire Council.

Ahead of the ICB's first Birthday on 1 July, the Chair, Dr Rima Makarem, set out the ICB's achievements in its first year of operation alongside the major challenges faced in the year ahead.

The Chief Executive provided an update on proposed changes to the Target Operating Model for the ICB.

There were no questions from the public.

The following items were discussed:

1. **Resident's story** – members heard directly from a Luton resident who was diagnosed with a brain tumour in 2021 and received primary, secondary and tertiary care, which, at times, were not well integrated. The Board discussed the importance of taking a personalised approach to delivering care, and the digital solutions that could better help patients to navigate through a complex health and care system in a user-friendly, supportive and more joined-up way.

2. **The Denny Review** – The Board welcomed the findings of the Denny Review into Health Inequalities and recognised the collective responsibility they have in delivering the recommendations outlined by Reverend Lloyd Denny. Members acknowledged the cultural shift required to respond effectively and the need to continue listening to seldom asked residents. The Board delegated responsibility for approving the full Report to the Working with People and Communities Committee later this year.

3. **Inequalities Funding** – members debated and agreed the proposal to delegate £500k inequalities funding to each Place to ensure that funding is available to meet the greatest needs of the population locally, noting that this did not set a precedent for the delegation of other funds. The Board also supported an allocation of funding to implement the recommendations from the Denny Review.

4. **BLMK Joint Forward Plan** – Following extensive engagement with partners, the Board formally approved the Joint Forward Plan for 2023-2040. The report has been published onto the BLMK Health and Care Partnership website. The Joint Forward Plan focuses on the needs of all residents, and given the pace of population growth across BLMK, extends its outlook to 2040. The plan reflects insights from local people, generated from extensive engagement with residents and wider partners from the last 12 months.

5. **Memorandum of Understanding with Healthwatch** – The Board approved the Memorandum of Understanding between the ICB and Healthwatch, recognising the important role that Healthwatch has as a strategic partner to the ICB. They welcomed the opportunity to forge a more formal relationship with Healthwatch to ensure the voice of residents is included in decision making and in recognition of Healthwatch's statutory role.

6. **Financial and operational reports** – members received formal updates from quality and performance, finance and governance, and approved Section 75 agreements with Luton and MK Councils. The Board also received updates from the four places on their work programmes and reviewed the Board Assurance Framework, agreeing to consider including a new risk based on the experiences highlighted in the resident story and the Denny Review about the challenges residents face accessing and navigating health services in the system.

The next meeting of the Integrated Care Board will be at 9am on 29 September at the Town Hall, Luton Council, Luton LU1 2BQ.

Members of the public and partner organisations are welcome to join in person or on-line. We ask that questions to the Board from members of the public are submitted two days in advance.

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

The Board meeting on 29 September will also include our Annual General Meeting (AGM). More information about the AGM will be published in due course.

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

Meeting Title	Trust Board	Date: 06 July 2023
Report Title	**Serious Incident/Incident (SI) report**	**Agenda Item Number: 8**
Lead Director	**Dr Ian Reckless, Medical Director and Deputy Chief Executive Kate Jarman, Director of Corporate Affairs and Communications**	
Report Author	**Tina Worth, Head of Risk & Clinical Governance**	

Introduction	Assurance Item		
Key Messages to Note	This report provides a quarterly overview of Risk Management processes/systems in relation to serious incidents. It also discusses Preventing Future Death (PFD) reports from HM Coroner to the Trust.		
Recommendation *(Tick the relevant box(es))*	**For Information** x	**For Approval**	**For Review** x

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	1. *Keeping you safe in our hospital* 3. *Ensuring you get the most effective treatment* 4. *Giving you access to timely care* 7. *Spending money well on the care you receive*

Report History	Weekly Reports to Serious Incident Review Group
Next Steps	Quarterly reporting detailing analysis and trends and relevant learning from SI investigations
Appendices/Attachments	Appendix 1 - SI log for Quarter 1 (up to 25/5/23)

Quarterly review April to 25 May 2023 (Q1)

Executive summary

This report summarises the position from a Trust perspective in relation to serious incidents (SIs) and concerns raised by HM Coroner from the Risk Management Team's perspective, detailing SI and inquest activity throughout the fourth quarter of the financial year (including noted trends, learning and concerns). These are included in appendix 1 – SI log in addition to those SIs reported in Quarter 1 2023 – 2024 (1) after the last QCRC report was submitted.

There were 55 SIs on the live log as of 25 May 2023.

There were 6 SIs in total this quarter (up to 25 May) reported on STEIS.

The 6 SIs can be broken down by month reported as follows.

- April 3
- May 3

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

HSIB - Healthcare Safety Investigation Branch

PSIRF - The Patient Safety Incident Response Framework sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety and will replace the current Serious Incident Framework of 2015.

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

SIRG meetings

SIRG was introduced to ensure that there was a corporate, senior robust process for the approval of SIs, with Trustwide sharing and learning, deep dives of noted trends and multi-disciplinary approval of RCA and action plans. The group has representation from the divisions and is chaired weekly by the Associate Medical Director, Medical Director, Chief Nurse or Director of Corporate Affairs (the Associate Medical Director is the default chair – although all Directors may be in attendance). In a no blame environment, staff are invited to present their draft RCAs and take any questions from the group before approval is given or request for representation later. SIRG is a really good forum for professional challenge and discussion from across the multi-disciplinary team (MDT), highlighting areas for improvement, where assurances are required and positive practices.

SIRG also reviews all incidents/events reported on the Radar system the preceding week with a grading of moderate or above, to consider if the grading is appropriate and/or further information is required to determine an SI. By taking this approach all incidents that are reported with a higher severity are collaboratively reviewed and discussed enabling cross

specialty scrutiny. Trends are also assessed from an incident category perspective and contributory factors with recent assurances sought from relevant teams/specialties.

SIRG receives monthly reports on inquests, claims and SIs which focus on trend analysis and learning and any areas of concern for further review, in addition to a monthly moderate log report (with learning) from Women's health who hold their own weekly MDT review of moderate incidents.

The final key role of each SIRG meeting is to discuss the key learning from the incidents/SI discussed (spotlight on safety) and this is then included in the weekly CEO newsletter for trust wide learning.

Clinical Governance Leads (CGLs)

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

Mortality and Morbidity (M&M) processes

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

CORs the M&M database is currently developing a dashboard that will enable live structured judgement reviews (SJRs) to be completed and the pulling of themes/data by set criteria such as sepsis as a cause of death or patient having a learning difficulty.

Main Report

Radar incident reporting

The Trust has an ongoing implementation project in relation to the Radar Healthcare System. The Trust went live with Incidents, Complaints, Compliments, Claims, Safety Alerts, Improvement Suggestions and Risk Register modules on 15th November 2021. The Trust also implemented direct reporting to NHS England's Learning from Patient Safety Events (LFPSE) form on the same date, becoming the first Trust to do so.

Due to the complexity of the required system build whilst also complying with restrictions required to support the LFPSE implementation, there are ongoing issues around the time it

takes to report incidents through the system, with ongoing work to improve the current incident reporting form and support staff reporting incidents.

Following some compromise from NHSE on the way the LFPSE form is able to dovetail into our local incident reporting forms, the Risk Manager is working with Radar to combine both forms into one more succinct and quicker incident reporting form. The initial aim of this work is to reduce the average time it takes to report an incident to below 10 minutes. Whilst it is recognised that 10 minutes is still too long, realistically this can only be reduced further by NHSE moving some of the questions away from the incident reporting form and into the investigator/governance sections of the workflow and some of the questions are mandatory so are largely out of MKUH's control. The form has now been amended and is currently in the 'test domain' to ensure it is fit for purpose.

To support MKUH with the above development work, our Radar Customer Success Manager will come onsite on 24 May after the test form has been shared with staff, so that Radar can get feedback directly from our frontline staff and support us with the ongoing development work. The purpose of their visit, on this occasion, will specifically be around the development and implementation of our new incident reporting form.

Work is also currently taking place to add all Trust documentation into the Radar Documentation Module. This will enable the easier management of documents and significantly improve staff accessibility to documents. Library Services are providing us with excellent support to develop 'tags' (keywords) to improve staffs' ability to search for documents.

Current document upload progress - 422 documents. The original target for the documents to be uploaded was 30th June 2023. Whilst work will continue with an aim to complete by the end of June 2023, due to the lack of resources, and no budget for agency staff to support this work, this is likely to be delayed.

The audit module anticipated that work is likely to commence Summer/early Autumn 2023.

Patient Safety Incident review framework (PSIRF)

PSIRF will replace the current Serious Incident Framework (2015) and represents a significant shift in the way the NHS responds to and learns from patient safety incidents and other safety intelligence. All NHS organisations are mandated to transition over to PSIRF by Autumn 2023 with the Trust sharing its PSIRF plan and policy by July 2023.

Progress over the past 2 months includes:

- PSIRF steering group meeting have agreed terms of reference (TOR) and task and finish groups, with group leads appointed.
- Sandra Vanreyk from the ICS is providing project management support 3 days a weeks which started from 5th April.
- Process mapping of the current incident review process completed with some mapping how the new process may look has begun.
- Incident triage pilot ran for a week with the initial aim to establish the number of level 1 (patient safety incident investigation), level 2 (patient safety response/learning) and level

3 (service incident review/improvement) there were in an average week. Small MDT PSIRF team set up, with plan now to progress to a second pilot week in June for 3 clinical areas, this time with those areas being involved and the new investigation levels for incidents implemented.
- Changes to roles across clinical governance, patient safety and QI are being discussed in order to facilitate the adoption of PSIRF. This will be subject to a consultation and recruitment plan in due course.
- Meetings in progress with each triumvirate to understand current governance/safety/QI processes, what's working well, and any changes needed.

Key risks and issues:

- Significant Radar system changes necessary to support the implementation of PSIRF.
- No additional resource available to implement and sustain the new framework.
- Data analyst support needed for the triangulation of safety data in order to inform our patient safety incident response plan.
- PSIRF requires an organisational cultural shift to truly embed a 'just culture' and sustainable training (QI, Radar, incident review).
- Risk assessment completed for consideration of PSIRF implementation being added to the corporate risk register.

Serious Incidents Reported (January - March 2023)

There have been 6 SIs reported so far this quarter. For details of all SIs please refer to appendix 1.

Given the small number it would not be that helpful to provide data/graphs on for this quarter's breakdown. The top two for the categories of diagnostic delays and suboptimal acre of the deteriorating patient. The quarterly comparison data on trends is however provided to demonstrate trends.

Chart 2 demonstrates the consistency of suboptimal care and diagnostic SIs month on month.

This is again a low reporting quarter which is thought to be reflective of SIRG's PSIRF approach to assessing incidents with the focus on learning, value of time for investigations and consideration of other quality improvement projects & as such avoidance of duplicate reviews. There has also been a noted reduction in the number of reported incidents on Radar relating to suboptimal or delayed care, with some concern (since reference din other forums) that these are not being reported.

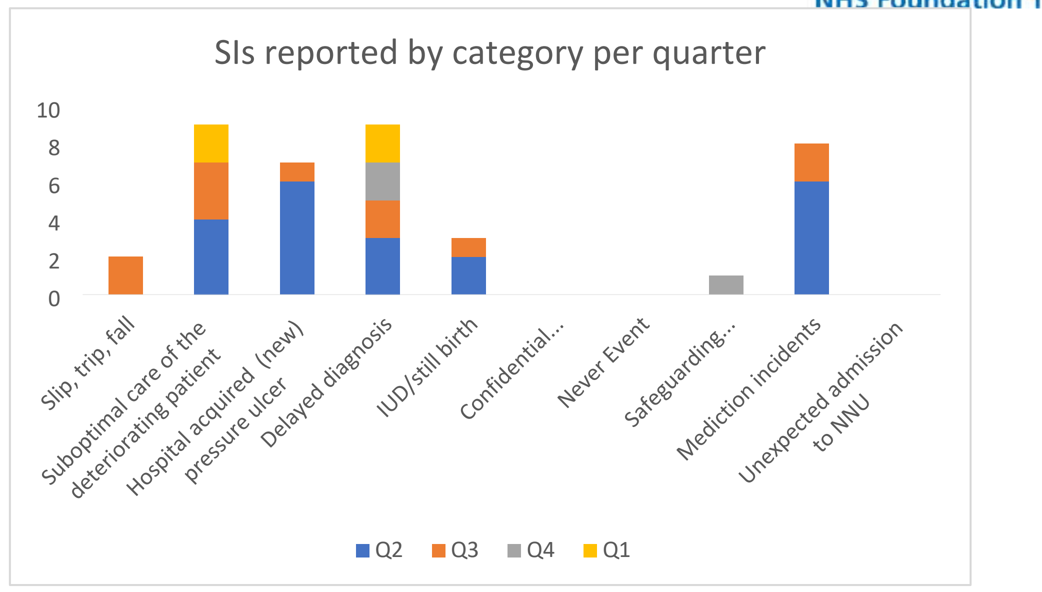


Chart 1 - Top SIs by category and by quarter (Q2 July to September 2022, Q3 October to 2 December 2022, Q4 January to March 2023 and Q1 April to 25 May 2023)

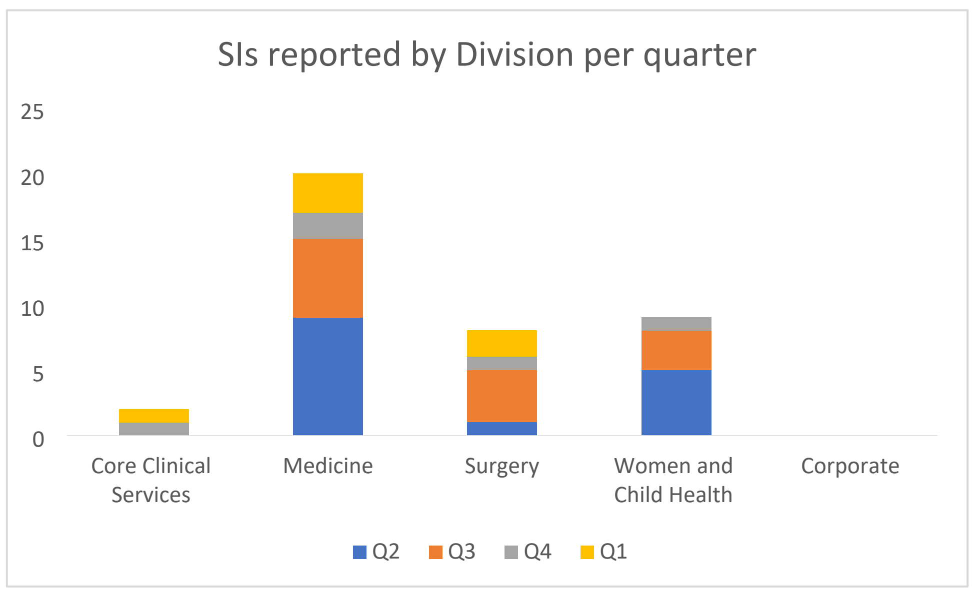


Chart 2 – SIs by Division per Quarter 2022 - 2023

Specific RCA investigations

2023/9270

A 50-year-old woman presented in Emergency Department (ED) for abdominal pain and distension. She passed away from multiple organ failure, sepsis, and pelvic malignancy 3

days after being admitted. This remains under investigation however MDT review and the synopsis report identified some key learning/concerns:

- A missed opportunity to identify sepsis and deterioration earlier.
- Gaps in frequency of vital observations and delayed escalation of abnormal observations on the National early Warning Score (NEWS)

Given coronial concerns, the inclusion of sepsis as one the Trust's priorities for 2023 – 2024 and previous PFDs, these points will be integral in the investigation.

2023/7384

A patient was discharged back to previous care home and on arrival was found to have chest secretions, appeared pale and cold to touch. Observations taken showed oxygen saturations 78%, heart rate 48 and temperature 35.7. An ambulance was called, and the patient taken to Bedford General Hospital. He subsequently died.

Key learning identified:

- That ward moves are minimised (accepting requirements based on clinical care needs) to ensure continuity of care from clinician and nursing teams. Patient on this occasion had multiple ward moves and one just prior to discharge
- If ward move required to enable another admission to the ward with a clinical priority this must be in due consultation and with the agreement of the patient's consultant
- That complex co morbid patients, even if discharge is planned are not discharged or moved to discharge unit before doctor review.
- Care home assessments are documented on eCARE and undertaken in collaboration with nursing and medical team.

2023/9271

Serious delay in cancer patient imaging/reporting. 2ww should be reported <7 days. Scan subsequently reported as abnormal, strongly suggesting perhaps both post radiotherapy changes and tumour recurrence. Patient reports yesterday deterioration in left arm function (plus ongoing pain). This remains under investigation however initial analysis identified the following points:

- Gaps in magnetic resonance (MR) reporting. Only 2 radiologists currently report brachial plexus.
- Backlogs to scan time and further delays on reports.
- Up to 4 weeks turnaround time for reports due to backlogs including cancer patients. Outsourcing companies do not accept complex scans such as brachial plexus.
- Teamworking between radiologists and imaging team and reporter accountability need of improvement.

The Clinical Director (CD) has emailed all radiologists proposing smaller MR reporting groups for each speciality, so accountability is more focused. In addition, the CD will be allocating the oldest of the urgent reports out.

There have also been 7 reported incidents in relation to the Ear, Nose and Throat (ENT) MKUH and Northampton General Hospital (NGH) detailing concerns about the pathway and Head & Neck cancer treatment delays. These have all been shared with NGN and the Medical Director has had a conversation with the Medical Director for Commissioning, East of England) and come away confident that he has a solid grasp of the issues. The key steps now are urgent discussions with OUH at the highest level, and a commissioner driven rapid audit of pathways (so there is a single view of the current / recent position and problems), both of which are being put in place.

Learning and breached SI action plan evidence

Learning generated from incidents and during discussions at SIRG meetings are shared via the 'Spotlight on Safety' message in the weekly CEO Newsletter. During April and May 2023, 9 individual learning/reflection/discussion or 'what's trending' points have been shared with the following themes:

- Repositioning is paramount in the prevention and management of pressure damage. It is important to ensure patients are repositioned as per their care plan and that we alter their position each time.
- Anti-embolic stockings (AES), also known as TEDS, can cause device-associated pressure damage. Please ensure these stockings are removed daily so that a skin inspection can be performed. AES are also prescribed on the drug chart, which is a great reminder for this daily check.
- It is essential to clearly document when and how a procedure, such as urinary catheterisation or IV cannulation, has been performed, including an accurate record of what equipment was used. Relevant information would include the date, time, person, type of procedure, type and number of swabs used, site of cannula insertion, number of attempts made and any complications.
- The importance of following the escalation pathways for clinical concerns and deteriorating patients. If you have escalated your concerns but don't feel you've had the response you hoped for or expected, don't stop there! Escalate to another appropriate or more senior colleague.
- We have conversations with patients and their families/carers every day, in every department. How can we ensure the information we are sharing is both heard and understood? Closed loop communication is one tool that can help with this.
- Do you provide clinical care to patients? This NEWS2 e-learning package has been developed in association with the Royal College of Physicians and provides an overview of the National Early Warning Score (NEWS2). It looks at what it is, how to use it and what this means in forming a clinical response.
- Civil work environments reduce errors, reduce stress and foster excellence. Our interactions with one another really matter. Civility between team members creates a sense of safety. Incivility robs teams of their potential #CivilitySavesLives. Remaining civil is hard when working under pressure and when fatigued. In the face of these challenges, how can we all show active kindness to each other?
- It is possible for 'threat actors'/hackers to clone personal mobile phones. This enabled these individuals to access patient identifiable information which had been shared via a work team WhatsApp group. Please be mindful of what is shared via WhatsApp and consider using password protected apps such as Microsoft Outlook and Teams.
- Double independent checking of blood at the bedside must be done independently, i.e., first checker independently completes all stages of the bedside administration checklist

confirming the details are correct, and then the second checker repeats all the checks, also independently, and only when they confirm that all the details are correct can the blood be attached to the patient by the second checker.

Inquests

Regulation 28 report/PFD

MK 2649

Narrative Conclusion - Mr B attended Milton Keynes University Hospital (MKUH) on the 9th July 2022 with a likely acute abdomen. He was sent there by the GP in the nearby Urgent Care Centre. The doctor who saw and assessed him in the ED did not read the Urgent Care Centre communication that was provided to Mr B and did not record important factual information in the clinical note. Mr B was discharged but returned 2 days later on the 11th July 2022 when he was suffering from sepsis consequent on a previously undiagnosed bowel perforation. There is insufficient evidence available to me to establish whether he was resuscitated adequately when he attended the ED on the 11th July 2022. He went on to have emergency surgery but arrested immediately prior. He was resuscitated, surgery completed and Mr B was moved to ITU. He then, later the next day, arrested again and died. **This was an avoidable death.**

HM Coroner also advised that he would be issuing a PFD. This has yet to be received but it is expected it will detail concerns relating to fluid management as part of the sepsis 6 care bundle.

This will be the third PFD relating to sepsis for the Trust since 2021. A sepsis working group has been set up with a view to in-depth analysis to understand what the key issues are and then what can be done to mitigate these.

All hospital deaths relating to sepsis and referred to HM Coroner are also being forwarded to the Head of Risk & Clinical Governance by the Medical Examiners on their review so early consideration can be given to any trends and/or legal involvement.

Duty of Candour (DOC)

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

In quarter 4 the Trust reported 0 breaches. Quarter 1 data is not due until the end of June 2023.

Recommendations

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

Appendix 1 SI log for Quarter 4 2022 – 2023 (with 2 incidents from the end of Q3 – in green below)

SI reference no.	Category	Location/department/CSU	Description
2023/5713	Venous Thromboembolism (VTE)	Gynaecology	DVT post admission with hyperemesis. Linked to a previous SI on the same theme
2023/7333	Medication incident	Medicine (Cancer Centre)	Failure to give patient GCSF (stimulates bone marrow) in take home medications (TTO). Patient later admitted to hospital neutropenic unwell.
2023/7384	Discharge	Medicine (Ward 19)	Patient discharged back to previous care home on arrival was found to have chest secretions, appeared pale and cold to touch. Observations taken showed oxygen saturations 78%, heart rate 48 and temperature 35.7. An ambulance was called, and the patient taken to Bedford General Hospital. Patient died
2023/7385	Medication/medical device	Core Clinical Services (Imaging)	Extravasation post scan. Patient returned to the Emergency Department (ED) that evening and was rushed to Stoke Mandeville and had 2 emergency operations under the plastics team
2023/9270	Suboptimal care	Surgery	A 50-year-old woman presented in Emergency Department (ED) for abdominal pain and distension. She passed away from multiple organ failure, sepsis, and pelvic malignancy 3 days after being admitted.
2023/9271	Delayed diagnosis	Cancer Services	Patient with known previous breast cancer referred to neurology under the 2WW pathway because of worrying left arm symptoms. Differential of cancer recurrence in the brachial plexus or post radiotherapy plexopathy. MRI brachial plexus requested with appropriate clinical information. Despite requesting the scan using the 2WW option, scan completed 55 days later and remained unreported for a further 28 days thereafter. Scan abnormal, strongly suggesting perhaps both post radiotherapy changes and tumour recurrence.

2023/9690	Suboptimal care deteriorating patient	Surgery (Ward 20)	Re-admission to the Intensive Care Unit (ICU) for drop in Glasgow Coma Score (GCS) with diabetic ketoacidosis (DKA) following ICU stepdown. Missed opportunity of endocrinology review as patient diabetes management complex & in handover between ICU & the ward.

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

Meeting Title	Trust Board	Date: 06 July 2023
Report Title	2023-24 Executive Summary M02	Agenda Item Number: 9
Lead Director	John Blakesley, Deputy CEO	
Report Author	Information Team	

Introduction	Purpose of the report: Standing Agenda Item
Key Messages to Note	**Emergency Department:** - There were 8,738 ED attendances in May 2023, an increase of 1,071 attendances when compared to April 2023. - The percentage of attendances admitted, transferred or discharged within 4 hours was 73.5%, a decrease of 1.6% when compared to April 2023. - 80.1% of ambulance handovers took less than 30 minutes in May 2023 and 97.2% took less than 60 minutes. **Outpatient Transformation:** - There were 35,269 outpatient attendances in May 2023, an increase of 2,524 attendances compared to April 2023. - 11.6% of these appointments were attended virtually and 5.8% of patients did not attend their appointment in May 2023. **Elective Recovery:** - There were 2,745 elective spells in May 2023, an increase of 916 spells from April 2023. - At the end of May 2023, 39,003 patients were on an open RTT pathway: o 2,674 patients were waiting over 52 weeks: 293 more than in April 2023. o 505 patients were waiting more than 65 weeks. - At the end of May 2023, 8,243 patients were waiting for a diagnostic test, of which 78.52% were waiting less than 6 weeks. **Inpatients:** - Overnight bed occupancy in adult G&A beds was 90.1% during May 2023, within the threshold of 92% and a reduction compared to April 2023 (91.1%). - A considerable proportion of beds were unavailable due to: o 111 super stranded patients (length of stay 21 days or more). o 78 patients not meeting the criteria to reside. **Human Resources:** - In May 2023: o Substantive staff turnover reduced slightly to 14.9% but was above the threshold of 12.5%. o Agency expenditure decreased to 5.6% from 6.0% in April 2023, above the threshold of 5%. o Appraisals (excluding doctors) increased to 91% from 89% in April 2023, below the 90% threshold. o Mandatory Training was above the threshold at 95%.

	Patient Safety: - In May 2023, the following infections were reported: ○ C. Difficile: 4 ○ Klebsiella Spp.: 1		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Review** ☐

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

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

Trust Performance Summary: M02 (May 2023)

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 ID	Indicator Description	Transitional Target	Constitutional Target
4.1a	ED 4 hour target (includes UCS)	76%	95%
4.2	RTT Incomplete Pathways <18 weeks	46.8%	92%
4.5a	RTT Patients waiting over 65 weeks	586	0
4.6	Diagnostic Waits <6 weeks	85%	99%

To ensure that the continued impact the impact of COVID-19 is reflected, monthly trajectories are to be put in place to ensure that they are reasonable and reflect a realistic level of recovery for the Trust to achieve. These are not yet all confirmed at the time of reporting.

2.0 Operational Performance Targets

May 2023 performance against transitional targets and recovery trajectories:

ID	Indicator	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1a	ED 4 hour target (includes UCS)	76%	76%	74.3%	73.5%	✗	▼	✗	
4.2	RTT Incomplete Pathways <18 weeks	47.4%	46.8%		44.5%	✗	▼		
4.5b	RTT Patients waiting over 65 weeks	0	586		505	✓	▼		
4.6	Diagnostic Waits <6 weeks	85.6%	85.0%		78.5%	✗	▼		
4.9	62 day standard (Quarterly)	85%	85%		54.5%	✗	▼		

The percentage of ED attendances that were admitted, transferred, or discharged within 4 hours was 73.5%, a 1.6% reduction on April 2023 performance and the national performance was 74.0%. However, MKUH performance exceeded the performance of most other trusts within its Peer Group (see Appendix 1).

The volume of open RTT pathways was 39,003, decreasing from 40,032 at the end of April 2023. Of this total, 505 patients had been waiting more than 65 weeks for treatment. The Trust has robust recovery plans in place to support an improvement in RTT performance and to reduce patient waiting times. The cancellation of non-urgent elective activity and treatment for patients on an incomplete RTT pathway is also being proactively managed.

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

In Q4 2022/23, our 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) was 54.5% against a national target of 85%, declining from 63.7% in the previous quarter. The percentage of patients to begin cancer treatment within 31 days of a decision to treat declined to 93.5%, below the national target of 96%. The percentage of patients to attend an outpatient appointment within two weeks of an urgent GP referral for suspected cancer was 75.4% against the national target of 93%.

3.0 Urgent and Emergency Care

During May 2023, three of the five key indicators saw a month-on-month improvement:

ID	Indicator	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.4	Cancelled Ops - On Day	1%	1%	0.50%	0.35%	✓	▲	✓	
3.2	Ward Discharges by Midday	25%	25%	14.0%	13.2%	✗	▼	✗	
3.5	Patients not meeting Criteria to Reside	50			78	✗	▲		
3.6b	Number of Super Stranded Patients (LOS>=21 Days)	50			111	✗	▲		
3.9a	Ambulance Handovers <30 mins (%)	95%	95%	82.9%	80.1%	✗	▼	✗	

Cancelled Operations on the Day

In May 2023, there were 9 operations that were cancelled on the day for non-clinical reasons, representing 0.35% of all planned operations. Most of the cancellation reasons given were related to insufficient time or bed availability.

Patients not Meeting Criteria to Reside

The number of inpatients not meeting the criteria to reside at the end of May 2023 was 78. This was an improvement in performance compared to April 2023, which saw 86 inpatients not meeting the criteria to reside. However, it was above the threshold of 50.

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 111, an improvement compared to 123 patients at the end of April 2023.

Ambulance Handovers

In May 2023, the percentage of ambulance handovers to the Emergency Department taking less than 30 minutes was 80.1%; a reduction compared to the previous month (85.9%).

4.0 Elective Pathways

During May 2023, two of the four key indicators saw a month-on-month improvement:

ID	Indicator	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight Bed Occupancy - Adult G&A	92%	92%	90.6%	90.1%	✓	▲	✓	
4.2	RTT Incomplete Pathways <18 weeks	47.4%	46.8%		44.5%	✗	▼		
4.4	RTT Total Open Pathways	39,636	38,530		39,003	✗	▲		
4.6	Diagnostic Waits <6 weeks	85.6%	85.0%		78.5%	✗	▼		

Overnight Bed Occupancy

Overnight bed occupancy was 90.1% in May 2023, within the desired 92% threshold.

RTT Incomplete Pathways

The Trust's RTT Incomplete Pathways <18 weeks at the end of May 2023 was 44.5% and the number of patients waiting over 65 weeks was 505. Total RTT open pathways was 39,003.

Diagnostic Waits <6 weeks

At the end of May 2023, performance was 78.53%, declining from 81.22% in April 2023. However, performance in recent months reflects that recovery in this area is being effectively managed given that the starting point in April 2022 was as low as 61.9%.

5.0 Patient Safety

Infection Control

In May 2023, the following infections were reported:

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

ENDS

Appendix 1: ED Performance - Peer Group Comparison

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

March 2023 to May 2023 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	Mar-23	Apr-23	May-23
Barnsley Hospital NHS Foundation Trust	63.8%	75.2%	78.7%
Homerton Healthcare NHS Foundation Trust	80.9%	83.5%	77.4%
Southport and Ormskirk Hospital NHS Trust	73.7%	78.0%	75.5%
Milton Keynes University Hospital NHS Foundation Trust	79.1%	75.1%	73.5%
The Hillingdon Hospitals NHS Foundation Trust	68.3%	74.8%	71.9%
North Middlesex University Hospital NHS Trust	63.9%	68.2%	71.3%
Oxford University Hospitals NHS Foundation Trust	64.7%	70.6%	70.3%
Buckinghamshire Healthcare NHS Trust	70.0%	71.2%	68.5%
Northampton General Hospital NHS Trust	66.4%	68.6%	67.7%
Mid Cheshire Hospitals NHS Foundation Trust	60.0%	62.6%	65.9%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	62.4%	65.0%	64.4%
The Princess Alexandra Hospital NHS Trust	51.6%	54.8%	53.0%

Board Performance Report 2023/24
May 2023 (M02)

OBJECTIVE 1 - PATIENT SAFETY

ID	Indicator	DQ Assurance	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
1.1	Mortality - (HSMR) ★		102.2	102.2		107.7	✗	▲		
1.2	Mortality - (SHMI)		100.0	100.0		Not Available				
1.3	Never Events		0	0	0	0	✓	▬	✓	
1.4	Clostridium Difficile		13	<3	8	4	✗	▬	✗	
1.5	MRSA bacteraemia (avoidable)		0	0	0	0	✓	▬	✓	
1.6	Falls with harm (per 1,000 bed days)		0.12	0.12	0.07	0.07	✓	▬	✓	
1.7b	Midwife to birth ratio (Actual for Month)		28			33	✗	▲		
1.8	Incident Rate (per 1,000 bed days)		50	50	47.57	50.48	✓	▲	✗	
1.9	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▬	✓	
1.10	E-Coli		27	<5	3	0	✓	▲	✓	
1.11	MSSA		17	<3	2	0	✓	▲	✓	
1.12	VTE Assessment		95%	95%	97.3%	97.4%	✓	▲	✓	
1.14	Klebsiella Spp bacteraemia		14	<3	1	1	✓	▼	✓	
1.15	P.aeruginosa bacteraemia		9	<2	0	0	✓	▬	✓	

OBJECTIVE 2 - PATIENT EXPERIENCE

ID	Indicator	DQ Assurance	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.2	RED Complaints Received		0	0	1	0	✓	▲	✗	
2.3	Complaints response in agreed time		90%	90%	85.2%	80.4%	✗	▼	✗	
2.4	Cancelled Ops - On Day		1%	1%	0.50%	0.35%	✓	▲	✓	
2.5	Over 75s Ward Moves at Night		1,500	250	248	139	✗	▼	✓	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS

ID	Indicator	DQ Assurance	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight Bed Occupancy - Adult G&A		92%	92%	90.6%	90.1%	✓	▲	✓	
3.2	Ward Discharges by Midday		25%	25%	14.0%	13.2%	✗	▼	✗	
3.3	Weekend Discharges		63%	63%	60.9%	65.7%	✓	▲	✗	
3.5	Patients not meeting Criteria to Reside		50			78	✗	▲		
3.6a	Number of Stranded Patients (LOS>=7 Days)		184			273	✗	▼		
3.6b	Number of Super Stranded Patients (LOS>=21 Days)		50			111	✗	▲		
3.8	Discharges from PDU (%)		12.5%	12.5%	7.2%	6.8%	✗	▼	✗	
3.9a	Ambulance Handovers <30 mins (%)		95%	95%	82.9%	80.1%	✗	▼	✗	
3.9b	Ambulance Handovers <60 mins (%)		100%	100%	97.6%	97.2%	✗	▼	✗	

OBJECTIVE 4 - KEY TARGETS

ID	Indicator	DQ Assurance	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1a	ED 4 hour target (includes UCS)		76%	76%	74.3%	73.5%	✗	▼	✗	
4.1b	Total time in ED no more than 12 hours		95%	95%	93.3%	93.6%	✗	▲	✗	
4.1c	Triage within 15 Minutes		90%	90%	61.5%	58.1%	✗	▼	✗	
4.2	RTT Incomplete Pathways <18 weeks		47.4%	46.8%		44.5%	✗	▼		
4.4	RTT Total Open Pathways		39,636	38,530		39,003	✗	▲		
4.5a	RTT Patients waiting over 52 weeks		1,920	2,453		2,674	✗	▼		
4.5b	RTT Patients waiting over 65 weeks		0	586		505	✓	▼		
4.6	Diagnostic Waits <6 weeks		85.6%	85.0%		78.5%	✗	▼		
4.7	All 2 week wait all cancers (Quarterly) ✎		93%	93%		75.4%	✗	▼		
4.8	31 days Diagnosis to Treatment (Quarterly) ✎		96%	96%		93.5%	✗	▼		
4.9	62 day standard (Quarterly) ✎		85%	85%		54.5%	✗	▼		
4.9b	28 Day Faster Diagnosis (Quarterly) ✎		75%	75%		76.7%	✓	▼		

OBJECTIVE 5 - SUSTAINABILITY

ID	Indicator	DQ Assurance	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
5.1	Total Referrals Received		Not Available		29,600	14,575	Not Available	▼	Not Available	
5.1b	Total ASIs		0	0		2,448	✗	▲		
5.1c	Total RTT Non-Admitted Open Pathways		32,776	32,214		33,291	✗	▲		
5.1d	Total RTT Admitted Open Pathways		6,860	6,316		5,712	✓	▲		
5.2	A&E Attendances		103,507	17,296	16,405	8,738	✓	▼	✓	
5.3	Elective Spells		25,968	4,328	4,574	2,745	✓	▲	✓	
5.4	Non-Elective Spells		28,660	4,777	4,852	2,481	✗	▼	✗	
5.5	OP Attendances / Procs (Total)		409,197	68,199	68,014	35,269	✓	▲	✗	
5.6	Outpatient DNA Rate		6%	6%	5.1%	5.8%	✓	▼	✓	
5.7	Virtual Outpatient Activity		25%	25%	12.9%	11.6%	✗	▼	✗	

OBJECTIVE 7 - FINANCIAL PERFORMANCE

ID	Indicator	DQ Assurance	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
7.1	Income £'000		360,945	56,904	57,930	29,236	✓	▲	✓	
7.2	Pay £'000		(215,539)	(36,021)	(39,629)	(19,930)	✗	▼	✗	
7.3	Non-pay £'000		(100,693)	(16,751)	(18,731)	(9,499)	✗	▼	✗	
7.4	Non-operating costs £'000		(44,713)	(3,969)	(3,598)	(1,805)	✓	▼	✓	
7.5	I&E Total £'000		0	163	(4,028)	(1,998)	✗	▼	✗	
7.6	Cash Balance £'000			25,630		23,542	✗	▼		
7.7	Savings Delivered £'000		17,335	2,889	25	25	✗	▲	✗	
7.8	Capital Expenditure £'000		(46,842)	(8,021)	(7,512)	(7,042)	✗	▲	✗	
7.9	Elective Spells (% of 2019/20 performance)		102%	102%	100.3%	101.5%	✗	▲	✗	
7.10	OP Attendances (% of 2019/20 performance)		112%	112%	102.2%	105.3%	✗	▲	✗	

OBJECTIVE 8 - WORKFORCE PERFORMANCE

ID	Indicator	DQ Assurance	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
8.1	Staff Vacancies % of establishment		10.0%	10.0%		6.5%	✓	▲		
8.2	Agency Expenditure %		5.0%	5.0%	5.8%	5.6%	✗	▲	✗	
8.3	Staff Sickness % - Days Lost (Rolling 12 months) ✎		5.0%	5.0%		4.7%	✓	▲		
8.4a	Appraisals (excluding doctors)		90%	90%		91.0%	✓	▲		
8.5	Statutory Mandatory training		90%	90%		95.0%	✓	▬		
8.6	Substantive Staff Turnover		12.5%	12.5%		14.9%	✗	▲		
8.7	Percentage of Employed Consultants with a Job Plan Signed off within the last 12 months (Rolling)		90%	90%		44.8%	✗	▼		

OBJECTIVES - OTHER

ID	Indicator	DQ Assurance	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
O.1	Total Number of NICE Breaches		8	8		35	✗	▬		
O.2	Rebooked cancelled OPs - 28 day rule		90%	90%	79.4%	100.0%	✓	▲	✗	
O.4	Overdue Incidents >1 month		TBC	TBC		279	Not Available	▼		
O.5	Serious Incidents		75	<13	6	3	✓	▬	✓	

Key: Monthly/Quarterly Change

▲	Improvement in monthly / quarterly performance
▬	Monthly performance remains constant
▼	Deterioration in monthly / quarterly performance
	NHS Improvement target (as represented in the ID columns)
✎	Reported one month/quarter in arrears
★	There was a notable increase in the value of Mortality (HSMR) in January 2022 due to the baseline being rebased. Further, from February 2022, the HSMR threshold may change on a monthly basis as we will be using the monthly peer value to compare MKUH performance against.

YTD Position

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

Data Quality Assurance Definitions

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

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

SD=3

1.1 Mortality - HSMR (Rolling 15 months)

125 120 115 110 105 100 95 90 85

Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Performance Mean LCL UCL Threshold

SD=3

1.2 Mortality - SHMI (Rolling 15 months)

115 110 105 100 95

Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Performance Mean LCL UCL Threshold

1.3 - Never events

5 4 3 2 1 0

M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12

Actual 2022/23

1.4 - C.Diff Infections

5 4 3 2 1 0

M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12

Actual Plan 2022/23

1.5 - MRSA Bacteraemia

5 4 3 2 1 0

M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12

Actual 2022/23

SD=3

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

0.5 0.4 0.3 0.2 0.1 0.0

Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Performance Mean LCL UCL Threshold

SD=3

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

39 37 35 33 31 29 27 25

Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Performance Mean LCL UCL Threshold

SD=3

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

70 60 50 40 30

Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Performance Mean LCL UCL Threshold

1.9- Duty of Candour Breaches

10 8 6 4 2 0

Q1 Q2 Q3 Q4

Actual 2022/23

SD=3

1.10 - E-Coli

8 6 4 2 0

Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Performance Mean LCL UCL Threshold

SD=3

1.11 - MSSA

6 5 4 3 2 1 0

Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Performance Mean LCL UCL Threshold

SD=3

1.12 - VTE Assessment

100% 98% 96% 94% 92% 90%

Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Performance Mean LCL UCL Threshold

SD=3

1.14 - Klebsiella Spp bacteraemia

5 4 3 2 1 0

Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Performance Mean LCL UCL Threshold

SD=3

1.15 - P.aeruginosa bacteraemia

3 2 1 0

Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

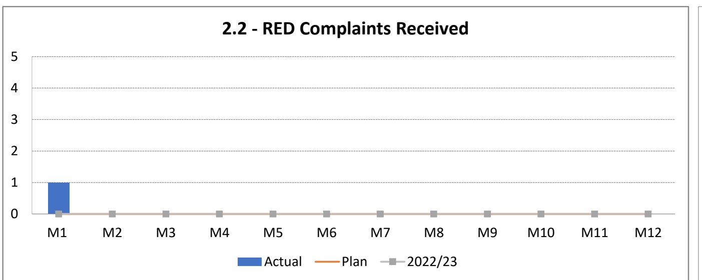
Performance Mean LCL UCL Threshold

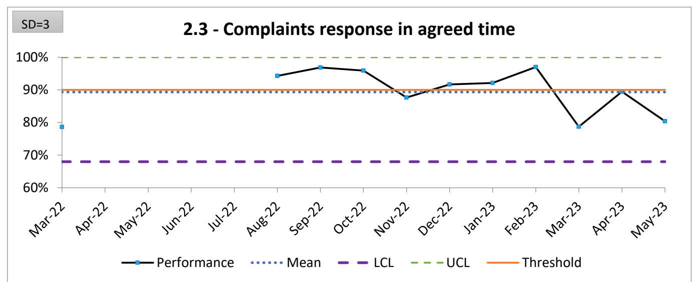
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

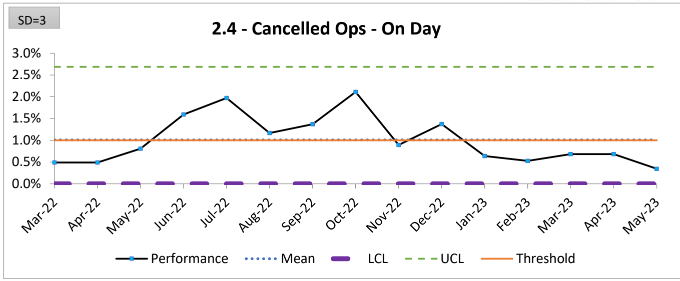
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

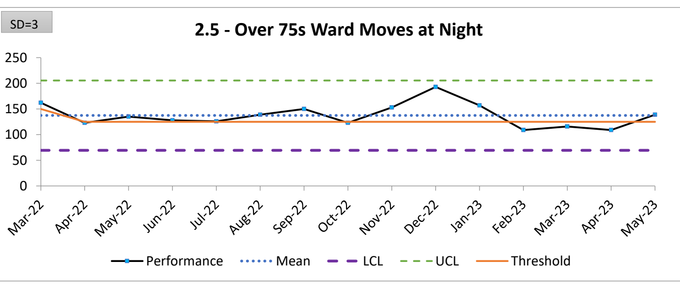
Board Performance Report 2023/24

OBJECTIVE 2 - PATIENT EXPERIENCE





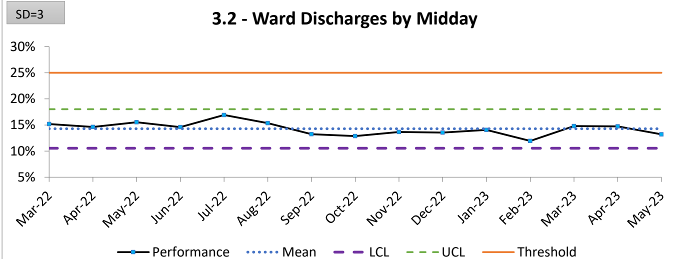


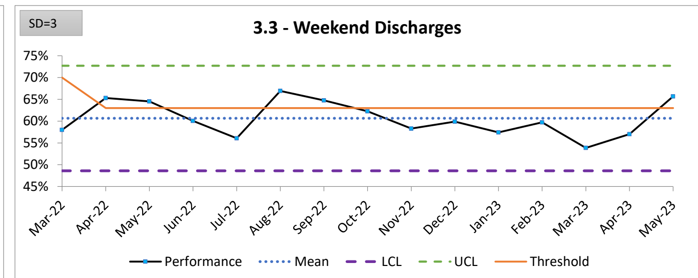


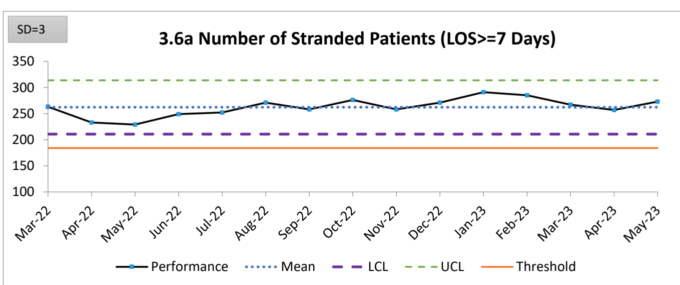
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

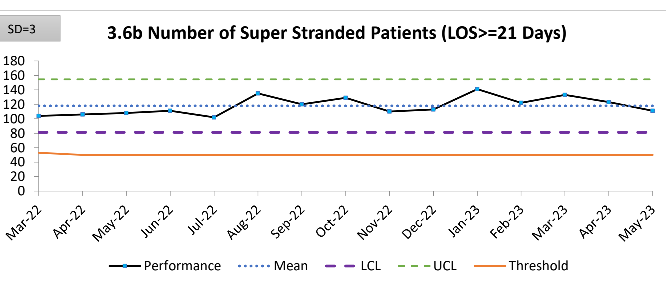
Performance activity on a rolling 15 months/quarterly
Average on a rolling 15 months/quarterly
Lower Control Limit (LCL)
Upper Control Limit
Targets/Thresholds/NHSI Trajectories

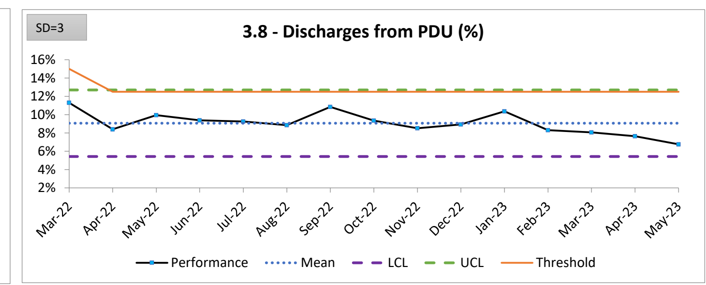
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

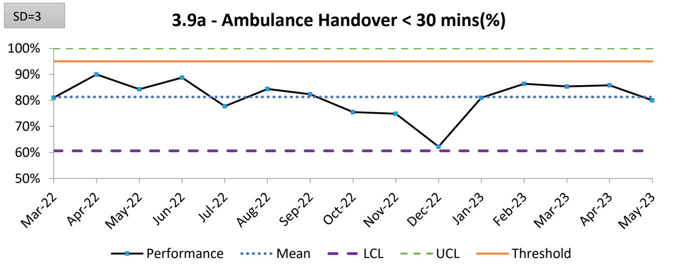


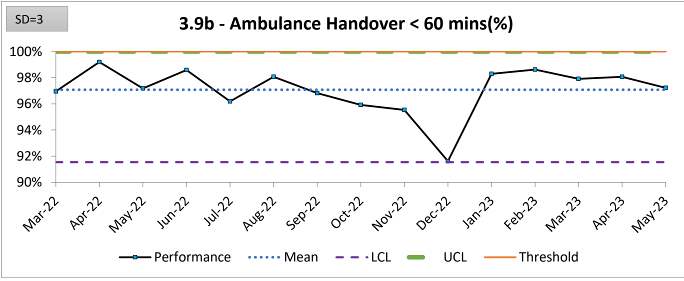












If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

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

OBJECTIVE 4 - KEY TARGETS

SD=3

4.1a - ED Hour Target (includes UCS)

Performance · Mean · LCL · UCL · Threshold

SD=3

4.1b - Total time in ED no more than 12 hours

Performance · Mean · LCL · UCL · Threshold

SD=3

4.1c - Triage within 15 Minutes

Performance · Mean · LCL · UCL · Threshold

SD=3

4.2 - RTT Incomplete Pathways <18 weeks

Performance · Mean · LCL · UCL · Threshold

4.4 - RTT Total Open Pathways

Actual · Plan · "2022/23"

4.5a - RTT Patients Waiting Over 52 weeks

Actual · Plan · 2022/23

4.5b - RTT Patients Waiting Over 65 weeks

Actual · Plan · 2022/23

SD=3

4.6 - Diagnostic Waits < 6 weeks

Performance · Mean · LCL · UCL · Threshold

SD=3

4.7 - 2 Week Wait - Cancer

Performance · Mean · LCL · UCL · Threshold

SD=3

4.8 - 31 day diagnosis to treatment - Cancer

Performance · Mean · LCL · UCL · Threshold

SD=3

4.9 - 62 day standard - Cancer

Performance · Mean · LCL · UCL · Threshold

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

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

OBJECTIVE 5 - SUSTAINABILITY

SD=3

5.1 - Total Referrals Received

25,000
22,500
20,000
17,500
15,000
12,500
10,000

Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Performance Mean LCL UCL Threshold

SD=3

5.1b - Total ASIs

4,000
3,000
2,000
1,000
0

Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Performance Mean LCL UCL Threshold

5.1c - Total RTT Non-Admitted Open Pathways

40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0

M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12

Actual Plan 2022/23

5.1d - Total RTT Admitted Open Pathways

8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0

M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12

Actual Plan 2022/23

SD=3

5.2 - A&E Attendances

11,000
10,000
9,000
8,000
7,000
6,000

Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Performance Mean LCL UCL Threshold

SD=3

5.3 - Elective Spells (PbR)

3,000
2,500
2,000
1,500
1,000

Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Performance Mean LCL UCL Threshold

SD=3

5.4 - Non -Elective Spells

3,500
3,000
2,500
2,000
1,500

Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Performance Mean LCL UCL Threshold

SD=3

5.5 - Outpatient Attendances/Procedures

42,500
40,000
37,500
35,000
32,500
30,000
27,500

Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Performance Mean LCL UCL Threshold

SD=3

5.6 - Outpatient DNA Rate (%)

10%
9%
8%
7%
6%
5%
4%

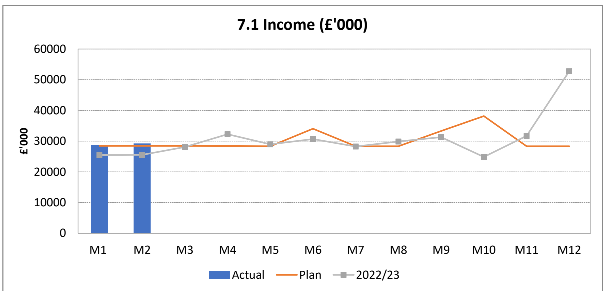
Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

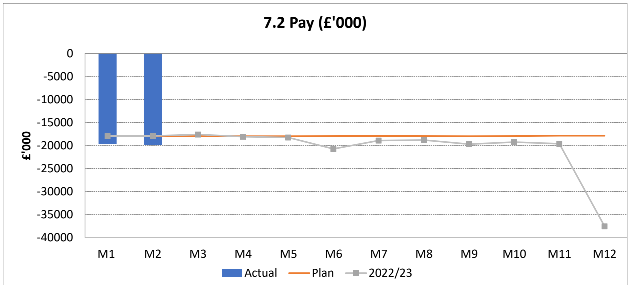
Performance Mean LCL UCL Threshold

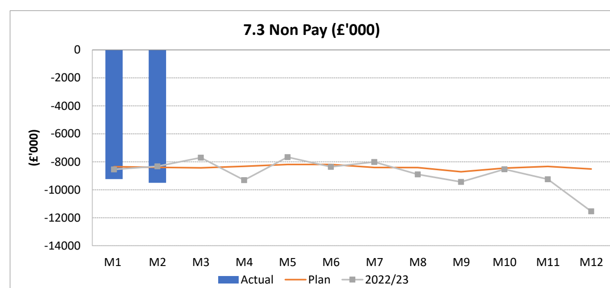
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

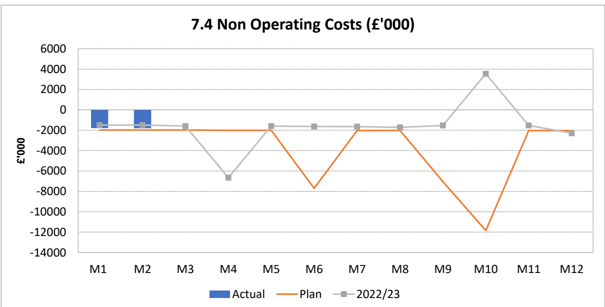
Performance activity on a rolling 15 months/quarterly
Average on a rolling 15 months/quarterly
Lower Control Limit (LCL)
Upper Control Limit
Targets/Thresholds/NHSI Trajectories

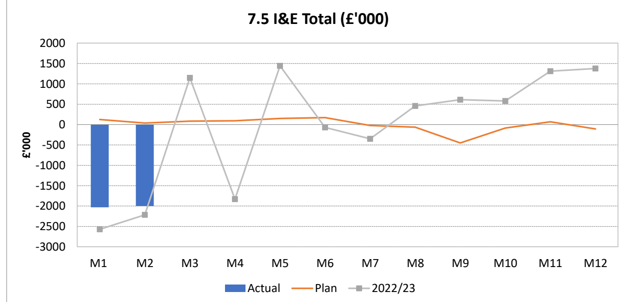
OBJECTIVE 7 - FINANCIAL PERFORMANCE

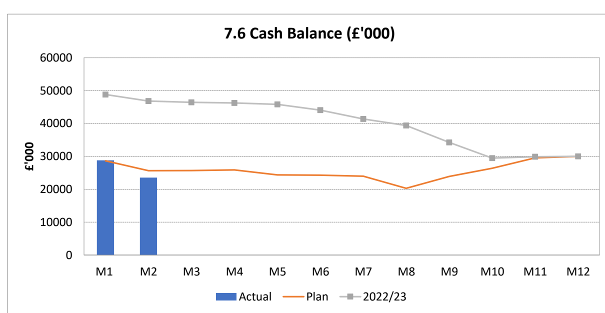


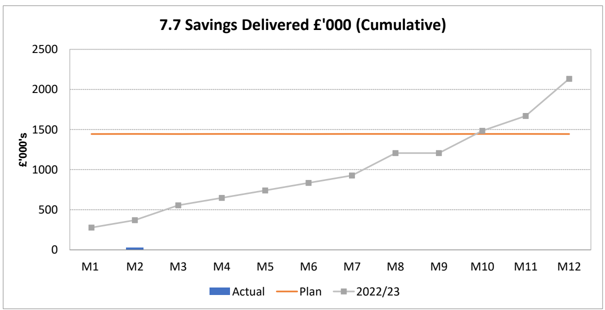


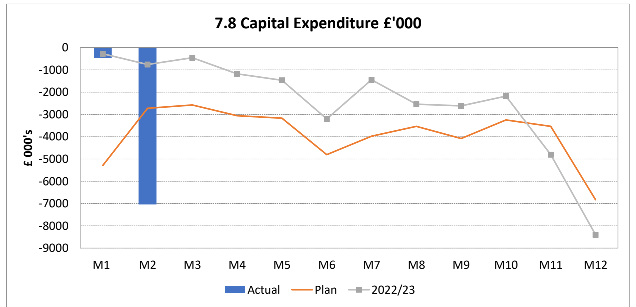


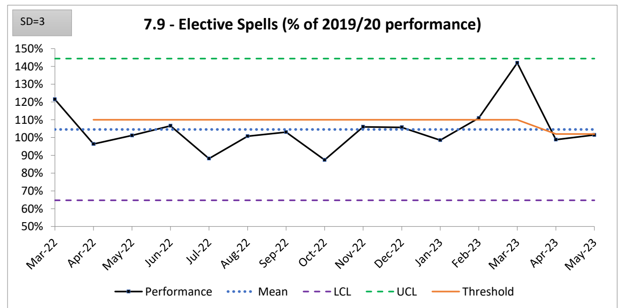


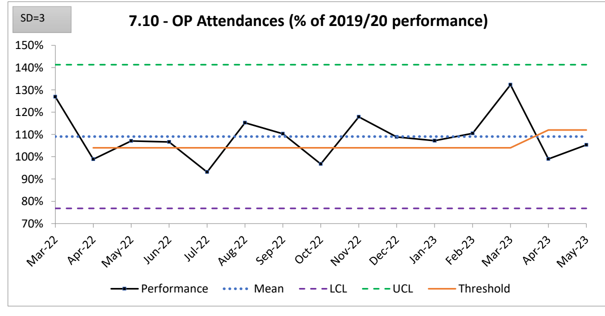




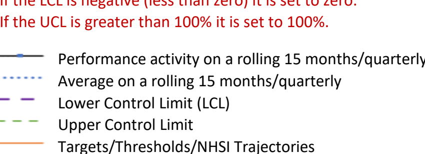




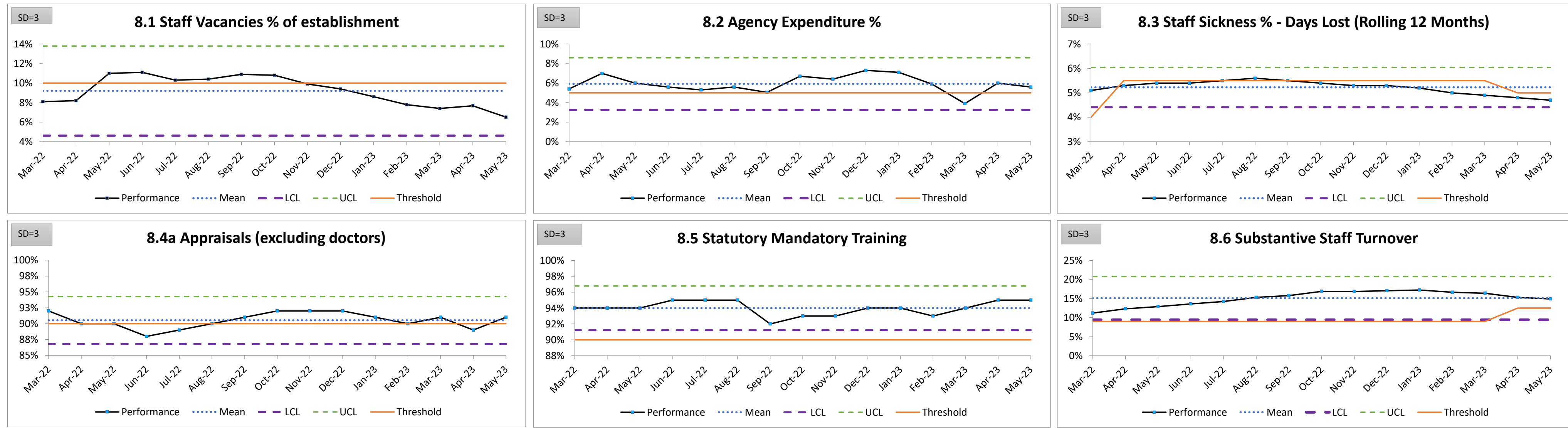




If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.



OBJECTIVE 8 - WORKFORCE PERFORMANCE



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

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

SD=3

O.1 - Total Number of Nice Breaches

60
50
40
30
20
10
0

Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Performance Mean LCL UCL Threshold

SD=3

O.2 - Rebooked cancelled OPs - 28 day rule

100%
80%
60%
40%
20%
0%

Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Performance Mean LCL UCL Threshold

O.4 - Overdue Incidents >1 month

700
600
500
400
300
200
100
0

M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12

Actual 2022/23

SD=3

O.5 - Serious Incidents

25
20
15
10
5
0

Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Performance Mean LCL UCL Threshold

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

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

Meeting Title	Public Board	Date:
Report Title	**Finance Paper Month 2 2023-24**	**Agenda Item Number: 10**
Lead Director	Terry Whittle	Director of Finance
Report Authors	Sue Fox Cheryl Williams	Head of Financial Management Head of Financial Control and Capital

Introduction	The Purpose of the report is to provide an update on the financial position of the Trust at Month 2 (May 23).					
Key Messages to Note	The Trust is reporting a £4m deficit (on a Control Total basis) to the end of the May 2023. This is £4.2m worse than plan. There is a continued pay cost burden from bank and premium agency costs to cover escalation areas, strike impact, vacancies, and supernumerary nursing arrangements. The savings target for the year is £17m (5% of expenditure). £2.9m of this was expected to be delivered to May. ERF delivery is behind the 106% target but this has been fully recognised at month 2 as per NHSE guidance.					
Recommendation *Tick the relevant box(es)*	**For Information**	☐	**For Approval**	☐	**For Review**	x

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

Report history	None
Next steps	
Appendices	Pages 12-14

FINANCE REPORT FOR THE MONTH TO 31st MAY 2023

TRUST BOARD

CONTENTS

1	Executive summary	Page 3
2	Financial performance - month 1 (May)	Page 4
3	Financial performance – cumulative (Apr-May)	Page 5
4	Activity & Elective Recovery Fund	Page 6
5	Efficiency savings	Page 7
6	Capital	Page 8
7	Cash	Page 9
8	Statement of Financial Position (Balance Sheet)	Page 10
9	Recommendations to the Board	Page 11
10	Appendices	Pages 12-14
11	Glossary of terms	Page 15

EXECUTIVE SUMMARY

(1 & 2.) Revenue – Clinical revenue (BLMK Integrated Care Board block contract and variable non-ICB income) is above plan due to income recognised for emergency care which partly covers the cost of escalation. Other revenue is above plan due to income received for education and training.

(3. & 4.) Operating expenses – Pay costs are higher than plan due to the cost of temporary agency staff working in escalation wards and supernumerary staff covering new international recruits. Non-pay is above plan due to additional spend on drugs, clinical consumables in unfunded escalation areas and clinical outsourcing.

(5.) Non-operating expenditure – Lower than plan due to interest received in month.

(8.) Covid expenditure – Direct Covid costs mainly relating to backfill for staff sickness absence.

(10.) Financial Efficiency– The cost improvement programme has been delayed and only a small number of schemes are currently in place. A number of new schemes are currently going through the approval process.

(11.) Cash – Cash balance is £23.5m, equivalent to 26 days cash to cover operating expenses.

(12.) Capital – Capital expenditure is behind plan. This is accounted for by the delay in committing to capital schemes due to the unresolved capital approved shortfall of £5m for 2023/24

Measures

Ref	All Figures in £'000	Month 2 YTD Plan	Month 2 YTD Actual	Month 2 YTD Var	Full Year Plan	Full Year Forecast	Full Year Var	RAG
1	Clinical Revenue	53,070	53,549	479	318,419	318,419	-	
2	Other Revenue	3,774	4,381	607	42,168	42,168	-	
3	Pay	(36,047)	(39,629)	(3,582)	(215,695)	(215,695)	-	
4	Non Pay	(16,777)	(18,730)	(1,953)	(100,853)	(100,853)	-	
5	Financing & Non-Ops	(3,959)	(3,699)	260	(24,139)	(24,139)	-	
6	Surplus/(Deficit)	59	(4,128)	(4,188)	19,900	19,900	-	
7	Control Total Surplus/(Deficit)	161	(4,026)	(4,188)	-	-	-	

Memos

Ref	All Figures in £'000	Month 2 YTD Plan	Month 2 YTD Actual	Month 2 YTD Var	Full Year Plan	Full Year Forecast	Full Year Var	RAG
8	COVID expenditure	(143)	(308)	(165)	(860)	(860)	-	
9	High Cost Drugs	(3,845)	(3,877)	(32)	(22,600)	(22,600)	-	
10	Financial Efficiency	2,889	25	(2,864)	17,335	17,335	-	
11	Cash	25,630	23,542	(2,088)	29,995	29,995	-	
12	Capital Plan	(8,021)	(7,512)	509	(46,842)	(46,842)	-	

Key message

The Trust is reporting a £4m deficit (on a Control Total basis) to the end of the May 2023. This is £4.2m worse than plan.

There is a continued pay cost burden from bank and premium agency costs to cover escalation areas, strike impact, vacancies, and supernumerary nursing arrangements.

The savings target for the year is £17m (5% of expenditure). £2.9m of this was budgeted to be delivered by May 2023.

ERF delivery is behind the 106% target but this has been fully recognised at month 2 as per NHSE guidance.

The capital expenditure programme is £0.5m below its capital plan, due to the delay in resolving the capital shortfall. The trust is still waiting approval for the £5m shortfall in its approved 23/24 ICS CDEL allocation.

FINANCIAL PERFORMANCE - OVERVIEW MONTH 2

2. **Summary Month 2**

   For the month of May 2023, financial performance (on a Control Total basis) is a £2m deficit, this is £2m adverse to plan.

3. Clinical Income
   Clinical income shows a favourable variance of £0.3m. This is due to income recognised for urgent and emergency care above the planned value to cover the cost of escalation.

4. Other Income
   Other income shows a favourable variance of £0.5m due to income for education and training. This if offset by an equal and opposite adjustment in pay.

5. Pay
   Pay spend is above plan by £1.9m. Several escalation areas were open in May incurring premium agency staffing costs. Supernumerary costs for international recruits cost an additional £0.1m and agency to cover mental health nursing cost £0.1m in month. Further pay detail is included in Appendix 2.

6. Non-Pay
   Non-pay is above plan due to increased spend on drugs, clinical consumables, and clinical outsourcing. Further detail is included in Appendix 3.

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

	Month 2			Month 2 YTD			Plan		
All Figures in £'000	Plan	Actual	Var	Plan	Actual	Var	Plan	Forecast	Var
Clinical Revenue	26,535	26,856	321	53,070	53,549	479	318,419	318,419	0
Other Revenue	1,887	2,380	493	3,774	4,381	607	21,646	21,646	0
Total Income	28,422	29,236	814	56,844	57,930	1,087	340,065	340,065	0
Pay	(18,046)	(19,930)	(1,884)	(36,047)	(39,629)	(3,582)	(215,695)	(215,695)	0
Non Pay	(8,411)	(9,499)	(1,087)	(16,777)	(18,730)	(1,953)	(100,853)	(100,853)	0
Total Operational Expenditure	(26,457)	(29,428)	(2,971)	(52,825)	(58,359)	(5,534)	(316,548)	(316,548)	0
EBITDA	1,965	(192)	(2,157)	4,019	(429)	(4,448)	23,517	23,517	0
Financing & Non-Op. Costs	(1,928)	(1,805)	123	(3,857)	(3,597)	260	(23,517)	(23,517)	0
Control Total Deficit (excl. top ups)	**37**	**(1,997)**	**(2,033)**	**161**	**(4,026)**	**(4,188)**	**0**	**0**	**0**
Control Total Deficit (incl. top ups)	**37**	**(1,997)**	**(2,033)**	**161**	**(4,026)**	**(4,188)**	**0**	**0**	**0**
Donated income	0	0	0	0	0	0	20,522	20,522	0
Depreciation	(51)	(51)	0	(102)	(102)	0	(622)	(622)	0
Impairments & Rounding	0	0	0	0	0	0	0	0	0
Reported deficit/surplus	**(14)**	**(2,048)**	**(2,033)**	**59**	**(4,128)**	**(4,188)**	**19,900**	**19,900**	**0**

Key message
For the month of May 2023, the position on a Control Total basis is a £2m deficit, which is worse than plan. The deficit is due to the continued spend on premium staffing costs and a challenging financial plan which includes a savings target of 5% (£17m). This equates to £1.4 in month 2.

8. **Summary Year to Date**

Cumulative financial performance (April - May) on a Control Total basis is a deficit of £4.2m, against a break even plan. Overspends on pay costs are partly offset by increased income.

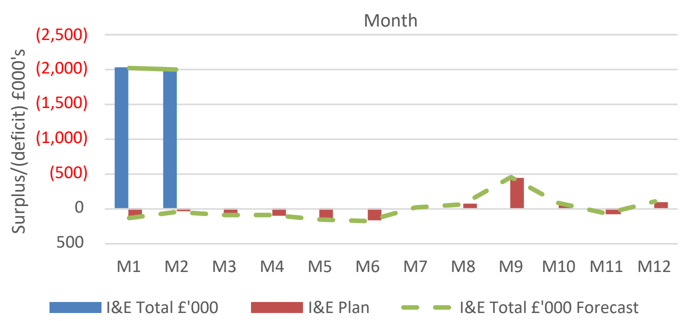
9. Clinical Income YTD
Clinical income shows a favourable variance of £0.5m which is due to income recognised for urgent and emergency care to cover the cost of escalation capacity. The variable planned care activity underperformed by £0.7m, driven by the bank holidays and the recent staff strikes Further detail is included in Appendix 1.

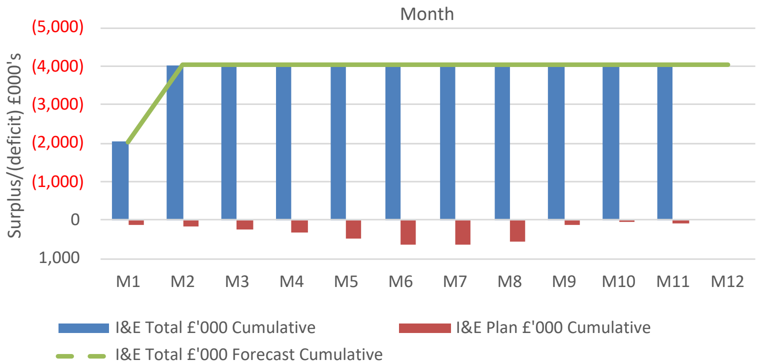
10. Other Income YTD
Other income shows a favourable variance of £0.6m. The majority of this is income received for education and training.

11. Pay YTD
Pay spend is above plan by £3.6m YTD due partly to the cost of escalation and partly due to unidentified cost improvements. Spend on temporary staffing costs is continuing at a consistent run rate. Further detail is included in Appendices 1 & 4.

12. Non-Pay YTD
Non pay is above plan due to expenditure on drugs and clinical supplies and services relating to both activity and inflationary pressures. Further detail is included in Appendices 1 & 5.

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





Key message
Up to May 2023, the position on a Control Total basis is a deficit of £4m. This is worse than plan. Overspends on pay and a challenging efficiency target the main drivers of this position.

Deferred income of £1.2m has been released to support the current position, this is £0.4m higher than the planned release to date.

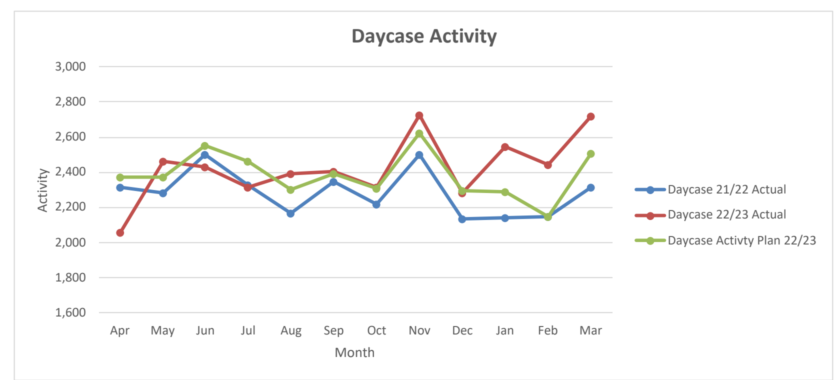
ACTIVITY PERFORMANCE & ERF

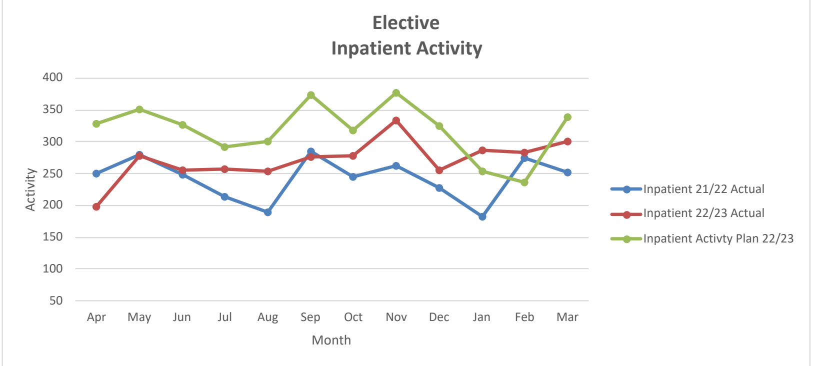
14. The Trust has recognised 100% of the expected elective recovery fund (ERF) income available for the month on the basis that this will not be subject to commissioner clawback. This is expected to continue through the financial year, although there are expected to be some exceptions for the recent (and any future) staff strikes. The revised budget includes full achievement of the £66.7m of variable ERF funds allocated to MKUH. The 2023/24 ERF target is based on a stretch target of 106% of the 2019-20 baseline volumes.

    The below analysis looks at the Trust CIVICA SLAM performance, to give an indication of our expected ERF position. However, ERF the rules are slightly different and the ERF output will differ from the below:

15. Activity vs Plan (as per CIVICA)

Day case activity- Day cases YTD activity is 103% of the 23/24 plan, but the financial value is 93%. This is caused by uncoded activity within the position.
Elective Inpatient Activity- Similar to day cases, the inpatient elective finances are under stated due to uncoded activity. The activity is below plan, showing 93% of the 23/24 plan and the finances are 82%.
Outpatient Activity- Outpatient attendances are over performing, but procedures are significantly under: First attendance activity is 112% of the 23/24 plan, and finance is 125%. Follow Ups are part of the fixed block funding, the activity is 117% of the 23/24 plan. Procedures are materially underperforming, caused by uncoded procedures appearing as attendances.
Non-Elective Spells- Non elective funding is part of the fixed block, the YTD activity is 73% of the 23/24 plan.
A&E activity- A&E activity is part of the fixed block, the YTD activity is 96% of the 23/24 plan.





Key message
Elective planned care activity is below the 23/24 financial plan, driven by a high volume of uncoded activity in the position understating the value of the activity. For most elective care types the activity is above 23/24 plan, but the finances are lower. Non elective and A&E activity is part of the fixed block, so any over performance is unfunded. Currently both are underperforming, but that is likely to change as we move through the financial year.

EFFICIENCY SAVINGS

16. The efficiency target for 2023/24 is £17.3m. This equates to around 5% of expenditure for the year. The targets have now been split out to divisions and are based on controllable spend. Pass through costs, such as the clinical negligence premium, have been excluded before applying the percentage CIP target. The targets remain largely the same as last year with an additional £5m which has been assigned to trust wide schemes.

	£000's
Medicine	3,450
Surgery	2,600
W&C	1,400
Core Clinical	2,500
Corporate	2,385
Trustwide	5,000
TOTAL	**17,335**

17. The clinical divisions are working through their savings plans and draft figure of £8.3m has been identified to date however this figure has not been risk adjusted e.g., due to slippage or realism in delivery.

Key message
YTD the Trust has an efficiency requirement of £17.3m for the 2023/24 financial year. Work is progressing through the Trust 'Better Values' programme to identify new opportunities.

CAPITAL - OVERVIEW YTD

18. The YTD spend to the end of May is £7.5m which is £0.5m below YTD plan. The main area of variance relates to unallocated funding which relates to schemes that are being held until there is clarity over the £5m funding shortfall

19. The Trust's ICS CDEL approved allocation is £13.3m however this is £5m short of its £18.3m submitted plan for ICS CDEL. The Trust is in on-going discussions with NHSE about this shortfall. The Trust also has Nationally approved CDEL of £6.6m, an additional £0.9m from the previous month that relates to Imaging funding for a CT scanner m and is awaiting approval for its IFRS16 lease funding of £2.4m and £3m for Urgent and Emergency Care capital funding . The current requested CDEL is £30.2m which includes ICS allocation, leases and nationally approved funding.

20. In addition, the Trust has external funding from donations of £20.5m which is excluded from the CDEL allocation. The Trust's total forecast spend for 2023/24 is £50.8m which includes the items waiting national approval for.

21. The full breakdown of all funding and sources of application is shown in the table below.

	ICS Required Funding 2023/24	ICS Approved CDEL Allocation 2023/24 including bonus	National Approved CDEL Allocation 2023/24	*Awaiting Approval CDEL 2023/24*	***Total CDEL inc awaiting approval***	**Externally Funded**
Funding Subcategory	**Internally Funded**	Internally Funded	Nationally funded	*Internally Funded*		**Externally Funded**
		£m	£m	*£m*	*£m*	£m
Depreciation	18.29	13.29		*5.00*	18.29	
IFRS16				*2.36*	2.36	
PDC Funded National						
New Hospital Programme			1.16		*1.16*	
Digital Diagnostic Funding - Pathology			0.30		*0.30*	
Digital Diagnostic Funding - Imaging			0.27		*0.27*	
CDC - Lloyds Court & Whitehouse Park			3.95		*3.95*	
Imagaing Transformation - CT Scanner*			0.90		*0.90*	
Urgent & Emergency Care Funding*				*3.00*	*3.00*	
Sub Total CDEL	**18.29**	13.29	6.58	5.00	**30.23**	
Donated Funding						
Council (Radiotherapy & CDC)						10.00
Donor (Radiotherapy)						5.70
Salix						4.82
Total Donated Funding						**20.52**

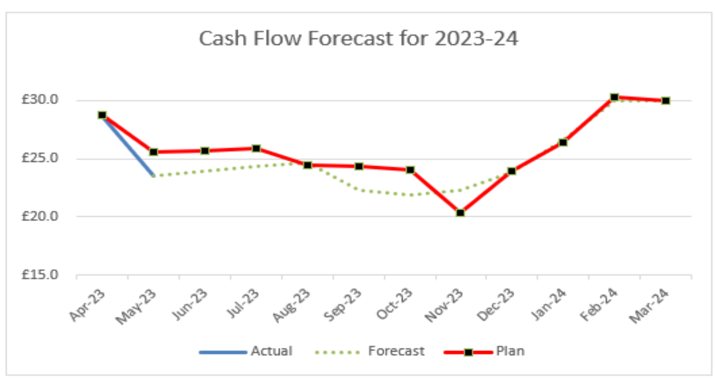
	Value of approved BC £m	**23/24 YTD Mth 2 Plan £m**	**23/24 YTD Mth 2 Actual £m**	**YTD Variance to YTD Plan £m**	**Status**	**Comments**
Pre-commitments						
CBIG	0.48	0.06	0.04	- 0.02		
Strategic	0.56	0.03	0.13	0.10		Small variance relating to the timing of the breast screening scheme that is ahead of the plan
Total Pre-commitments	**1.03**	**0.09**	**0.18**	**0.08**		
Scheme Allocations For 23/24 schemes						
CBIG including IT and Contingency	0.94	0.24	0.19	-0.04		CBIG plan only approved in early May resulting in a timing impact for the approval of business cases
Strategic Radiotherapy	1.91	0.35	0.31	- 0.04		YTD spend slightly behind plan
Strategic Salix	1.99	0	-	- 0.09		
Total Proposed Scheme Allocations	**4.85**	**0.68**	**0.50**	**- 0.18**		-
Funding to be allocated	**0.00**	**0.83**	**0.00**	**-0.83**		Due to the uncertainly of the approved plan, not all funding is currently being released to schemes
Hospital capacity (Fees only)						BC submitted to June FIC, waiting Board approval
Adjustment			1.47	1.47		Costs accrued to support commitments made
Donated Funded Schemes (excluded from CDEL)						
Strategic Radiotherapy	10.70	1.94	1.74	-0.20		
Strategic Salix	4.82	0.00	0.00	0.00		
Strategic CDC - Lloyds Court & Whitehouse Park	0.00	0.83	0.00	-0.83		
Total Donated Funded Schemes	**15.52**	**2.77**	**1.74**	**-1.03**		
Total Pre-commitments and Scheme Allocations (ICS CDEL Allocation)	**5.89**	**4.38**	**3.89**	**- 0.49**		
Nationally approved schemes						
NHP	1.16	0.19	0.20	0.01		Timing of spend slightly ahead of plan, expected to be as per forecast by the year end
Digital Diagnostic Funding -Pathology	0.00	0.00	0.00	-		
Digital Diagnostic Funding - Imaging	0.00	0.00	0.00	-		
CDC - Lloyds Court & Whitehouse Park	0.00	1.13	1.11	- 0.02		
Imaging Transformation - CT Scanner						BC going to July FIC
Total Nationally approved schemes	1.16	1.32	1.31	- 0.02		
CDEL Submitted capital plan	**7.05**	**5.70**	**5.19**	**- 0.50**		
New Leases Impact under IFRS 16 - held centrally	2.36	2.32	2.32	0.00		As per plan
Submitted CDEL capital plan	**9.41**	**8.02**	**7.52**	**-0.50**		
Total Capital spend	**24.93**	**8.02**	**7.52**	**- 0.50**		-

CASH

22. Summary of Cash Flow
The cash balance at the end of May was £23.5m, £2.5m lower than the planned figure of £26m and a £5.2m decrease on last month's figure of £28.7m (see opposite).
See appendices 6-8 for the cashflow detail.

23. Cash arrangements 2023/24
The Trust will receive block funding for FY24 which will include an uplift for growth plus any additional incentive funding linked to activity delivery and funding for high-cost drugs on a pass-through basis.

24. Better Payment Practice
The Trust has fallen below the national target of 95% of all bills paid within the target timeframe in terms of value and volume. This is mainly due to the repatriation of SBS AP services, and the ongoing issues with agency invoicing. Both issues are being addressed and action plans are in progress to resolve them. This metric will continue to be monitored in accordance with national guidance and best practice.



Better payment practice code	Actual M2 YTD Number	Actual M2 YTD £'000	Actual M1 YTD Number	Actual M1 YTD £'000
Non NHS				
Total bills paid in the year	11,716	33,579	3,966	15,220
Total bills paid within target	10,427	31,907	3,457	14,992
Percentage of bills paid within target	**89.0%**	**95.0%**	**87.2%**	**98.5%**
NHS				
Total bills paid in the year	270	783	132	329
Total bills paid within target	219	478	113	234
Percentage of bills paid within target	**81.1%**	**61.1%**	**85.6%**	**71.1%**
Total				
Total bills paid in the year	**11,986**	**34,362**	**4,098**	**15,549**
Total bills paid within target	**10,646**	**32,385**	**3,570**	**15,226**
Percentage of bills paid within target	**88.8%**	**94.2%**	**87.1%**	**97.9%**

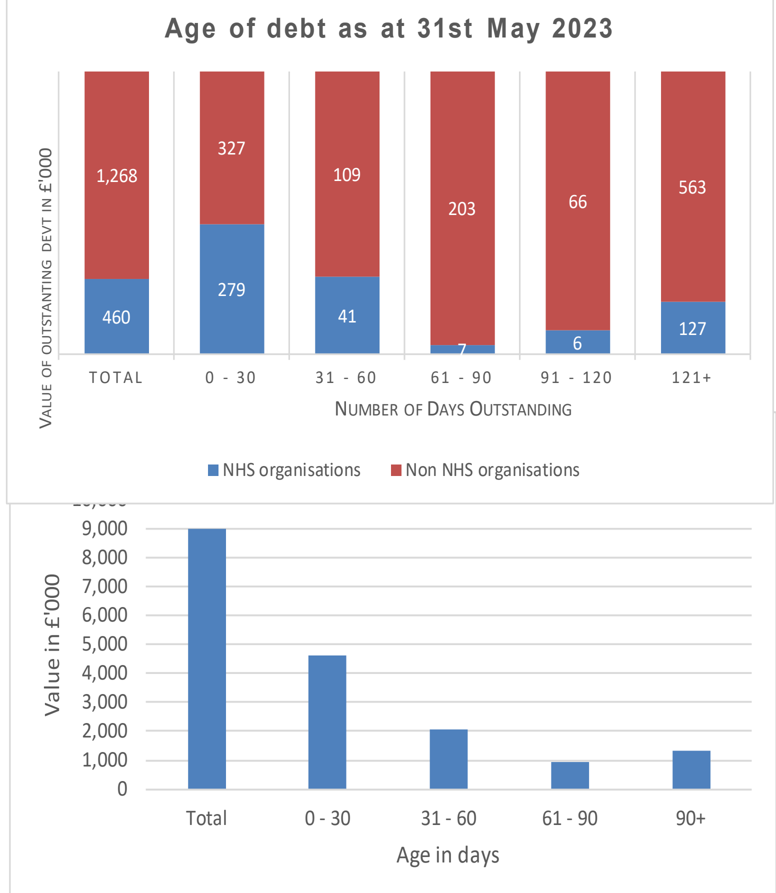
Key message
Cash at the end of May was behind plan at £23.5m. The Trust has fallen below the 95% target for BPPC, mainly due to issues experienced by SBS during their repatriation of AP services, and ongoing agency invoicing issues. Management is working to rectify payment performance to levels required.

BALANCE SHEET

25. Statement of Financial Position
The statement of financial position is set out in Appendix 9. The key movements include:
    - Non-Current Assets have increased from March 23 by £4.6m; this is driven by capital purchases in year offset by in year depreciation.
    - Current assets have decreased by £3.7m; this is mainly due to the decrease in cash £6.5m offset by an increase in receivables (£2.8m).
    - Current liabilities have increased by £2.5m; this is mainly due to the increase in trade payables £4m and a £1m decrease in Deferred Income.
    - Non-Current Liabilities have increased from March 23 by £2.5m; this is due to the Right of Use assets, related to IFRS 16.

26. Aged debt
- The debtors position as of May 23 is £1.7m, which is a decrease of £0.4m from the prior month. Of this total £0.7m is over 121 days old; the detail is shown in Appendix 10.
- The three largest NHS debtors are Bedford Hospitals NHS Foundation Trust £0.2m for salary recharges, Oxford University Hospitals NHS Trust £0.1m for salary/renal recharges and Oxford Health NHS FT for utility recharges £0.1m. The largest non-NHS debtors include £0.3m for overseas patient, £0.2m with Medical Property Ltd for utility recharges, £0.1m with University of Buckinghamshire Ltd for utilities recharges and training recharges. Further details of the aged debtors are shown in Appendix 11.

27. Creditors
- The creditors position as of May 23 is £8.9m, which is a decrease of £4.0m from the prior month. Of this, £4.4m is over 30 days with £2.0m approved for payment. The breakdown of creditors is shown in Appendix 12.



Key message
Main movements in year on the statement of financial position are reduction in trade payables of £4m, the reduction in cash of £6.5m, and the non-current assets increase of £4.6m.

RECOMMENDATIONS TO BOARD

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

APPENDICIES

Appendix 1

Statement of Comprehensive Income
For the period ending 31st May 2023

	FY23	M2 CUMULATIVE			M2			PRIOR MONTH	
	Annual Budget £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	M1 Actual £'000	Change £'000
INCOME									
Outpatients	51,003	8,501	7,824	(677)	4,453	4,149	(304)	3,675 ▲	474
Elective admissions	31,549	5,258	4,680	(578)	2,629	2,353	(276)	2,327 ▲	26
Emergency admissions	84,770	14,128	14,122	(7)	7,064	8,254	1,189	5,868 ▲	2,386
Emergency adm's marginal rate (MRET)	0	0	0	0	0	0	0	0 ▲	0
Readmissions Penalty	0	0	0	0	0	0	0	0 ▲	0
A&E	19,738	3,290	3,290	(0)	1,645	1,788	143	1,502 ▲	286
Other Admissions	2,108	2,416	361	(2,056)	2,416	124	(2,293)	237 ▼	(113)
Maternity	20,417	1,348	3,401	2,053	(534)	2,111	2,645	1,290 ▲	821
Critical Care & Neonatal	6,707	1,118	1,118	0	559	394	(165)	724 ▼	(330)
Excess bed days	0	0	0	0	0	0	0	0 ▲	0
Imaging	6,812	1,135	1,135	0	567	577	10	558 ▲	19
Direct access Pathology	5,770	962	962	0	481	534	53	428 ▲	106
Non Tariff Drugs and Devices (high cost/individual drugs)	21,139	3,523	3,526	3	1,761	1,719	(42)	1,807 ▼	(88)
Other (inc. home visits and best practice tariffs)	5,958	993	2,676	1,683	294	2,410	2,116	266 ▲	2,144
CQUINS	0	0	0	0	0	0	0	0 ▲	0
Contract Risk Provision - General challenge & CIP offset	0	0	0	0	0	0	0	0 ▲	0
RTT Plans	0	0	0	0	0	0	0	0 ▲	0
Other Adj	0	0	0	0	0	0	0	0 ▲	0
National Block/Top up	62,389	10,398	10,455	57	5,200	2,444	(2,756)	8,011 ▼	(5,567)
MKCCG Block adj	0	0	0	0	0	0	0	0 ▲	0
Prior Month Adj		0	0	0	0	0	0	0 ▲	0
Contract Income CIP		0	0	0	0	0	0	0 ▲	0
Delayed Discharges		0	0	0	0	0	0	0 ▲	0
Brokerage	0	0	0	0	0	0	0	0 ▲	0
Clinical Income	**318,419**	**53,070**	**53,549**	**479**	**26,535**	**26,856**	**321**	**26,693 ▲**	**162**
Non-Patient Income	21,646	3,774	4,382	608	1,887	2,381	494	2,001 ▲	380
PSF Income	0	0	(0)	(0)	0	0	0	(0) ▲	0
Donations	20,522	0	(0)	(0)	0	(0)	(0)	0 ▼	(0)
Non-Patient Income	**42,168**	**3,774**	**4,381**	**607**	**1,887**	**2,380**	**493**	**2,001 ▲**	**379**
TOTAL INCOME	**360,586**	**56,843**	**57,930**	**1,086**	**28,422**	**29,236**	**814**	**28,694 ▲**	**542**
EXPENDITURE									
Pay - Substantive	(195,355)	(32,592)	(32,649)	(56)	(16,319)	(16,424)	(105)	(16,225) ▼	(199)
Pay - Bank	(11,115)	(1,802)	(3,305)	(1,503)	(900)	(1,650)	(750)	(1,655) ▲	5
Pay - Locum	(2,957)	(510)	(1,210)	(700)	(255)	(664)	(409)	(546) ▼	(118)
Pay - Agency	(5,556)	(1,014)	(2,307)	(1,293)	(507)	(1,119)	(612)	(1,188) ▲	69
Pay - Other	(821)	(137)	(158)	(21)	(68)	(72)	(4)	(86) ▲	13
Pay CIP	41	7	0	(7)	3	0	(3)	0 ▲	0
Vacancy Factor	69	1	0	(1)	1	0	(1)	0 ▲	0
Pay	**(215,695)**	**(36,047)**	**(39,629)**	**(3,582)**	**(18,046)**	**(19,930)**	**(1,884)**	**(19,699) ▼**	**(230)**
Non Pay	**(100,853)**	**(16,777)**	**(18,730)**	**(1,953)**	**(8,411)**	**(9,499)**	**(1,087)**	**(9,232) ▼**	**(267)**
TOTAL EXPENDITURE	**(316,548)**	**(52,825)**	**(58,359)**	**(5,534)**	**(26,457)**	**(29,428)**	**(2,971)**	**(28,931) ▼**	**(497)**
EARNINGS BEFORE INTEREST, TAXATION, DEPRECIATION AND AMORTISATION (EBITDA)	**44,038**	**4,019**	**(429)**	**(4,448)**	**1,964**	**(192)**	**(2,157)**	**(237) ▲**	**45**
Interest Receivable	360	60	268	208	30	127	97	140 ▼	(13)
Interest Payable	(687)	(114)	(118)	(3)	(57)	(60)	(3)	(57) ▼	(3)
Depreciation, Impairments & Profit/Loss on Asset Disposal	(16,622)	(2,708)	(2,652)	56	(1,353)	(1,324)	29	(1,328) ▲	3
Donated Asset Depreciation	(622)	(102)	(102)	0	(51)	(51)	0	(51) ▲	0
Profit/Loss on Asset Disposal & Impairments	0	0	0	0	0	0	0	0 ▲	0
DEL Impairments	(560)	(93)	(93)	0	(47)	(47)	0	(47) ▲	0
AME Impairments	0	0	0	0	0	0	0	0 ▲	0
Unwinding of Discounts	0	0	0	0	0	0	0	0 ▲	0
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**25,907**	**1,060**	**(3,127)**	**(4,187)**	**486**	**(1,547)**	**(2,033)**	**(1,579) ▲**	**33**
Dividends Payable	(6,007)	(1,001)	(1,002)	(1)	(501)	(501)	(0)	(501) ▲	0
OPERATING SURPLUS/(DEFICIT) AFTER DIVIDENDS	**19,900**	**59**	**(4,129)**	**(4,188)**	**(15)**	**(2,048)**	**(2,033)**	**(2,080) ▲**	**33**

Statement of Cash Flow
As of 31st May 2023

	Mth12 2022-23 £000	Mth 2 £000	Mth 1 £000	In Month Movement £000
Cash flows from operating activities				
Operating (deficit) from continuing operations	(2,225)	(3,181)	(1,615)	(1,566)
Operating (deficit)	**(2,225)**	**(3,181)**	**(1,615)**	**(1,566)**
Non-cash income and expense:				
Depreciation and amortisation	14,941	2,753	1,379	1,374
Impairments	1,899	0	0	0
(Increase)/Decrease in Trade and Other Receivables	(8,203)	(1,258)	(2,049)	791
(Increase)/Decrease in Inventories	(1,096)	11	6	5
Increase/(Decrease) in Trade and Other Payables	(7,239)	1,191	4,875	(3,684)
Increase/(Decrease) in Other Liabilities	(1,935)	(2,506)	(142)	(2,364)
Increase/(Decrease) in Provisions	420	(9)	(5)	(4)
NHS Charitable Funds	(181)	0	0	0
Other movements in operating cash flows	1,730	(5)	(4)	(1)
NET CASH GENERATED FROM OPERATIONS	**(1,889)**	**(3,004)**	**2,445**	**(5,449)**
Cash flows from investing activities				
Interest received	871	268	140	128
Addition of ROU assets	(40)	0	0	0
Purchase of intangible assets	(2,673)	5,363	4,114	1,249
Purchase of Property, Plant and Equipment	(25,097)	(10,998)	(7,713)	(3,285)
Net cash generated (used in) investing activities	**(26,939)**	**(5,367)**	**(3,459)**	**(1,908)**
Cash flows from financing activities				
Public dividend capital received	8,040	0	0	0
Capital element of finance lease rental payments	(2,235)	2,129	(96)	2,225
Unwinding of discount	0	(93)	(47)	(46)
Interest element of finance lease	(378)	(118)	(57)	(61)
PDC Dividend paid	(4,760)	0	0	0
Receipt of cash donations to purchase capital assets	181	0	0	0
Net cash generated from/(used in) financing activities	**848**	**1,918**	**(200)**	**2,118**
Increase/(decrease) in cash and cash equivalents	**(27,980)**	**(6,453)**	**(1,214)**	**(5,239)**
Opening Cash and Cash equivalents	**57,975**	**29,995**	**29,995**	
Closing Cash and Cash equivalents	**29,995**	**23,542**	**28,781**	**(5,239)**

Appendix 3

Statement of Financial Position as of 31st May 2023

	Mar-23 Unaudited	May-23 YTD Actual	YTD Mvmt	% Variance
Assets Non-Current				
Tangible Assets	205.6	208.8	3.2	1.6%
Intangible Assets	19.6	19.2	(0.4)	(2.0%)
ROU Assets	25.5	27.4	1.9	7.5%
Other Assets	1.0	0.9	(0.1)	(13.7%)
Total Non Current Assets	**251.7**	**256.3**	**4.6**	**1.8%**
Assets Current				
Inventory	5.1	5.1	0.0	0.0%
NHS Receivables	9.8	11.4	1.6	16.0%
Other Receivables	8.5	9.7	1.2	14.1%
Cash	30.0	23.5	(6.5)	(21.7%)
Total Current Assets	**53.4**	**49.7**	**(3.7)**	**(7.0%)**
Liabilities Current				
Interest -bearing borrowings	(1.8)	(1.3)	0.5	(27.8%)
Deferred Income	(18.0)	(17.0)	1.0	(5.7%)
Provisions	(2.8)	(2.8)	0.0	0.0%
Trade & other Creditors (incl NHS)	(51.6)	(55.6)	(4.0)	7.8%
Total Current Liabilities	**(74.2)**	**(76.7)**	**(2.5)**	**3.3%**
Net current assets	**(20.8)**	**(27.0)**	**(6.2)**	**29.8%**
Liabilities Non-Current				
Long-term Interest bearing borrowings	(23.8)	(26.3)	(2.5)	10.5%
Deferred Income	(1.0)	(1.0)	0.0	0.0%
Provisions for liabilities and charges	(1.8)	(1.8)	0.0	0.0%
Total non-current liabilities	**(26.6)**	**(29.1)**	**(2.5)**	**9.4%**
Total Assets Employed	**204.3**	**200.2**	**(5.8)**	**(2.8%)**
Taxpayers Equity				
Public Dividend Capital (PDC)	283.2	283.2	0.0	0.0%
Revaluation Reserve	61.8	61.8	0.0	0.0%
Financial assets at FV through OCI reserve	(2.6)	(2.6)	0.0	0.0%
I&E Reserve	(138.1)	(142.2)	(4.1)	3.0%
Total Taxpayers Equity	**204.3**	**200.2**	**(5.1)**	**(2.5%)**

GLOSSARY OF TERMS

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

Meeting Title	Board Report	Date: July 2023
Report Title	**Workforce Report – Month 2**	**Agenda Item Number: 11**
Lead Director	Danielle Petch, Director of Workforce	
Report Author	Louise Clayton, Deputy Director of Workforce	

Introduction	Standing Agenda Item		
Key Messages to Note	This report provides a summary of workforce Key Performance Indicators for the previous 12 months up to 31 May 2023 (Month 2) and relevant Workforce and Organisational Development updates to Trust Board.		
Recommendation *(Tick the relevant box(es))*	**For Information** x	**For Approval** ☐	**For Review** ☐

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	Employ and retain the best people to care for you
Report History	
Next Steps	JCNC & TEC
Appendices/Attachments	None

1. Purpose of the report

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

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

Indicator	Measure	Target	05/2022	06/2022	07/2022	08/2022	09/2022	10/2022	11/2022	12/2022	01/2023	02/2023	03/2023	04/2023	05/2023
Staff in post *(as at report date)*	Actual WTE		3418.8	3417.5	3445.6	3437.0	3458.0	3467.9	3507.1	3524.8	3572.5	3605.1	3618.5	3636.0	**3697.4**
	Headcount		3904	3901	3930	3917	3946	3956	4001	4018	4075	4107	4142	4165	**4206**
Establishment *(as per ESR)*	WTE		3839.8	3842.5	3840.8	3837.0	3881.4	3887.9	3892.8	3892.4	3908.4	3909.8	3907.7	3951.1	**3956.4**
	%, Vacancy Rate - Trust Total	**10.0%**	11.0%	11.1%	10.3%	10.4%	10.9%	10.8%	9.9%	9.4%	8.6%	7.8%	7.4%	8.0%	**6.5%**
	%, Vacancy Rate - Add Prof Scientific and Technical		33.9%	33.2%	35.2%	32.4%	31.3%	33.7%	32.2%	32.5%	32.7%	33.2%	33.2%	31.2%	**24.4%**
	%, Vacancy Rate - Additional Clinical Services *(Includes **HCA** s)*		2.9%	4.0%	4.3%	3.3%	10.1%	10.7%	11.2%	9.0%	12.2%	11.3%	7.7%	9.3%	**6.4%**
	%, Vacancy Rate - Administrative and Clerical		8.8%	8.6%	8.5%	8.4%	8.1%	8.8%	7.6%	7.5%	5.5%	5.4%	5.0%	4.3%	**3.0%**
	%, Vacancy Rate - Allied Health Professionals		18.7%	19.5%	20.2%	18.8%	18.9%	17.8%	16.7%	16.4%	13.6%	12.7%	12.0%	13.6%	**16.5%**
	%, Vacancy Rate - Estates and Ancillary		13.9%	14.4%	14.3%	12.9%	11.5%	10.4%	9.0%	9.5%	8.3%	8.3%	8.6%	11.9%	**8.4%**
	%, Vacancy Rate - Healthcare Scientists		3.5%	0.6%	0.8%	0.0%	0.0%	0.7%	0.0%	1.8%	4.0%	1.7%	1.7%	1.8%	**6.3%**
	%, Vacancy Rate - Medical and Dental		4.9%	3.3%	0.0%	2.8%	0.0%	0.0%	0.0%	0.0%	0.7%	0.8%	3.9%	2.9%	**0.0%**
	%, Vacancy Rate - Nursing and Midwifery Registered		15.3%	16.0%	15.5%	15.3%	15.3%	14.6%	12.8%	12.2%	9.3%	7.4%	7.1%	7.9%	**7.7%**
Staff Costs (12 months) *(as per finance data)*	%, Temp Staff Cost (%, £)		13.7%	14.0%	14.3%	14.5%	14.8%	15.1%	15.3%	15.6%	15.7%	15.7%	15.3%	15.3%	**15.3%**
	%, Temp Staff Usage (%, WTE)		13.7%	13.8%	14.0%	14.1%	14.2%	14.4%	14.4%	14.5%	14.5%	14.5%	14.5%	14.3%	**14.3%**
Absence (12 months)	%, 12 month Absence Rate	**5.0%**	5.4%	5.5%	5.6%	5.5%	5.4%	5.3%	5.3%	5.2%	5.0%	4.9%	4.8%	**4.7%**	*4.7%*
	- %, 12 month Absence Rate - Long Term		*3.0%*	*3.0%*	*2.9%*	*2.9%*	*2.8%*	*2.6%*	*2.6%*	*2.5%*	*2.5%*	*2.4%*	*2.4%*	***2.4%***	*2.4%*
	- %, 12 month Absence Rate - Short Term		*2.4%*	*2.5%*	*2.7%*	*2.6%*	*2.6%*	*2.7%*	*2.7%*	*2.7%*	*2.5%*	*2.5%*	*2.4%*	***2.3%***	*2.3%*
	%,In month Absence Rate - Total		4.3%	4.4%	5.6%	4.1%	4.2%	5.0%	4.7%	5.0%	4.1%	4.0%	4.1%	**4.0%**	*3.9%*
	- %, In month Absence Rate - Long Term		*2.6%*	*2.6%*	*2.6%*	*2.5%*	*2.3%*	*2.3%*	*2.6%*	*2.7%*	*2.4%*	*2.5%*	*2.2%*	***2.3%***	*2.3%*
	- %, In month Absence Rate - Short Term		*1.7%*	*1.8%*	*3.0%*	*1.6%*	*1.9%*	*2.7%*	*2.1%*	*2.3%*	*1.7%*	*1.5%*	*1.9%*	***1.6%***	*1.6%*
Starters, Leavers and T/O rate (12 months)	WTE, Starters (In-month)		33.9	29.7	50.9	55.0	59.4	49.2	49.1	54.1	65.5	52.5	61.8	46.8	**62.6**
	Headcount, Starters (In-month)		40	35	57	58	68	58	55	60	76	55	65	53	**71**
	WTE, Leavers (In-month)		37.0	37.5	50.3	46.1	52.9	51.2	27.9	41.7	41.6	25.2	45.3	22.6	**25.4**
	Headcount, Leavers (In-month)		43	45	60	58	60	62	35	48	48	29	52	27	**30**
	%, Leaver Turnover Rate (12 months)	**12.5%**	12.9%	13.6%	14.2%	15.3%	15.8%	16.9%	16.9%	17.1%	17.2%	16.7%	16.4%	15.3%	**14.9%**
Statutory/Mandatory Training	%, Compliance	**90%**	94%	95%	95%	95%	92%	93%	93%	94%	94%	93%	94%	95%	**95%**
Appraisals	%, Compliance	**90%**	90%	88%	89%	90%	91%	92%	92%	92%	91%	90%	91%	89%	**91%**
Time to Hire (days)	General Recruitment	**35**	52	65	59	64	56	54	53	48	50	43	41	43	**51**
	Medical Recruitment (excl Deanery)	**35**	79	63	89	72	73	63	80	33	67	59	87	78	**70**
Employee relations	Number of open disciplinary cases		4	9	13	14	15	22	26	22	24	23	20	19	**19**

2.1. **Temporary staffing usage** has remained around 14% for the past 6 months. Work continues to ensure scrutiny of all agency spend, with a line by line agency review taking place in month. The HRBPs keep updated the exit strategies for each agency-worker in their Division, ensuring agency use is minimised. It is anticipated that this work will have a positive impact on reducing agency and agency spend as the year progresses.

2.2. The Trust's **headcount continues to increase** and there are now 4206 employees in post in the Trust, which is the highest it has been, with an additional 302 staff in post compared to the same period in the previous year. Despite an **increase in budgeted establishment** the vacancy rate has continued to fall and is currently at **6.5%** with improvements across several staff groups.

2.3. **Staff absence has reduced to 3.9%** in month with a sustained improvement on short-term absence rates. There has been an increase in absence management which is being managed through the Employee Relations Advisors.

2.4. **Staff turnover** continues to make small improvements with a **decrease down to 14.9%**, its lowest point since August 2022. Retention projects in areas of high turnover continue and the work is being monitored through Workforce Board and Workforce Development and Assurance Committee.

2.5. **Time to hire** has increased to 51 days with technical issues with the national system occurring in M2 and M3 which have impacted on this.

2.6. The number of **open disciplinary cases** has reduced but **remains high** and this is having a negative impact on case length. In addition to disciplinary cases, there are high numbers of grievance and attendance meetings. The team have put together a training package as part of the MK Way programme for managers on investigations, case report writing, presenting at hearings, and chairing hearings. This will go live in M4. A detailed Employee Relations case report is produced monthly to JCNC and on a quarterly basis for Workforce Board.

2.7. **Statutory and mandatory training** compliance is at 95% and **appraisals** compliance is at 91% with Women's and Children's still showing as non-compliant. The Division is asked to create a recovery plan to get back within target within 2 months.

2.8. There are **61 nursing vacancies** across the Trust, a decrease of 3 wte from the previous month. The third cohort of the 2023 internationally educated intake arrived in month 2, consisting of 25 internationally educated nurses and 2 international educated midwives. There are currently 45 international and 21 domestic nurses in the recruitment pipeline.

2.9. There are **101 HCSW vacancies** (B2 and B3 and including Maternity Support Workers) across the Trust which is a decrease of 20 on the previous month. There are currently 19 candidates in the recruitment pipeline. There remains significant competition for candidates for these roles locally and so alternative recruitment initiatives are being explored.

3. Continuous Improvement, Transformation and Innovation

3.1. **Agency Review** Meetings have commenced to scrutinise all agency use across the Trust. These meetings were chaired by Execs and a decision about continued usage was made taking into account impact on patients and safety. From M4 any requests for single shift agency use will be automated to ensure that there is greater oversight through set approval structures within the Divisions. The forms will also require the submitter to provide more information related to the request to enable Executive approvers to be able to make informed decisions on staffing levels at final approval stage. There will also be an escalated approval rate request form for approval through the same hierarchy.

3.2. The **Resourcing Team** will be rolling out Trust ID in M4 which will mean that candidates can have their ID checked online without having to come on site for a face-to-face appointment. This will speed up DBS and Right to Work ID checks and provide an automatic pass or fail for the candidate.

4. Culture and Staff Engagement

4.1. The HR Services Team are planning to roll out a **Freedom to Speak Up App** in M4/5 which will create an easy and anonymous solution to raising concerns through the FTSU Guardian and Champion Team.

4.2. The **Staff Survey** is being rolled out to Divisions, CSUs, and Departments through the HR Business Partnering Team. This will also support the Retention Projects that the HRBPs are taking forwards for areas with high turnover.

5. Current Affairs & Hot Topics

5.1. The national Agenda for Change **Pay Award** was paid in salaries in June with the team facilitating stepped payment of the 2022/23 award for 70 employees to ensure it did not negatively impact on their Universal Credit.

5.2. The Trust has launched its **collaborative Healthcare Support Worker recruitment campaign** in M3. This campaign is a joint venture with Bedfordshire Hospitals through the BLMK ICS and over the next three months there will be spotify adverts, videos on social media and leaflet drops to promote the role across the NHS Acute sector.

6. Recommendations

6.1. Members are asked to note the report.

Meeting title	Trust Board of Directors	Date July 2023
Report title:	Trust wide Report – Annual claims report	Agenda item: 12
Lead directors **Report author Sponsor(s)**	Ian Reckless Kate Burke Tina Worth	Medical Director Director of Corporate Affairs Head of Risk and Clinical Governance
FoI status:	Public document	

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

Strategic objectives links	Refer to main objective and link to others 1. Improve Patient Safety 3. Improve Clinical Effectiveness 4. Deliver Key Targets 7. Become Well-Governed and Financially Viable
Board Assurance Framework links	Lack of learning from incidents is a key risk identified on the BAF
CQC outcome/ regulation links	This report relates to CQC: Regulation 12 – Safe care & treatment Regulation 17 – Good governance Regulation 20 – Duty of Candour
Identified risks and risk management actions	Lack of learning from incidents is a key risk identified on the BAF
Resource implications	Litigation costs in relation to defence and claimant and damages paid
Legal implications including equality and diversity assessment	Contractual and regulatory reporting requirements.

Report history	Monthly reports to SIRG (Thursdays) Quality and Clinical Risk Committee, June 2023
Next steps	Benchmarking review from data from NHS Resolution
Appendices	Appendix 1 – NHSR claims abbreviated dashboard Appendix 2 – all opened claims 2022 – 2023 Appendix 3 – all closed claims 2022 - 2023

Executive summary re the overall national picture for clinical negligence claims

The Trust works in collaboration with NNS resolution (NHSR) and Capsticks in the management of its clinical negligence claims. The majority of claims nationally received by NHSR are resolved without formal court proceedings and, in these early stages, more claims are resolved without payment of damages than with payment of damages.

Nationally total payments relating to NHS Resolution's clinical schemes (not including administrative costs) stood at £2,209.3 million in 2020/21. This was a decrease of £114.9 million from £2,324.2 million in 2019/20. Damages paid to claimants in 2020/21 stood at £1,609.8 million, including personal injury discount rate (PIDR) expenditure (PIDR is used by the courts "to place a current value on claims settlements where there is an element of future loss"). This was a decrease of £73.4 million from £1,683.2 million in 2019/20. Claimant legal costs also decreased from £497.5 million to £448.1 million. NHS Resolution has stated there has also been a reduction in the volume of high value claims that have had damages and claimant legal cost payments and that the average value of these payments reduced in 2020/21, but it has said that the pandemic may have had an effect on reduced costs:

"This may be in part due to the operational challenges experienced in the legal and health environments during the pandemic to progress claims. Also, costs are increased when a case enters formal court proceedings and therefore the decrease in claims entering formal proceedings may also have contributed to the decrease in spending in these areas."

The number of clinical claims closing with and without the payment of damages has generally been increasing since 2006/07, although claims closing with the payment of damages has levelled off in recent years. In 2020/21, 6,574 clinical claims received damages compared to 7,523 in 2019/20. Clinical claims receiving no damages stood at 5,079 in 2020/21 compared with 4,469 in 2019/20.

The cost of CNST clinical negligence claims incurred as a result of incidents in 2020/21 was £7.9 billion. NHS Resolution has said that 60% of this cost related to maternity services (£4.8 billion as at 31 March 2021).

NHS Resolution states that the majority of claims it receives are resolved without formal court proceedings and that "in these early stages, more claims are resolved without payment of damages than with payment of damages". Claims not needing court proceedings are managed by NHS Resolution's internal teams. It has said that the "overwhelming majority" were resolved "by negotiation in correspondence, in meetings between the parties, or using some form of alternative dispute resolution, including formal mediation".

This report will detail claims information taken from the NHSR dashboard and the Trust's Radar system and will include:

- Number of clinical negligence claims opened
- Number of clinical negligence claims closed
- Brief analysis

Opened Clinical negligence claims

There were 80 opened claims 2022 – 2023 broken down as follows:

- Medicine – 18
- Emergency Medicine – 9

- Surgery (including anaesthetics & Head & Neck) - 17
- Women's Health (Gynaecology & Obstetrics) – 23
- Musculoskeletal – 9
- Pending clarity - 4

This is a significant decrease from the previous year when 103 were reported which may be linked on Covid-19, as we come out of the pandemic.

The details pertaining to a lot of these remain unknown or minimal pending legal processes to collate information. Women's Health remains the highest received specialty which is replicable to the national picture.

A detailed report is presented at the Trust's Serious Incident Review Group (SIRG) each month based on opened/closed claims from the preceding month and cross references any related complaints, incidents, inquests or serious incidents. The Divisions/specialties are also notified by the Litigation office of all new claims (once letter of claim/details of claim received) to facilitate the collation of supporting information and any learning previously noted at governance or Mortality and Morbidity (M&M) meetings which may help in supporting the Trust's liability, enable ongoing learning and identify and trends.

Clinical negligence claims closed

There were 84 claims closed 2022- 20203 broken down as follows:

- Medicine – 12
- Emergency Medicine - 18
- Surgery (including anaesthesia/Intensive Care) – 18
- Women's Health – 24
- Musculoskeletal – 10
- Therapies – 2

This is comparable with the preceding year. Of these, 45 incurred no costs usually since abandoned or closed due to inactivity.

The top 3 incidents that incurred the highest paid out damages for a claim were:

- MK 1359 - £21,4999 - alleged 18 month delay in diagnosing and treating Ewing's Sarcoma. The delay resulted in the need for more extensive surgery due to the spread of the disease and the magnetic resonance imaging (MRI) resulted in damage to the claimant's left femoral prosthesis.
- MK-2381 - £22,0000 – this claim relates to the Trust's failure to recognise that the Claimant's (age 60) respiratory symptoms were related to nitrofurantoin medication, which had been prescribed to prevent urinary tract infections. It is alleged that the failure to stop this medication caused the Claimant to suffer a worse outcome in terms of lung damage. Her prognosis is uncertain. Costs agreed on basis of expert expected life expectancy report.
- MK1802 - £475,000 - Came into the Emergency Department (ED) with suspected gastroenteritis and food poisoning and went home next day with Erythromycin. Next day his wife found him unresponsive on the floor at home. Liability accepted and costs negotiated.

Liability is always very much contested however this would be dependent on the available evidence to support a claim hence the importance of clarity in documentation in the medical

notes and explicit risk/benefit communications at the time of consent. Closure and pay outs cane be linked to expert evidence with costs agreed out of court.

A closed claims spreadsheet is shared with the Clinical Service Units (CSUs) each month to support learning and improve proactive if/where appropriate.

Common issues identified in respect of claims and pay outs, for wider learning relate to:

- Care below expected standard (against national best practice guidelines)
- Inappropriate or delayed prescribing of required medications
- Insufficient or unsupportive evidence to support a defence
- Inadequate assessments and examinations – take reasonable care
- Poor surgical technique
- Treatment/procedural delays

NHSR

NHSR provides trusts with dashboards noting our Trust's position against other similar sized trusts and allocating claims by value/risk:

- High Value = £1m and over, High Volume 3 or more (red)
- High Value= £1m and over, Low Volume< 3 claims (amber)
- Low Value < £1m, High Volume = 3 or more (blue)
- Low Value < £1m, Low Volume < 3 (green)

The latest Trust scorecard up to 30 June 2022 covers claims received with an incident date between 1/4/12 – 31/3/2022, with total number of clinical negligence claims received totalling 360 and a total value of £145,411 774. There is however, no supporting narrative to explain and/or triangulate the data.

Appendix 1 provides the NHSR score card with detailed analysis per specialty including costs, causes, outcomes and trends.

Key points to note include:

- The largest volume of claims relate to Obstetrics – 24%, with 80% of the Trust's claims in value
- Top injuries by value in Emergency Medicine – paraplegia, fatality & pain
- Top causes by value in Emergency Medicine – failure/delayed treatment, inappropriate discharge & failure to interpret x-rays
- Top injuries by value for General Surgery – fatality, bowel damage/dysfunction & limb deformity
- Top causes by value for General Surgery – intraoperative problems, failure/delated diagnosis & failure/delayed diagnosis
- Top causes by volume for Obstetrics - failure/delayed treatment, failure delayed diagnosis & failure of antenatal screening

Chart 1 below highlights the more frequently seen causes of low value claims the majority of which are replicable with the incidents reported on the Trust's incident reporting system. With the implementation of the new national patient safety framework (PSIRF) there will be greater triangulation with incidents, litigation and complaints with a new a new focus on minor harm incidents and low rag rated claims/complaints to identify the learning that may help mitigate more significant concerns in the future

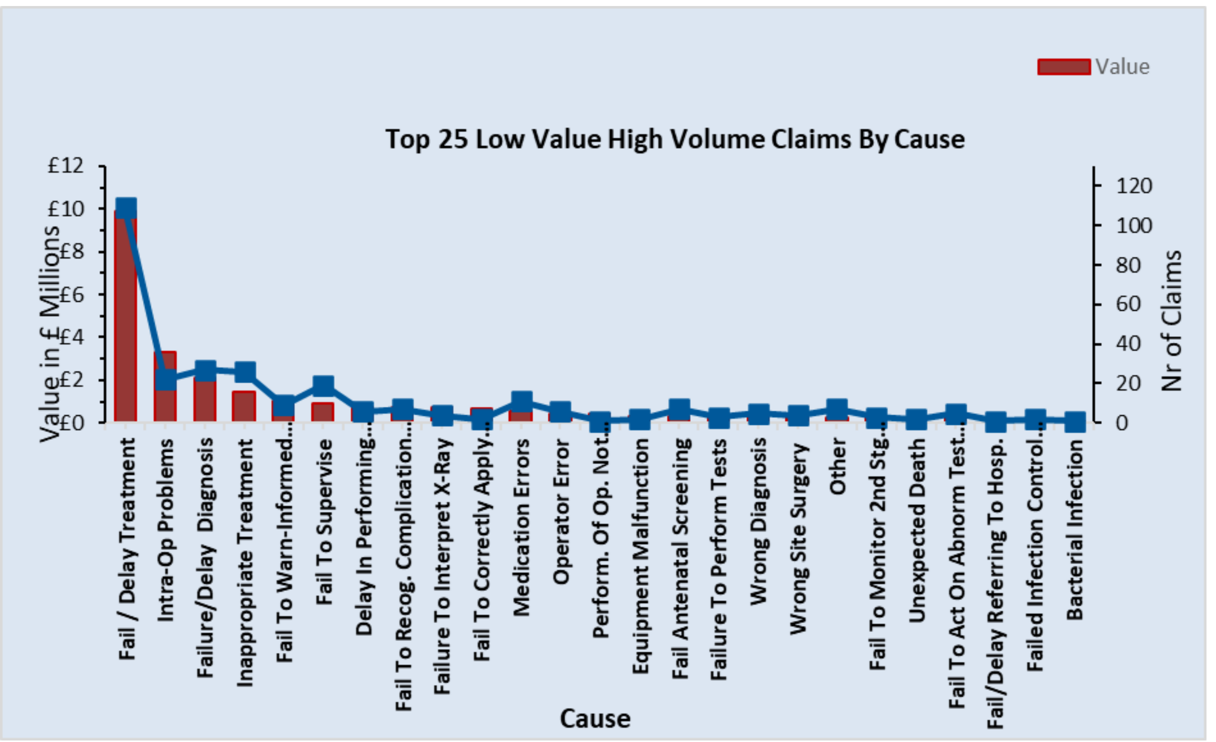


Chart 1 – low value high volum claims by cause

The high value red claims as detailed below all relate to maternity care, and all remain ongoing, so the value is estimated. Obstetrics by nature of the associated risks and potential high costs for brain damaged babies, who may require ongoing high levels of care for life has a tendency to always flag as red both locally & nationally in other trusts.

Cause	Value	Nr Claims
Fail To Supervise	£13,610,000.00	1
Fail / Delay Treatment	£53,925,000.00	4
Application Of Excess Force	£2,452,000.00	2
Not Specified	£26,896,500.00	2
Fail Antenatal Screening	£13,286,500.00	1
Grand Total	£110,170,000.00	10

- M16CT164/047 - alleged failure to properly monitor the claimant during her pregnancy and provide anti-hypertensive treatment. She was admitted with eclamptic fits at 27+5 weeks gestation & an emergency caesarean section was performed resulting in the delivery of her child who was transferred to the Neonatal Unit due to prematurity.
- M16CT164/050 - Delay in delivery caused cerebral palsy
- M17CT164/007 – early notification scheme (ENS) Hypoxic ischemic encephalopathy (HIE) grade III. Neonatal meningitis.
- M17CT164/032 - Mother presented at 38 weeks with reduced fetal movements. Not in labour. Possible delay in acting on an abnormal antenatal cardiotocograph (CTG).

Baby transferred to John Radcliffe so neonatal notes very limited. Baby appears to be doing well.

- M17CT164/041 - Mismanagement of birth resulting in severe brain damage
- M14CT164/064 - Shoulder dystocia at birth
- M17CT164/052 - Alleged negligent ante natal care and delivery provided to the mother and baby resulting in a delivery with shoulder dystocia. As a result, the baby has been diagnosed with Erb's Palsy and the mother is bringing a claim for Psychiatric injury following the traumatic birth.
- M18164/003 - Maternity incident. Hyperbilirubinemia (jaundice) Clinical outcome for baby not clear.
- M18CT164/005 - ENS Unexpected admission to NNU. Transferred to Oxford for cooling. HIE
- M18CT164/023 - ENS - Baby delivered in poor condition after prolonged second stage labour with instrumental delivery required active cooling

There are 327 blue claims with the top 5 specialties:

- Obstetrics - 75
- Emergency Medicine – 54
- Trauma & Orthopaedics - 33
- Surgery – 72 (including anaesthesia & specialties)
- General Medicine – 35

The green claims tend to relate so smaller specialties like Radiology, Palliative Care, Audiology & Renal.

NHR is now looking to focus on the steps that would help to alleviate current clinical NHS pressures (similar to the approach adopted during the Covid-19 pandemic).

In particular, they have undertaken a review of the interactions we had w when it came to the management of claims being brought against your organisation and identified a number of touch points within the claims process, where we felt we could remove the need to liaise with and take instructions from your staff, hopefully reducing some of the burden upon them.

Notwithstanding the fact that the pandemic is now over, our successful efforts to engage closely with our members have revealed that there remain ongoing, significant and widespread challenges, such that we are once again opening up an offer of support.

By way of reminder, the regulations, rules and practices under which we operate our indemnity schemes impose two specific instances where NHS Resolution requires the agreement from members of your staff before taking certain steps in the conduct of a claim: (a) authority to admit liability and (b) the signing of certain court documents.

The offer that I therefore make is that, subject to your express agreement to do so, we be permitted to:-

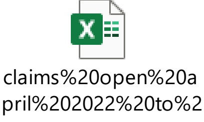
a) make liability decisions on your behalf; and
b) instruct panel firms to sign court documents on your behalf

In both cases, this would operate in claims where the estimated compensation award is equal to or less than £100,000.

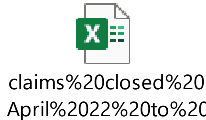
By agreeing to this temporary delegated authority, until 1 November 2023, it will reduce the need for us and our panel law firms to contact your staff members. I fully appreciate that you may be hesitant in providing such authority and that resource and work pressures may not be experienced across the board. However, I would like to reassure you that if you do provide this delegated authority, our experienced case managers, alongside our legal panel, will assess each case based upon the facts and evidence obtained in order to make an informed decision on the best way to proceed. Moreover, we would not seek to exercise delegated authority in any claims which you feel are likely to cause adverse publicity, are novel and contentious or where there is any other reason why you consider that delegated authority should be withheld; we will, of course, maintain a dialogue with your staff in the usual way.

Appendix 1 – NHSR dashboard

Appendix 2 – New clinical negligence claims opened on Datix 2022– 2023



Appendix 3 – Closed clinical negligence claims 2022 – 2023



The Quality and Clinical Risk Committee is asked to accept this brief report and await the NHSR benchmark review at the next meeting.

Meeting Title	Trust Board	Date: 06 July 2023
Report Title	**Antimicrobial Stewardship Annual Report for Milton Keynes University Hospital: 2022-23**	**Agenda Item Number: 13**
Lead Director	Ian Reckless, Medical Director	
Report Author	Prithwiraj Chakrabarti and Lauren Ramm	

Introduction	Assurance and Compliance Report		
Key Messages to Note	1. Antimicrobial stewardship – ensuring that antibiotics are used appropriately in terms of: (1) the indication for use of antibiotics; (2) the appropriateness of the type of antibiotic used; (3) the duration of the course; and, (4) the route of administration – is a vital activity in reducing the pace at which anti-microbial resistance emerges. This global threat has been well described by leading minds, including Professor Dame Sally Davies, former Chief Medical Adviser to the UK Government. 2. MKUH performs well against peers in matters pertaining to antimicrobial stewardship but there remains room for improvement. 3. QCRC is invited to receive the report and discuss its content. Of note, the Infection Prevention and Control Annual Report is scheduled to come to the September 2023 Committee meeting. 4. The report provides an overview of antimicrobial stewardship activities and benchmarked performance in respect of antimicrobial usage. Particular emphasis on: • IV to oral switch • Achievement of the 4.5% expected reduction in broad spectrum antibiotic use – a stable picture in respect of antimicrobial use more broadly. Maintenance of previous reductions in usage is positive given the unstable environment over the year (Covid-19 and invasive Group A Strep) • Commonwealth Pharmacists AntiMicrobial Stewardship Scheme • Productive engagement in QI and research agendas		
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Review** [x]

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

Report History	Antimicrobial Stewardship Group Infection Prevention & Control Committee Quality and Clinical Risk Committee, June 2023
Next Steps	N/A

Appendices/Attachments	Annual Report

Antimicrobial Stewardship Annual Report for Milton Keynes University Hospital: 2022-23

Executive summary

This report summarizes the key performance indicators and the major activities performed by the antimicrobial stewardship (AMS) team between April 2022 and March 2023. Despite many challenges in 2022-23, the AMS team continued to provide support and vigilance in respect of antimicrobial consumption at MKUH. The AMS team regained its strength with the appointment of a lead antimicrobial pharmacist in June 2022 after a year-long gap where the post had been vacant. The AMS ward rounds were continued throughout this period despite the lack of an AMS pharmacist.

The key focus of the AMS team in 2022-23 was to launch the IV to oral switch project to reduce the duration of unnecessary IV antibiotics. Reduction of IV antibiotics has been shown to save significant nursing time, cost, length of stay, carbon footprint, and line associated infections, as well as to facilitate early discharge. The IV to oral switch policy has been updated and a pharmacy led IV to oral switch was piloted in some wards across medicine and cardiology. Further progress is required to implement the policy trust wide.

High clinical activity, ongoing COVID admissions, an increase in Group A streptococcal and other complicated infections remained a challenge for AMS throughout 2022-23, and led to higher consumption of most antibiotics than in the previous year. However, MKUH has continued to reduce the use of broad spectrum carbapenems year-on-year. As per the NHS standard contract, MKUH has achieved a 4.5% reduction of broad-spectrum antibiotics (based on the **WHO AWaRe** categories of **A**ccess, **Wa**tch and **Re**serve) compared to a 2018 baseline. Local strategies are required to address the threat of increasing consumption of antimicrobials in the future.

Since the middle of 2022, the AMS team has focused on updating the antimicrobial policies on the *Microguide* app. *Microguide* is a platform used to access all antimicrobial guidelines and policies. The AMS team will continue working with clinical teams to update guidelines in the upcoming year.

Procalcitonin based individualised antimicrobial stewardship, the proactive antimicrobial ward round, staff-grade microbiologist support, educational activities and a 24/7 microbiology service remained the backbone of AMS activity throughout the year. Obtaining UKAS accreditation for the microbiology laboratory is an area of focus for the upcoming year to ensure the quality of the service.

The AMS service also actively participated in research activities including ongoing projects such as the TIDE and GBS trials and published results in reputable journals. MKUH has been successful in obtaining a grant (initially £10,000 extended up to a potential £55,000) from the Commonwealth Pharmacists AntiMicrobial Stewardship Scheme (CwPAMS) which is a health partnership scheme funded by the Department of Health and Social Care's Fleming Fund for collaborative AMS work. MKUH has created a partnership with University of Nigeria Teaching Hospital Ituku Ozalla, and colleagues are looking forward to working closely with them to develop and progress AMS activities in both partner organisations.

Introduction

The Antimicrobial Stewardship (AMS) team drives, supports and monitors AMS activity at MKUH. The AMS team consists of a consultant microbiologist (1 PA activity for AMS, 4 hours per week) and an antimicrobial pharmacist (0.57 WTE for AMS activity). The team reports to the Antimicrobial Stewardship Group (AMSG), which meet quarterly. Meetings are chaired by the Medical Director. AMSG reports through to Patient Safety Board. AMSG consists of clinicians, nurses, pharmacists, and managers from different disciplines. AMSG discusses and reviews AMS activities along with national and local AMS targets. This involves review and approval of policies and proposals for changes and setting out overall governance of AMS activity at MKUH. The main goal of AMS activity at MKUH is focussed on the reduction of unnecessary antimicrobial consumption supported by 24 hours a day microbiology service and a twice weekly AMS ward round which targets general medical and surgical wards across the trust. Suboptimal and excessive antimicrobial prescribing is the main driver of antimicrobial resistance locally, nationally and globally. Institutional antimicrobial prescribing practice is largely dependent on individual clinician's knowledge, attitude and perception towards prescribing antimicrobial drugs. This is constantly changing due to a perpetual movement in staffing, demography and epidemiology. Therefore, continuous attention to antimicrobial usage is required to monitor and gain assurance around antimicrobial prescribing practice among clinicians.

The key AMS activities during April 2022 – March 2023 are summarised below.

1. **AMS ward round:**

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

2. **IV to oral switch (IVOS) project**

The UK average % of antimicrobials given IV is approximately 25%. The proportion of antimicrobials prescribed by the IV route at MKUH in the last quarter was 25.69%. The East of England has been identified as a very high user of IV antimicrobials and as such in the last half of the financial year 2022-2023 trusts were asked to plan and implement projects to reduce IV use compared to PO use of antimicrobials. Switching from IV to oral may also allow removal of intravenous catheters which can themselves contribute to significant healthcare associated infection (driving further antibiotic usage).

To reduce the % of IV antimicrobials prescribed, the IV to PO switch policy has been updated and enables pharmacists to perform IV to PO switches under set criteria. This has been implemented on some cardiology and general medical wards and will be fully rolled out to other areas in the coming months.

Pharmacy vacancies have been one of the rate-limiting factors. Further training and promotion of this activity will be undertaken with pharmacists to increase the use of PO antibiotics and decrease the use of IVs. Ad hoc teaching with clinicians across the wards to improve knowledge and confidence around IV to PO switch, has also been undertaken and continues to be performed on antimicrobial stewardship ward rounds.

Our work on IVOS has been recognised as forward thinking and a great opportunity to utilise all members of the MDT. This work has been presented regionally and at a national antimicrobial conference in March 2023.

3. AMS policy update and Microguide

The Trust's antimicrobial policy needs to be continually reviewed and updated in response to local and national requirements. This ongoing process was delayed due to the lack of an antimicrobial pharmacist and due to the COVID-19 pandemic. The current MKUH antimicrobial guideline is available via the Trust intranet and the *Microguide* app. The AMS team has been working with respective clinical teams and divisions to upgrade local policies.

Antibiotic policy updates	Update date	Comment
Teicoplanin policy	October 2022	Awaiting final sign off by TDC and TEC
Gentamicin Policy including gentamicin calculator	October 2022	Awaiting final sign off by TDC and TEC
IV to oral Switch policy	October 2022	Awaiting final sign off by TDC and TEC
Splenectomy policy	October 2022	Awaiting final sign off by TDC and TEC
C. difficile policy	April 2023	AMS aspect completed – overall policy remains under review led by IPC
ENT policy	Ongoing	Working closely with ENT department to expand, agree and finalise antimicrobial policy for ENT
Cystoscopy antimicrobial policy	Ongoing	Working closely with urology to complete this

4. AMS audits / QI projects / Research

AMS audit / QIP

Targeted antimicrobial review of inpatients based on procalcitonin (PCT) value – quality improvement project completed. An audit undertaken showed that when the PCT value was low, a proactive microbiology discussion of the antibiotic therapy with the clinical team, helped to stop or switch 59% of antibiotics prescribed earlier, compared to the no intervention group. This strategy may be helpful to reduce the duration of other antibiotic prescriptions. The audit has been accepted for presentation at a national meeting (British Infection Association Conference May 2023).

Improving the use of antibiotics in flexible cystoscopy – quality improvement project completed. This project looked at improving the flexible cystoscopy pathway in the presence of positive urine analysis. The aim was to avoid unnecessary delays in the procedure. The project clarified that asymptomatic patients with positive urine analysis did not need antibiotic treatment thus delaying the procedure. Instead, prophylactic antibiotics can be given, if there is a risk of breach in the uroepithelium, to enable the procedure to go ahead. This audit was presented in the surgical CIG meeting in February 2023.

Research

TIDE trial (Trial for decolonization) is a multi-centre, randomised controlled, non-inferiority and cost effectiveness trial comparing Polyhexanide and Chlorhexidine with Neomycin to Mupirocin for nasal methicillin-resistant Staphylococcus aureus (MRSA) decolonisation amongst adult hospital in-patients. The trial is open for patient recruitment.

GBS (Group B Streptococcus) 3 trial – The clinical and cost-effectiveness of testing for Group B Streptococcus: a cluster randomised trial with economic and acceptability evaluations. This is a national project which is now ongoing at MKUH with relevant modification of the laboratory procedure for GBS detection. The trial is looking at standardising the GBS screening advice to pregnant women with possible reduction in exposure to antibiotics during labour. MKUH received coronial criticism in earlier years for not having screened a woman for GBS: this is not standard practice nationally and participating in this high quality study to form an evidence base on this topic is important.

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

ARK project – The work has finished and the results were published in Lancet Infectious Diseases.

Antibiotic review kit for hospitals (ARK-Hospital): a stepped-wedge cluster-randomised controlled trial - The Lancet Infectious Diseases

5. **Teaching:**

The microbiology and AMS team participates in teaching regularly through Grand Rounds, departmental teaching, and input alongside scheduled junior doctor and nursing teaching programmes. In 2022-23, 5-6 sessions were delivered focusing on shared learning through interdisciplinary management of critical infections including COVID, tuberculosis, nocardia, and Group A Streptococcal infections. The AMS team also offered a clinical observership to a consultant microbiologist from Dubai for a week in May 2022 providing an international view of AMS and allowing bi-directional learning and development.

6. **World Antimicrobial Awareness Week**

The AMS team celebrated World Antimicrobial Awareness Week between 18 and 24 November 2022. Various activities were undertaken including educational ward rounds incorporating pharmacy students, promotional stands to raise awareness amongst patients and staff. Educational sessions were also undertaken with pharmacy staff and communications were circulated regarding the importance of AMS.

7. **Local /regional networking**

BLMK AMS Pharmacy Group

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

TVIG (Thames Valley Infection Group)

The Thames Valley Infection Group is a network of local microbiologists and infection specialists (MKUH, Oxford, Swindon, Bucks and Royal Berkshire Hospitals). The group has been recently expanded to include laboratory specialists, infection control, pharmacists and the UKHSA. The group meets twice a year to share local audits, learning and implementation of local and national policies. MKUH have led the group since 2022 (Chair – Dr Prithwi Chakrabarti, Secretary – Dr Poonam Kapila). AMS is a focus of this group and several audits have been recently conducted and shared to improve antimicrobial prescribing including an audit on carbapenem resistant enterobacterales in 2022.

Progress against workplan for 2022-23

	Action Plan 2022-23	Comment
1.	**IV to oral switch: Regional AMS plan/ CQUIN**	IVOS policy awaiting final sign off by TDC and TEC. Once this has been completed pharmacist led IVOS will be fully rolled out across the trust following further training within the pharmacy department.

		Posters to be displayed in nursing IV cupboards to remind nurses to prompt for IV to PO switch. Ongoing training and education on wards with nurses, pharmacists and doctors.
2.	**Update of *microguide***	The *microguide* and the general antimicrobial policy need to be updated and focus time is required to undertake this. An extension has been granted to allow time to update the antimicrobial guidelines fully.
3.	**Gentamicin prescription audit action plan and safe gentamicin prescribing**	Action plan from 3rd cycle audit includes gentamicin power plan in e-care to support gentamicin prescribing. Progress has been made to alert prescribers with a safety dose prompt and integration of gentamicin calculator to *microguide* and eCare.
4.	**Strategic planning to reduce the broad-spectrum antibiotic usage (Taz / Mero / fluoroquinolones)**	An increase in broad spectrum antimicrobial consumption has been observed largely due to the impact of COVID, Group A Streptococcal infection, and NHS logistical challenges resulting sharp rise of complicated infections. The AMS team is working hard undertaking regular AMS rounds, ICU rounds and attending the haem/oncology MDT to focus on reducing antibiotic use. More time and resource are required to keep up with the rising pressure for AMS support.
5.	**Network collaboration for Microbiology IT integration**	Ongoing. Microbiology LIMS harmonisation with 3 other network hospitals has progressed through regular network meetings, although risks to the timeline remain.
6.	**Microbiology UKAS scope enhancement and full laboratory accreditation**	Serology and molecular testing achieved UKAS accreditation in 2021. A UKAS review inspection in Nov 2022 highlighted issues on the overall quality management system in the laboratory, resulting in temporary suspension of UKAS accreditation. Further work is now being conducted at pace to regain the

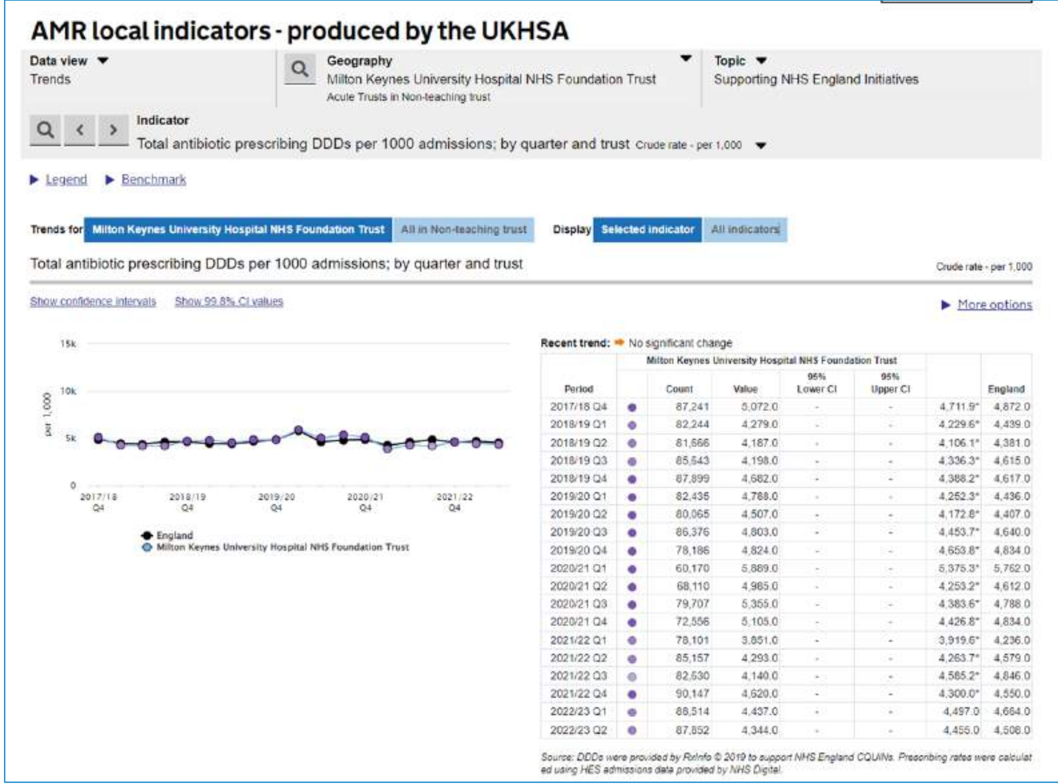
		accreditation standards. No major quality issues have been raised leading to any immediate patient safety concerns.
7.	**Carbapenemase producing Enterobacterales (CPE) management plan**	A network audit on CPE management at MKUH has been conducted and major action plans implemented. The CPE screen has now been expanded to all ICU patients, a CPE 'flag' (alert) has been created on eCare and the notification process has been updated by routine recording of CPE results with action plans in eCare and after discharge.
8.	**Nebulised gentamicin for selected respiratory ward patients**	Nebulised gentamicin could be used to reduce the use of broad spectrum antimicrobials in patients with chronic respiratory diseases (e.g. bronchiectasis) who require frequent admissions for IV antibiotics. The benefit of the project has been agreed in principal. The proposal has been discussed with the respiratory team. A general concern about a designated space for test doses of nebulised antibiotics has been raised which is the current barrier for this project in moving forward.
9.	**Research projects**	• TIDE study- A trial for new treatment regimen for MRSA decolonization started in February 2023. • GBS 3 trail is ongoing. • Delafloxacin MSC project is ongoing.

AMS performance data

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

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

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



Period	Milton Keynes University Hospital NHS Foundation Trust						England
		Count	Value	95% Lower CI	95% Upper CI		
2017/18 Q4	●	87,241	5,072.0	-	-	4,711.9*	4,872.0
2018/19 Q1	●	82,244	4,279.0	-	-	4,229.6*	4,439.0
2018/19 Q2	●	81,666	4,187.0	-	-	4,106.1*	4,381.0
2018/19 Q3	●	85,543	4,198.0	-	-	4,336.3*	4,615.0
2018/19 Q4	●	87,899	4,682.0	-	-	4,388.2*	4,617.0
2019/20 Q1	●	82,435	4,788.0	-	-	4,252.3*	4,436.0
2019/20 Q2	●	80,065	4,507.0	-	-	4,172.8*	4,407.0
2019/20 Q3	●	86,376	4,803.0	-	-	4,453.7*	4,640.0
2019/20 Q4	●	78,186	4,824.0	-	-	4,653.8*	4,834.0
2020/21 Q1	●	60,170	5,889.0	-	-	5,375.3*	5,762.0
2020/21 Q2	●	68,110	4,985.0	-	-	4,253.2*	4,612.0
2020/21 Q3	●	79,707	5,355.0	-	-	4,383.6*	4,788.0
2020/21 Q4	●	72,556	5,105.0	-	-	4,426.8*	4,834.0
2021/22 Q1	●	78,101	3,851.0	-	-	3,919.6*	4,236.0
2021/22 Q2	●	85,157	4,293.0	-	-	4,263.7*	4,579.0
2021/22 Q3	●	82,530	4,140.0	-	-	4,585.2*	4,846.0
2021/22 Q4	●	90,147	4,620.0	-	-	4,300.0*	4,550.0
2022/23 Q1	●	88,514	4,437.0	-	-	4,497.0	4,664.0
2022/23 Q2	●	87,852	4,344.0	-	-	4,455.0	4,508.0

Source: DDDs were provided by RxInfo © 2019 to support NHS England CQUINs. Prescribing rates were calculated using HES admissions data provided by NHS Digital.

Fig1 UKHSA data showing AM consumption rate per 1000 admissions at MKUH in 2022-23 has been below the national average. Q3 and Q4 data has yet to be published.

Standard Contract Previous Financial Year 2022-2023

The target for 2022-2023 was to reduce the amount of broad-spectrum antibiotics by 4.5% compared to a 2018 baseline. Broad spectrum antibiotics are defined by NHSEI as 'Watch' and 'Reserve' antibiotics from the adapted WHO AWaRe List for England. MKUH performed well throughout the financial year 2022-2023 and generally achieved the 4.5% reduction target. MKUH is one of 2 trusts in the East of England meeting the reduction target. Nationally, only 31% of trusts are currently achieving this target, of which MKUH is one.

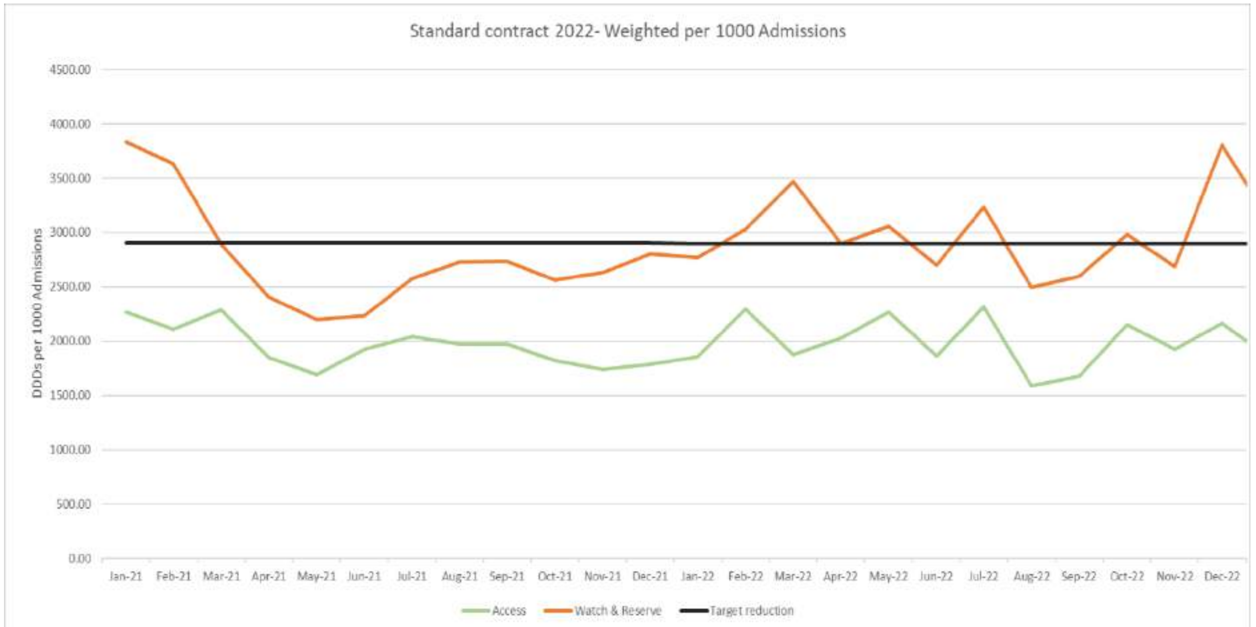


Fig 2: Overall the target of 4.5% reduction of antibiotics was achieved. There was a large 'spike' in the use of watch and reserve antimicrobials in December 2022 largely due to the nationally recognised increase in cases of Group A Streptococcus infections.

Local data on total consumption of AMs for 2022-23 has been collected from Refine shown below.

Total systemic antibiotic consumption at MKUH

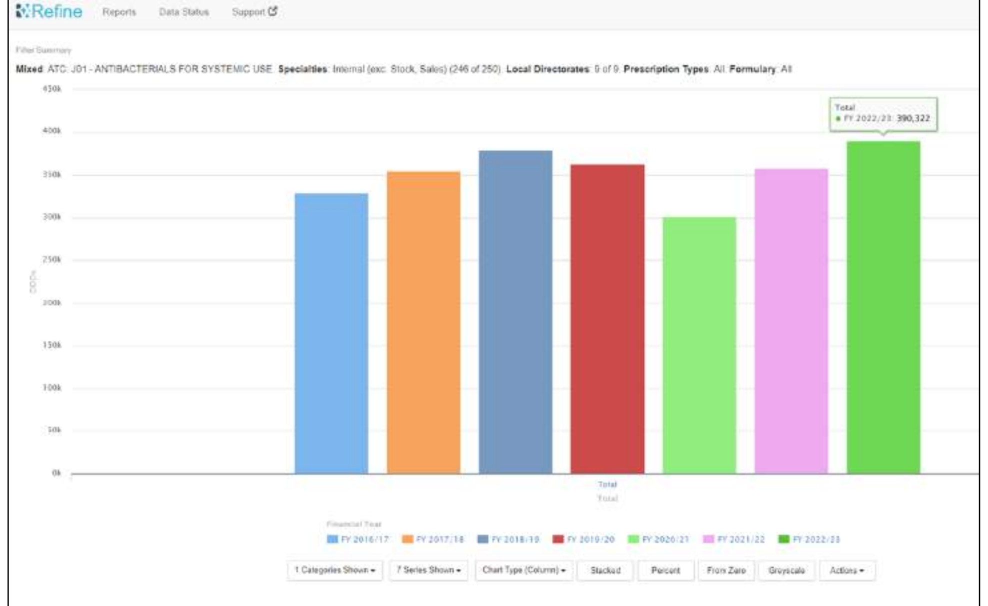


Fig 3.1 (Total DDD of all antimicrobials) Historic data from Rx information showed that the total consumption of AMs has gone up in 2022-23 compared to the previous year. This is likely due to continuous increase in NHS activity after the COVID pandemic.

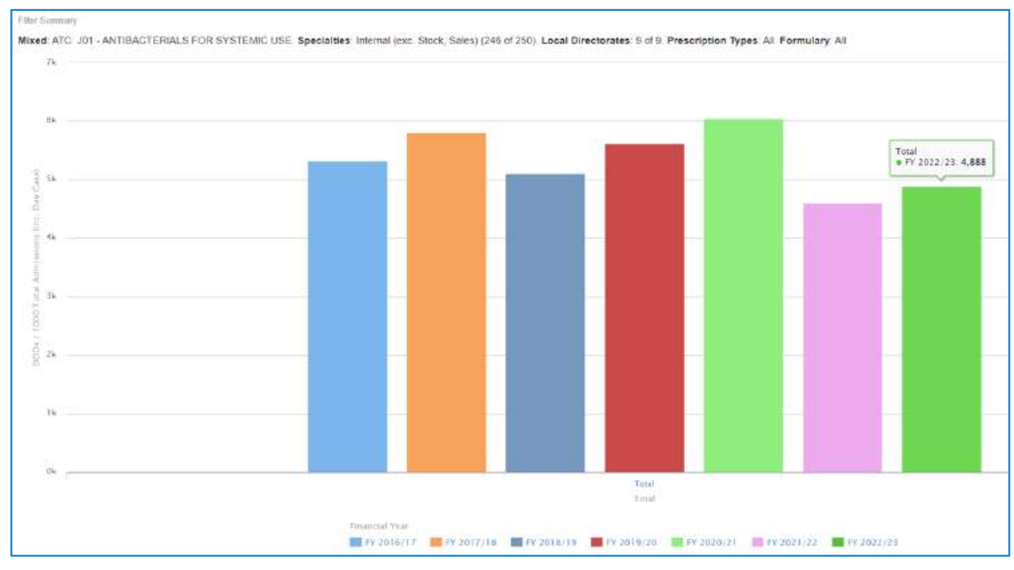
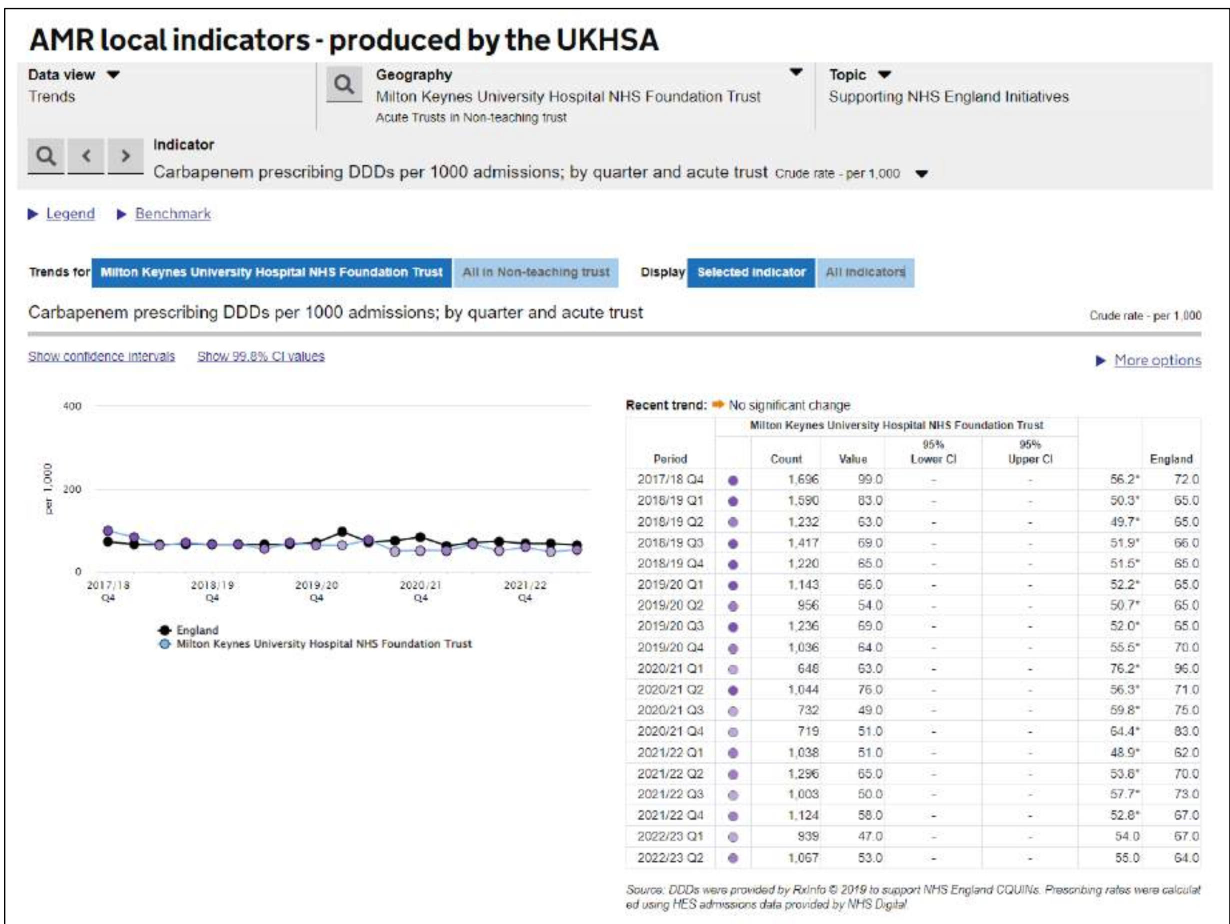


Fig 3.2 (DDD/1000 admissions of all AMs) Comparative DDDs at MKUH showed a slight increase in AM consumption in 2022-23 (4888 vs 4601 in 2021-22) compared to the previous year. The COVID admissions, surge of Group A streptococcal infections and other complicated infections put increasing pressure on AM usage.

Carbapenem consumption at MKUH

Carbapenems are the broadest spectrum antibiotics. Our AMS activity is specially focused on appropriate prescription and duration of carbapenem antibiotics in the trust. Meropenem and ertapenem are the two carbapenems used at MKUH. Carbapenem resistance is rapidly rising nationally and internationally, and mostly due to increased use/duration of carbapenems for treating difficult infections. The following figures (fig 4, 4.1 and 4.2) showed the trend of carbapenem use in MKUH.



AMR local indicators - produced by the UKHSA

Data view: Trends
Geography: Milton Keynes University Hospital NHS Foundation Trust — Acute Trusts in Non-teaching trust
Topic: Supporting NHS England Initiatives
Indicator: Carbapenem prescribing DDDs per 1000 admissions; by quarter and acute trust — Crude rate - per 1,000

Legend | Benchmark

Trends for: Milton Keynes University Hospital NHS Foundation Trust | All in Non-teaching trust — Display: Selected indicator | All indicators

Carbapenem prescribing DDDs per 1000 admissions; by quarter and acute trust — Crude rate - per 1,000

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

Recent trend: No significant change

Period	Milton Keynes University Hospital NHS Foundation Trust						
		Count	Value	95% Lower CI	95% Upper CI		England
2017/18 Q4	●	1,696	99.0	-	-	56.2*	72.0
2018/19 Q1	●	1,590	83.0	-	-	50.3*	65.0
2018/19 Q2	●	1,232	63.0	-	-	49.7*	65.0
2018/19 Q3	●	1,417	69.0	-	-	51.9*	66.0
2018/19 Q4	●	1,220	65.0	-	-	51.5*	65.0
2019/20 Q1	●	1,143	66.0	-	-	52.2*	65.0
2019/20 Q2	●	956	54.0	-	-	50.7*	65.0
2019/20 Q3	●	1,236	69.0	-	-	52.0*	65.0
2019/20 Q4	●	1,036	64.0	-	-	55.5*	70.0
2020/21 Q1	●	648	63.0	-	-	76.2*	96.0
2020/21 Q2	●	1,044	76.0	-	-	56.3*	71.0
2020/21 Q3	●	732	49.0	-	-	59.8*	75.0
2020/21 Q4	●	719	51.0	-	-	64.4*	83.0
2021/22 Q1	●	1,038	51.0	-	-	48.9*	62.0
2021/22 Q2	●	1,296	65.0	-	-	53.6*	70.0
2021/22 Q3	●	1,003	50.0	-	-	57.7*	73.0
2021/22 Q4	●	1,124	58.0	-	-	52.8*	67.0
2022/23 Q1	●	939	47.0	-	-	54.0	67.0
2022/23 Q2	●	1,067	53.0	-	-	55.0	64.0

Source: DDDs were provided by RxInfo © 2019 to support NHS England CQUINs. Prescribing rates were calculat ed using HES admissions data provided by NHS Digital

Fig 4. UKHSA data showed MKUH carbapenem use has continued to be below the national average. Q3 and Q4 data has yet to be published.

Carbapenem consumption at MKUH (local data, via Refine system)

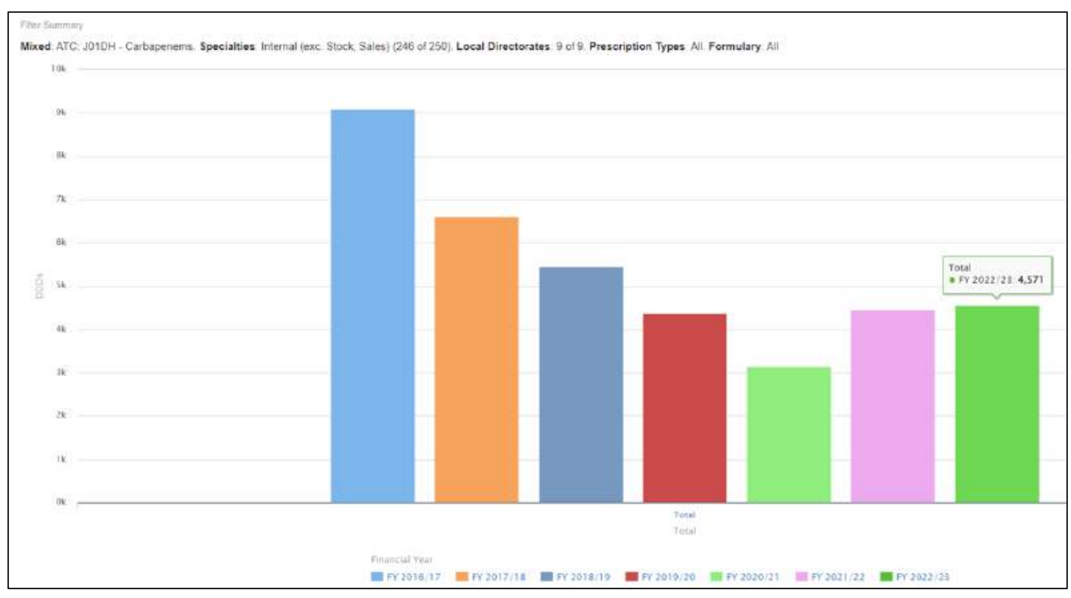


Fig 4.1 Total DDD of carbapenem: Carbapenem (Meropenem + Ertapenem) consumption at MKUH has gone up slightly compared to the previous year. This is likely due to increased activity at MKUH.

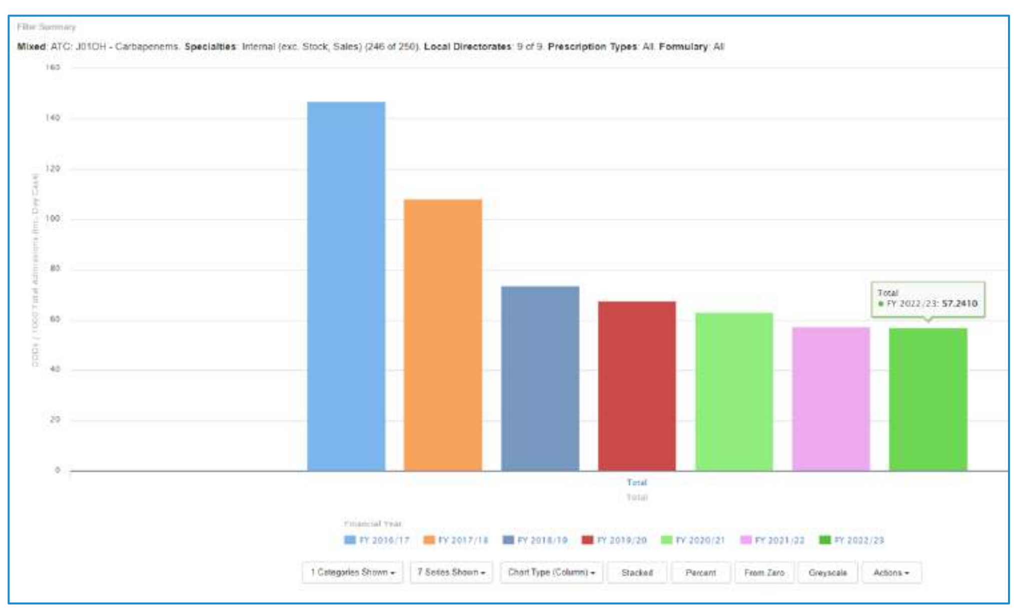


Fig 4.2 Carbapenem DDD per 1000 admissions: Carbapenem (Meropenem + Ertapenem) consumption at MKUH adjusted for admissions shows a stepwise reduction (57.36 in 2021-22 and 57.24 in 2022-23). This is very positive.

Piperacillin-Tazobactam (Tazocin) consumption at MKUH

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

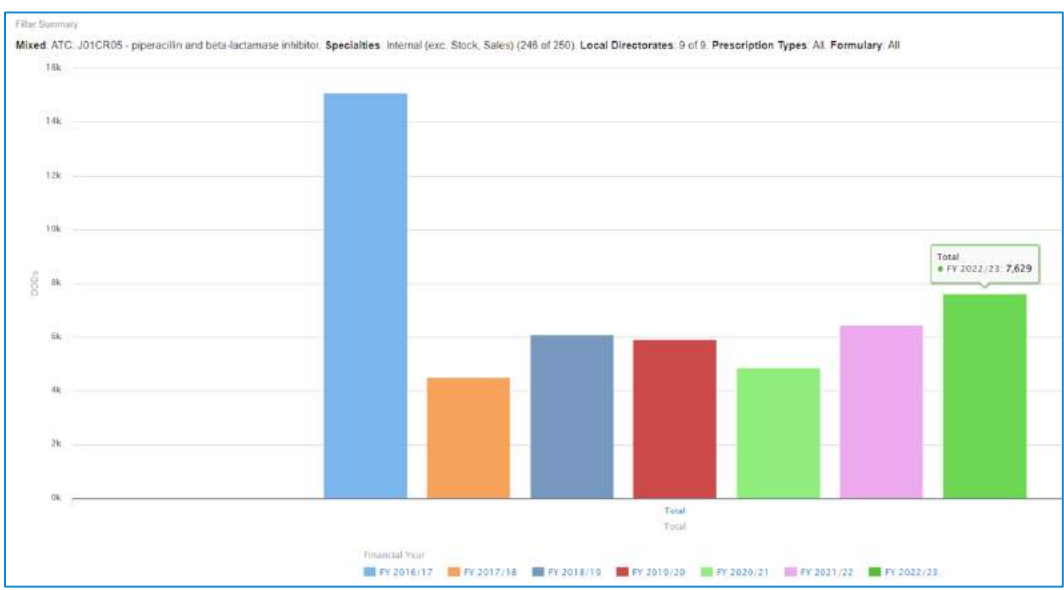


Fig 5.1 Total DDD of Tazocin: Refine data showed total Tazocin use at MKUH. The decrease in 2017-18 was likely due to a stock shortage of Tazocin that prompted a change of empiric antibiotic choice from Piperacillin-Tazobactam to co-amoxiclav and gentamicin. Tazocin consumption has since remained close to 6K DDD per year however the drop in 2020-21 may be due to a smaller number of hospital admissions as this data is not weighted per 1000 admissions. However, an increasing number of complicated infections contributed to increased use of Tazocin during 2022-23 (7.6K vs 6K). We are keen to continue Tazocin as a 2nd line antimicrobial choice for many infections to reduce the antibiotic pressure on development of resistance with regards to CPE. However, use needs to be carefully monitored and appropriateness of ongoing prescriptions reviewed regularly.

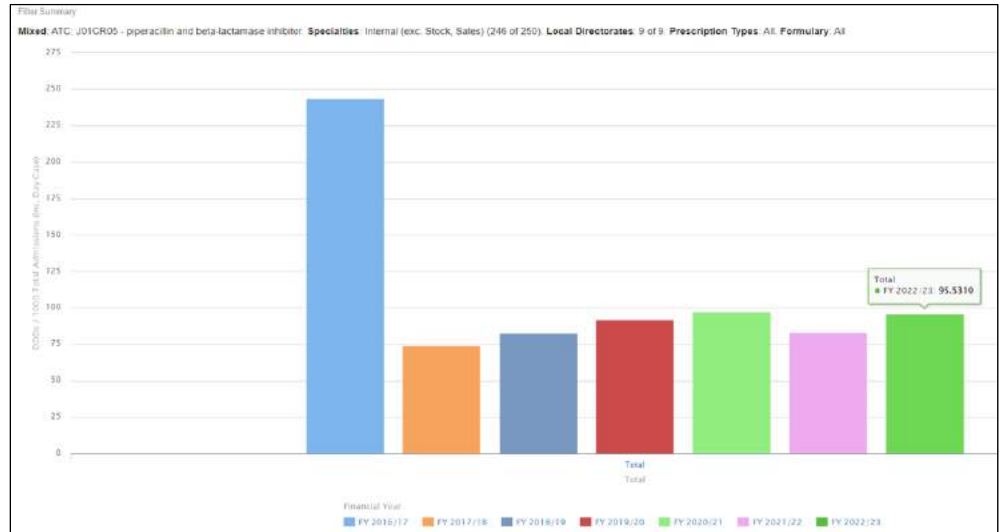


Fig 5.2 Piperacillin- Tazobactam DDD/1000 admission: Comparative DDD/1000 admissions showed a small rise of Tazocin use in 2022-23 compared to the previous year. Prescribers need to be aware of increasing Tazocin use and ensure that it is appropriate as it can contribute to ESBLs and other resistant gram-negative infections.

Co-amoxiclav use at MKUH

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

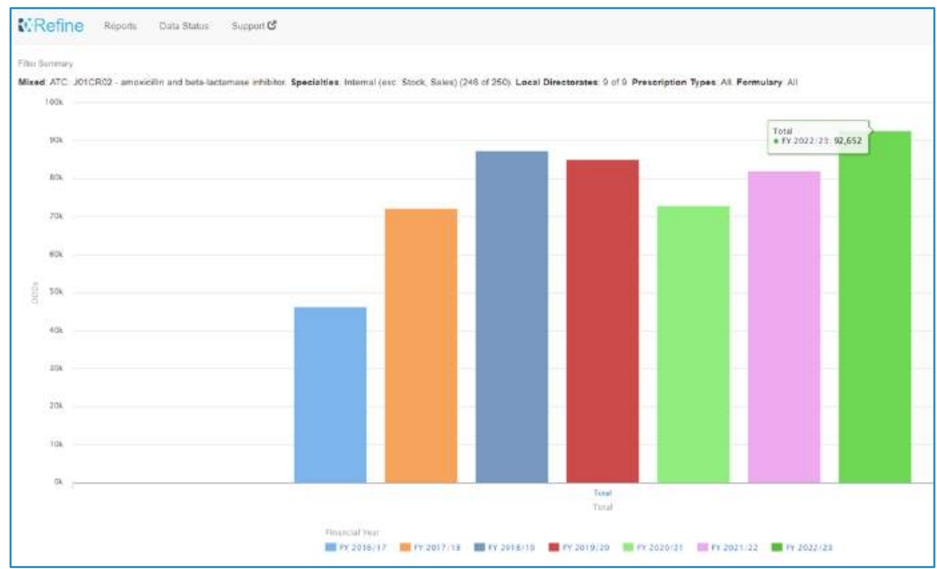


Fig 6.1 Total DDD of Co-amoxiclav: Refine data showed total Amoxicillin-clavulanic acid (co-amoxiclav) use at MKUH. The total co-amoxiclav use had gone up significantly in 2022-23. The high NHS activity, covid and group A streptococcal infections are possibly the main driver for this. Continued monitoring is required.

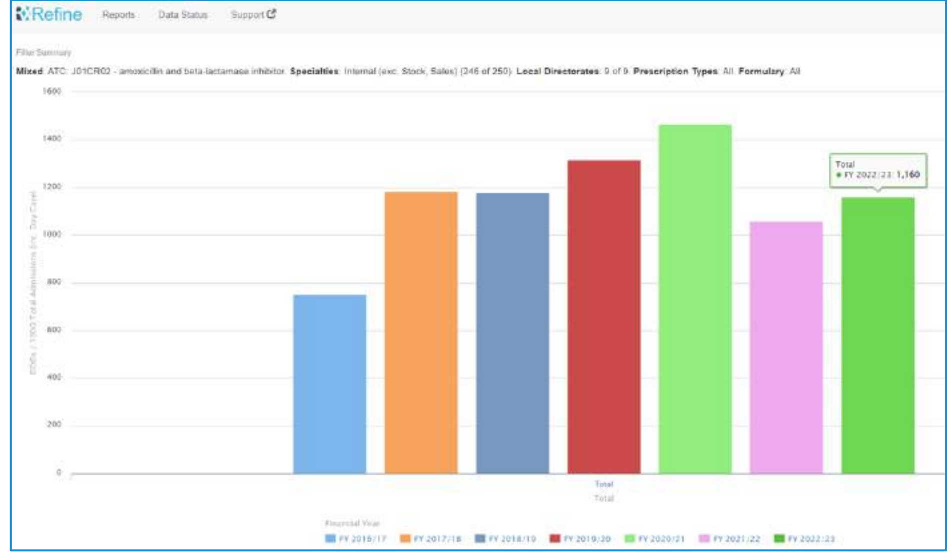
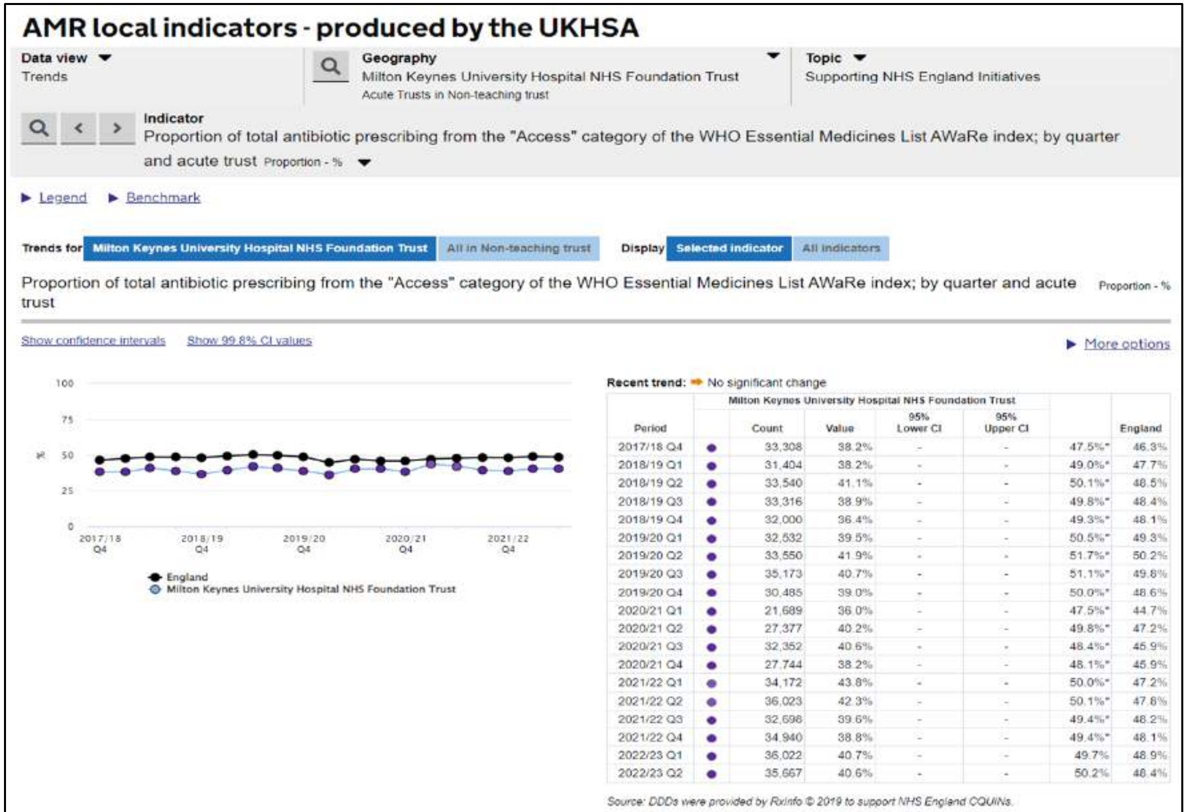


Fig 6.2 Co-amoxiclav DDD/1000 Admission: Comparative analysis showed co-amoxiclav DDD/1000 admissions has gone up compared to the previous year but remained lower than the preceding years. The AMS team is focused on reducing the duration of co-amoxiclav courses to 5 days where possible.

Use of WHO access category (narrower spectrum) antibiotics in MKUH



AMR local indicators - produced by the UKHSA

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

Indicator: Proportion of total antibiotic prescribing from the "Access" category of the WHO Essential Medicines List AWaRe index; by quarter and acute trust Proportion - %

Legend Benchmark

Trends for: Milton Keynes University Hospital NHS Foundation Trust | All in Non-teaching trust
Display: Selected indicator | All indicators

Proportion of total antibiotic prescribing from the "Access" category of the WHO Essential Medicines List AWaRe index; by quarter and acute trust Proportion - %

Show confidence intervals Show 99.8% CI values More options

Recent trend: No significant change

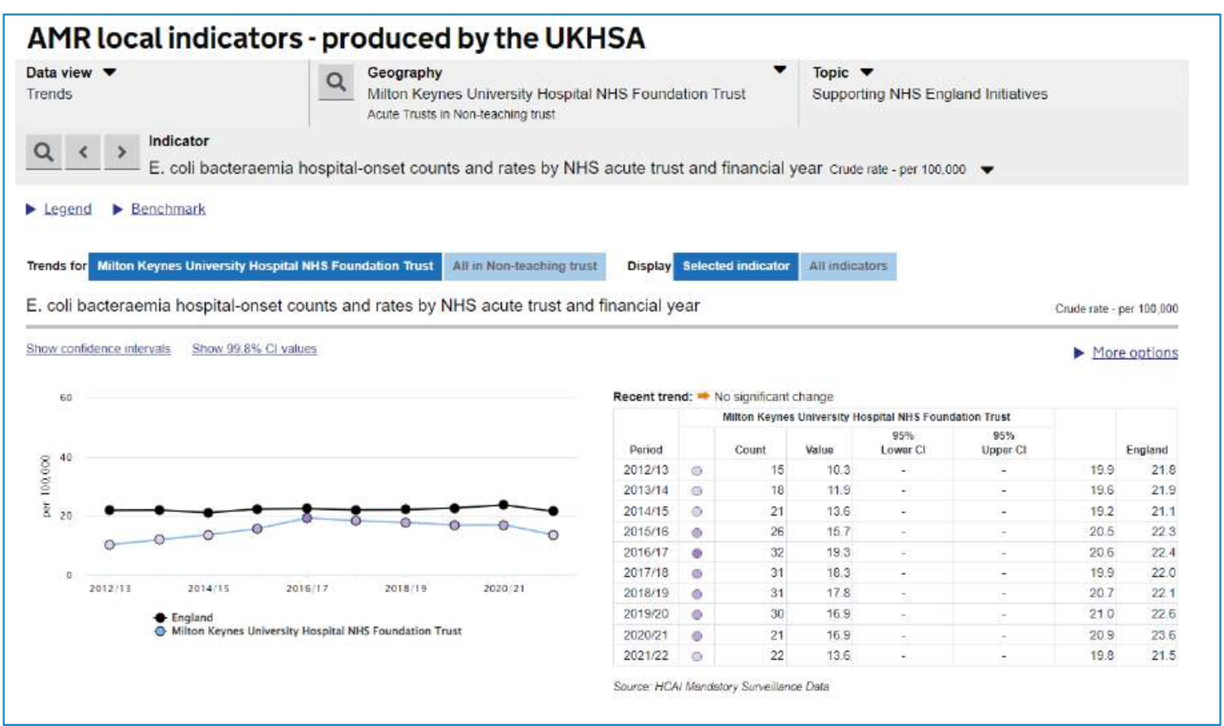
Period	Milton Keynes University Hospital NHS Foundation Trust						England
		Count	Value	95% Lower CI	95% Upper CI		
2017/18 Q4	●	33,308	38.2%	-	-	47.5%*	46.3%
2018/19 Q1	●	31,404	38.2%	-	-	49.0%*	47.7%
2018/19 Q2	●	33,540	41.1%	-	-	50.1%*	48.5%
2018/19 Q3	●	33,316	38.9%	-	-	49.8%*	48.4%
2018/19 Q4	●	32,000	36.4%	-	-	49.3%*	48.1%
2019/20 Q1	●	32,532	39.5%	-	-	50.5%*	49.3%
2019/20 Q2	●	33,550	41.9%	-	-	51.7%*	50.2%
2019/20 Q3	●	35,173	40.7%	-	-	51.1%*	49.8%
2019/20 Q4	●	30,485	39.0%	-	-	50.0%*	48.6%
2020/21 Q1	●	21,689	36.0%	-	-	47.5%*	44.7%
2020/21 Q2	●	27,377	40.2%	-	-	49.8%*	47.2%
2020/21 Q3	●	32,352	40.6%	-	-	48.4%*	45.9%
2020/21 Q4	●	27,744	38.2%	-	-	48.1%*	45.9%
2021/22 Q1	●	34,172	43.8%	-	-	50.0%*	47.2%
2021/22 Q2	●	36,023	42.3%	-	-	50.1%*	47.8%
2021/22 Q3	●	32,698	39.6%	-	-	49.4%*	48.2%
2021/22 Q4	●	34,940	38.8%	-	-	49.4%*	48.1%
2022/23 Q1	●	36,022	40.7%	-	-	49.7%	48.9%
2022/23 Q2	●	35,667	40.6%	-	-	50.2%	48.4%

Source: DDDs were provided by RxInfo © 2019 to support NHS England CQUINs.

Fig 7. PHE data shows that MKUH needs to improve the use of the WHO access category medicines. The WHO access category indicates narrower spectrum antibiotics. Use is stable but still higher than desirable. MKUH use co-amoxiclav for sepsis, UTI and chest infections, therefore co-amoxiclav remains the most common choice of antimicrobial. Co-amoxiclav is not classified as a WHO access category drug. The AMS team are focusing on the reduction of co-amoxiclav by suggesting amoxicillin, metronidazole and gentamicin for pre-operative prophylaxis for a range of surgical procedures and suggesting amoxicillin/ doxycycline for treatment of uncomplicated community acquired pneumonia.

https://fingertips.phe.org.uk/profile/amr-local-indicators

***E. coli* bacteremia at MKUH**



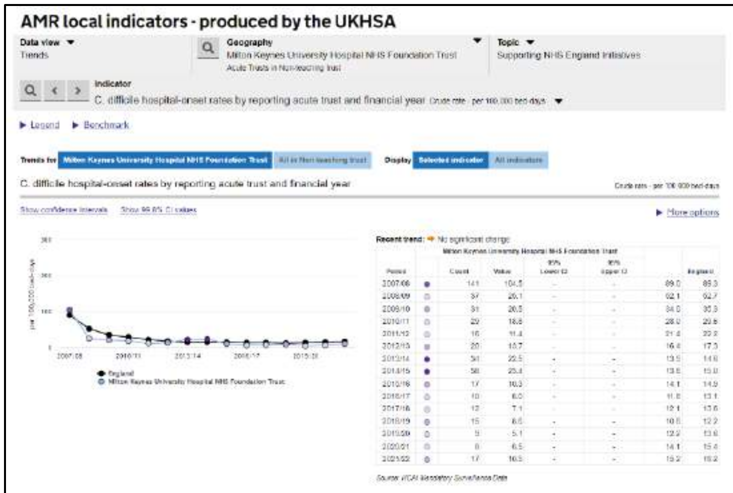
Period	Count	Value	95% Lower CI	95% Upper CI		England
	Milton Keynes University Hospital NHS Foundation Trust					
2012/13	15	10.3	-	-	19.9	21.8
2013/14	18	11.9	-	-	19.6	21.9
2014/15	21	13.6	-	-	19.2	21.1
2015/16	26	15.7	-	-	20.5	22.3
2016/17	32	19.3	-	-	20.6	22.4
2017/18	31	18.3	-	-	19.9	22.0
2018/19	31	17.8	-	-	20.7	22.1
2019/20	30	16.9	-	-	21.0	22.6
2020/21	21	16.9	-	-	20.9	23.6
2021/22	22	13.6	-	-	19.8	21.5

Source: HCAI Mandatory Surveillance Data

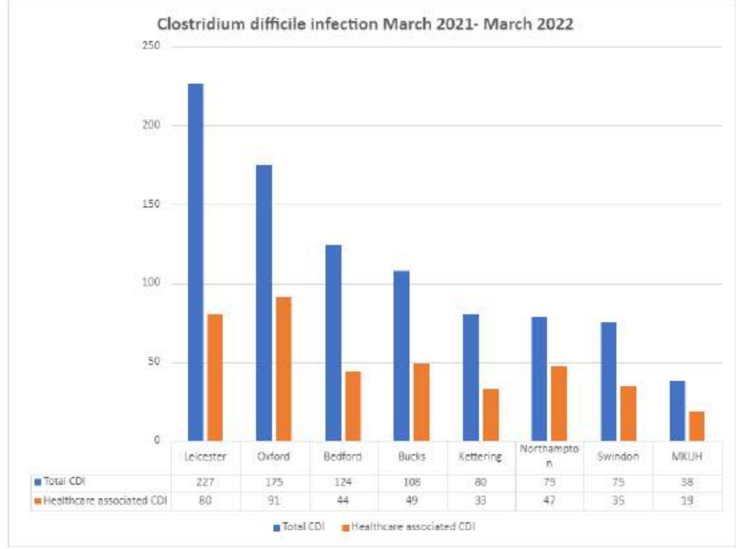
Fig 8 UKHSA data showed MKUH’s healthcare associated (HCA) *E.coli* bacteremia rate was lower than national average (13.6 vs 21.5).

C. difficile infection

C. difficile infection rates are an indicator of antibiotic practice as inappropriate antibiotic prescriptions can lead to a high number of *C. difficile* infections. MKUH reported 18 cases of health care associated CDI in 2022-23. Since 2015-16, MKUH CDI cases remained lower than the national average. However, the number of CDI cases has gone up since 2021-22 and a significantly higher number of community onset cases were also reported in 2022-23. This is likely related to higher antibiotic consumption in the community due to COVID, group A streptococcal infections and other complicated infections.



Period		Count	Value	95% Lower CI	95% Upper CI		England
2007/08		141	104.5	-	-	89.0	89.3
2008/09		37	26.1	-	-	62.1	62.7
2009/10		31	20.5	-	-	34.0	35.3
2010/11		22	18.8	-	-	28.0	29.6
2011/12		16	11.4	-	-	21.4	22.2
2012/13		20	13.7	-	-	16.4	17.3
2013/14		31	22.5	-	-	13.5	14.6
2014/15		38	25.4	-	-	13.6	15.0
2015/16		17	10.3	-	-	14.1	14.9
2016/17		10	6.0	-	-	11.8	13.1
2017/18		12	7.1	-	-	12.1	13.6
2018/19		15	8.6	-	-	10.8	12.2
2019/20		9	5.1	-	-	12.2	13.6
2020/21		8	6.5	-	-	14.1	15.4
2021/22		17	10.5	-	-	15.2	16.2



	Leicester	Oxford	Bedford	Bucks	Kettering	Northampton	Swindon	MKUH
Total CDI	227	175	124	108	80	79	75	38
Healthcare associated CDI	80	91	44	49	33	47	35	19

Fig 9-10: Number of *C. difficile* infections reported by MKUH between March 2021 and March 2022. A similar trend has been noticed last year at MKUH, but the infection numbers were significantly below the national average and other neighboring trusts.

Antimicrobial stewardship is a continuous process of governance and improving prescribing behaviour of the clinicians focusing on rationalising antimicrobial use to improve clinical care and reduce harm to patients. The COVID-19 pandemic had a huge impact on antimicrobial stewardship and the ongoing number of COVID infections are still proving challenging for both infection control and AMS teams. This is particularly the case on ward 8 (COVID ward) and the longer stay elderly care wards. The risk of a stepwise rise in total consumption and broad-spectrum antibiotic consumption remained high throughout 2022-2023, possibly due to high bed occupancy and an increasing number of complicated infections (including COVID and group A streptococcal infections). This was reflected nationally and globally and will likely impact antimicrobial resistance in the coming years. Therefore, AMS activity needs constant focus and strategic use of resources in specific areas which are at risk of antimicrobial overuse.

Areas of focus for 2023-24

The year 2022-23 was a challenging year for infection control and antimicrobial stewardship. COVID cases continued to be admitted into the trust throughout the year despite the severity of infection reducing. The number of group A streptococcal infections remained significantly higher than expected from October 2022 to February 2023. The overall total antimicrobial consumption increased compared to the previous year. Other healthcare associated infections like *C difficile* infection and MSSA bacteremia remained higher than expected. High bed occupancy, staff vacancies, delay in investigations and delayed discharge remained the major challenges for antimicrobial stewardship. Senior clinicians need to be proactive to support antimicrobial stewardship and take ownership of antimicrobial prescribing practice in their clinical areas. Regular feedback, audit, research and AMS promotion are required to ensure this is achieved and maintained following the COVID-19 pandemic.

1. **IV to oral switch: Regional AMS plan and CQUIN.**

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

As previously explained, MKUH has already started to work on this and has undertaken several activities to improve this aspect of antimicrobial stewardship. These will be continued in the upcoming year and the AMS team also plans to undertake further teaching and education to promote IVOS along with working closely with our senior nursing colleagues to make IVOS a priority across the trust.

Given the successful update of our IVOS guideline, MKUH have also been asked to prepare a case study of our strategy to promote IVOS which will be available amongst the national IVOS CQUIN resources.

2. **Update of guidelines/ Microguide**

The Microguide app provides easy availability of MKUH antimicrobial guidelines to the prescribers. *Microguide* was introduced in 2021 and needs constant review to ensure it is up to date and accurate. The antimicrobial guidelines and *Microguide* require updates to accommodate recent changes (local and national). The AMS team are working closely with various clinical teams across the trust to ensure the guidelines are updated according to current practice and according to the evidence base. This will require a large amount of time and resource, to ensure the guidelines are updated appropriately.

3. **Safe use of gentamicin**

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

A safety alert was issued by the MHRA in 2021 to address some cases of deafness following gentamicin use in some hospitals. A rare mitochondrial mutation has been linked to the likelihood of gentamicin related deafness. The MHRA alert highlights the risk and that genetic testing should be considered in patients who are likely to require gentamicin more frequently or for longer durations. The possibility of genetic testing and the groups of patients who may require this is still be considered.

To reduce the risk associated with inappropriate gentamicin prescribing, an eCare alert has been created to highlight when higher than usual gentamicin doses are prescribed, and the gentamicin dose calculator has been updated.

4. Strategic planning to reduce the broad-spectrum antibiotics

The disproportionate increase of pressure on the NHS has made antimicrobial stewardship susceptible to various challenges including a rapid rise in general antimicrobial consumption. The NHS standard contract target for antimicrobials for the financial year 2023-2024 has been amended to be in line with the 5-year national action plan for antimicrobial resistance. The requirement is now for MKUH to demonstrate a 10% reduction in broad spectrum antibiotic consumption against a baseline, determined by the calendar year 2017.

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

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

CPE are emerging as the most challenging resistant bacteria. The limited number of suitable antibiotics to treat CPE infections leads to high mortality and morbidity. In a regional audit, we found that if CPE is isolated from a patient (colonized or infected), the length of stay becomes significantly increased (average 25-30 days). Therefore, prevention of CPE transmission in the hospital setting is extremely important. The UKHSA provides guidelines for CPE screening and management. This has been audited and an action plan implemented. NDM (New Delhi metallobetalactamases) have been found to be the most prevalent CPE

type isolated at MKUH and the AMS team needs to work on a management plan for treatment of this type of infection by ensuring easy availability of appropriate antibiotics within the formulary.

6. Microbiology clinical service upgrades and UKAS preparation

The microbiology laboratory provides substantial support to AMS activity. The laboratory has been modernised significantly and provides a 24/7 service. The serology and molecular section of the laboratory were UKAS accredited in 2022 but failed to satisfy the UKAS standard in subsequent inspections. The laboratory needs wider improvement in its quality management system and work has been progressed significantly to regain the accreditation of serology within 2023 and further expansion of scope, to get the laboratory prepared for UKAS inspection by end of 2023-24.

7. Commonwealth Partnerships for Antimicrobial Stewardship (CwPAMS) Project

MKUH have been successful in obtaining a grant from CwPAMS which is a health partnership scheme funded by the UK Government Department of Health and Social Care's Fleming Fund in collaboration with the tropical health education trust (THET). MKUH will be partnering with the University of Nigeria Teaching Hospital Ituku Ozalla to strengthen AMS activities and establish a hub for quality control of antimicrobial medications.

The grant is initially for £10,000 for the first 3 months of the project but following this, there is the potential for a further £45,000 to be obtained to undertake the project. The full details of the project are still being determined but will involve teaching sessions for healthcare professionals in the Nigerian hospital and the development of guidelines supported by MKUH.

This is an amazing opportunity for MKUH to establish an international partnership and to improve antimicrobial stewardship on a wider scale. It is hoped that this project will enhance the skills of MKUH AMS staff and encourage other pharmacy staff within MKUH to become engaged and interested in widescale projects. We also hope that this may enable MKUH to enhance the AMS team through the development of a pharmacy technician to 'backfill' the lead antimicrobial pharmacists time by undertaking audit and other project work.

Conclusion

Despite many challenges in 2021-22, the AMS service continued to provide strong support and vigilance on antimicrobial consumption at MKUH. Total consumption of antimicrobials alongside use of Tazocin and co-amoxiclav have increased in 2022-2023 likely due to increased organisational activity. However, carbapenem consumption was slightly lower than previous years and a stepwise reduction in use has been observed in consecutive years. This is mostly due to a carbapenem focused AMS ward round. The ongoing COVID-19 pandemic, group A streptococcal and other complicated infections were big challenges over the year and impacted on antimicrobial stewardship and *C. difficile* infection. The introduction of procalcitonin (PCT) based individualised antimicrobial stewardship, proactive antimicrobial ward rounds, staff-grade microbiologist support, initiation of an IV to oral project and a 24/7 microbiology service, have supported

MKUH to maintain antimicrobial consumption below the national average (Q3 and Q4 data not yet published). This year the AMS team is keen to focus more on updating the antimicrobial guidelines and Microguide, achieving the IV to oral CQUIN, reduction of healthcare associated infections and strategic planning to reduce broad-spectrum antibiotics.

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9. British Thoracic Society Guideline for bronchiectasis in adults, 2018. https://thorax.bmj.com/content/74/Suppl_1/1
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Meeting Title	Trust Board of Directors	Date: July 2023
Report Title	**Annual Falls Prevention and Management Report 2022/23**	**Agenda Item Number: 14**
Lead Director	Yvonne Christley - Chief Nurse	
Report Author	Emma Codrington - Associate Chief Nurse	

Introduction	*Assurance*		
Key Messages to Note	This Trust annual report on inpatient falls prevention and management for the highlights the importance of reducing the incidence of falls among patients. Falls can result in serious injuries, prolonged hospital stays, and increased healthcare costs, making fall prevention a critical component of patient safety. The report outlines the various strategies employed by the Trust to prevent and manage inpatient falls. These include identifying patients at risk, assessing the patient's environment, implementing appropriate interventions, and educating patients, families, and healthcare staff. The report emphasizes the importance of conducting regular fall risk assessments and addressing environmental hazards promptly to prevent falls. The report concludes that by implementing a fall prevention quality improvement programme designed to reduce the incidence of falls, improve patient outcomes, and promote patient safety.		
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*

Report History	Quality and Clinical Risk Committee, June 2023
Next Steps	N/A
Appendices/Attachments	Report

Annual Inpatient Falls Report 2022/2023

Introduction

This report aims to provide an annual analysis of inpatient falls at Milton Keynes University Hospital (MKUH). The report includes information on the number and location of falls and the categories and levels of harm. The report summarises the work of the Harm Prevention Group and the Trust-wide falls prevention and management programme.

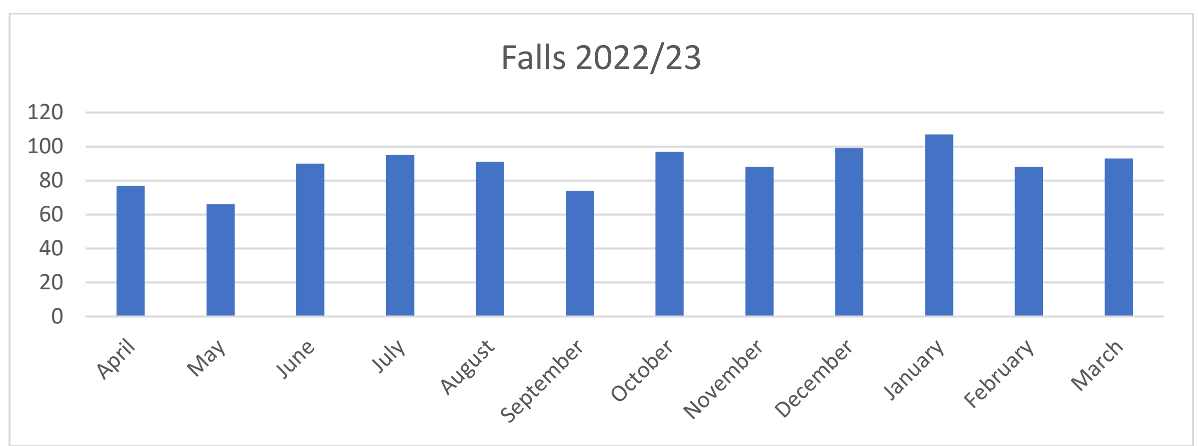
Background

Falls that occur while in the hospital can be perilous, particularly for older patients. It is essential to take all necessary precautions to prevent and manage such incidents. Factors contributing to inpatient falls include muscle weakness, poor balance, vision problems, multiple medications, environmental hazards, and certain medical conditions. To prevent falls, hospital staff should assess each patient's risk factors and take steps to minimise the risk of falling during their hospital stay.

Incidence of Inpatient Falls at MKUH

Between April 2022 and March 2023, MKUH documented and reported 1065 inpatient falls. Out of these, 1038 cases (97.5% of the total) resulted in no or low harm, while 27 patients (2.5% of the total) resulted in moderate to severe harm. Figure 1 below provides a monthly breakdown of the number of inpatient falls.

Figure 1: Inpatient Falls by Month



Any fall, regardless of the extent of injury, must be reported using the Trust Radar reporting system. If a fall results in moderate harm or above, a falls summit will occur, and the Serious Incident Review Group (SIRG) will be notified. The summit's purpose is to evaluate if the fall meets the criteria for a Serious Incident and, more importantly, to identify and share any lessons learned to enhance future care.

Falls by Ward Area

According to the data, 33% of inpatient falls at MKUH happened in four specific areas: Ward 19 (general medical ward), Ward 23 (trauma and orthopaedic ward), Ward 18 (general medical ward), and Ward 1 (acute medical admissions). These wards had more patients at risk of

falling due to the older age of the patients, the levels of reduced mobility and poor cognitive impairment.

Figure 2: Inpatient Falls by Ward

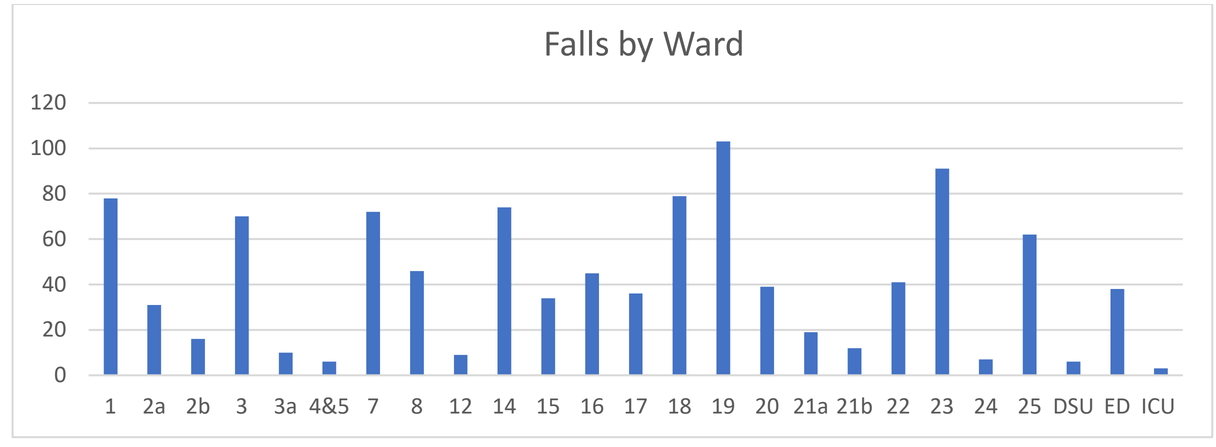


Figure 2 below shows the main categories of falls.

Out of all the falls more than 50% were not witnessed. The rest were seen, with 343 caused by falling from a wheelchair, chair, or commode, 243 from a bed, and 257 while mobilising without help.

The graph above shows the categories which all the falls reported for 2022/23 have been classified under. The top 3 categories are:

- Unknown (unwitnessed) - 579
- Lost Balance - 160
- Fall from Chair 85

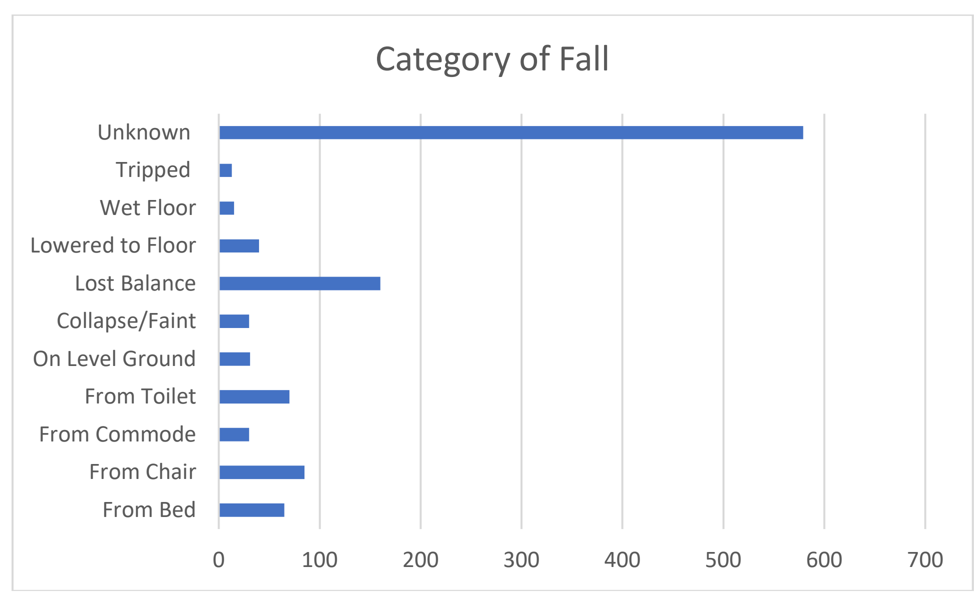
These equate to 77% of all reported falls during 2022/23.

Unwitnessed falls has the highest overall percentage (54%), recognising this, work has continued encouraging bay-based nursing and the appropriate placement of equipment such as the Workstation on Wheels (WOW's) to maximise the visibility of patients.

Category of Fall

This graph shows the categories of falls reported for the year 2022/23. The top three categories are unknown (unwitnessed), with 579 reported falls, lost balance, 160 reported falls, and falls from a chair, with 85 reported falls. These three categories makeup 77% of all falls reported during 2022/23.

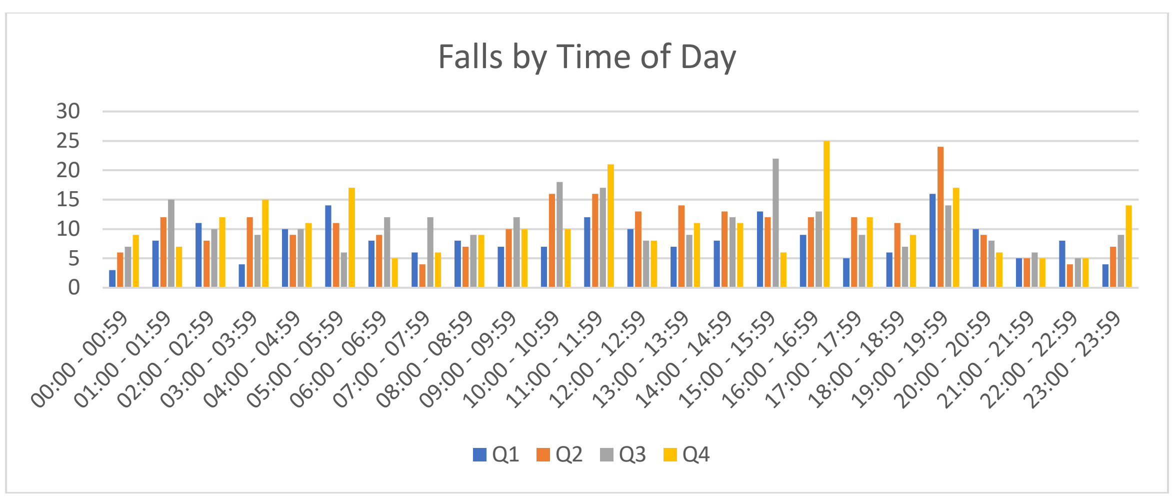
Figure 3: Category of Fall



Time of Day

The graph below shows that falls happened more frequently between 11:00-12:00 and 19:00-20:00 in all four quarters. Inpatient falls are more common the early afternoon and early evening, with a peak occurring between 7pm and 8 pm. This may be due to decreased staffing levels at shift handover. Additionally, patients who are taking multiple medications, have impaired mobility, confusion or dementia, or require assistance with activities of daily living (ADLs) are at an increased risk for a fall during this time period.

Figure 4: Falls by Time of Day



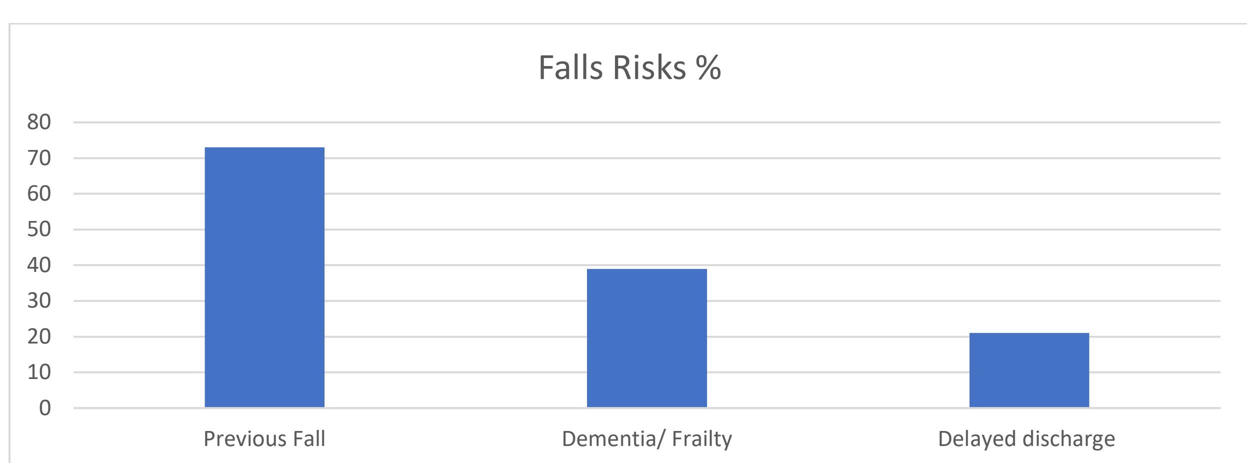
Analysis of Moderate Harms Falls

Of the patients who experienced moderate harm due to an inpatient fall, 73% had previously fallen or had a diagnosis that increased the risk of falling. A history of falls is a significant risk factor, as individuals who have fallen in the past year are at a high risk of falling again.

Additionally, 39% of patients who experienced moderate harm from a fall had a known diagnosis of dementia and/or were considered frail. Dementia is a known risk factor for falls, and frailty is associated with a higher risk of falls and greater harm resulting from a fall.

Patients waiting for discharge to be arranged or begin, it puts them at a higher risk for harm, including decreased mobility and falling. In fact, 21% of patients who suffered moderate harm from a fall were in this situation while waiting for a package of care or discharge plan.

Figure 5: Known Risk Factors for Falls



*Please note that the overall percentage exceeds 100% because some patients meet more than one risk factor.

The figures above indicate that the first step in managing falls risk is identifying those patients who are at higher risk of falling. Once the high-risk individuals are identified, a comprehensive assessment should be conducted to determine their specific needs. The goal of assessment is to identify any potential risks for falls so that interventions can be implemented to reduce the likelihood of an incident occurring.

The Harm Prevention Group (HPG)

The Trust Harm Prevention Group was created in August 2021 and is led by a Senior Matron. It is a forum made up of various healthcare professionals and concentrates on four crucial areas of patient care:

- preventing and managing pressure ulcers, maintaining proper nutrition and hydration, preventing patient falls, and addressing patient frailty.

The group's aim is to analyse and oversee any harm related to these areas, identify patterns and opportunities for improvement, and report progress to the Patient Safety Board on a quarterly basis.

Fall Prevention and Management Improvement Programme

To prevent and reduce the incidence of falls, the Trust is implementing the following:

1. All staff now have access to an updated online falls prevention e-learning package and a university-accredited frailty module designed for nursing staff. The frailty team teaches the module and focuses on preventing deconditioning in frail patients, helping them maintain their independence and reducing the risk of falls and other harm. In addition, the frailty team conducted a targeted falls awareness week in September 2022, attending each ward area to raise awareness of risk factors and appropriate interventions.
2. Improve patient assessment and risk stratification for falls. Work has commenced on a multifactorial assessment which will involve a comprehensive assessment to identify the specific risk factors contributing to their falls risk. Multifactorial assessments have been shown to be effective in reducing the risk of inpatient falls by up to 30% in hospitalised patients.
3. Assess and monitor ward performance against the completion of a falls assessment within 6 hours of admission is monitored via Business Intelligence (BI). Develop, implement a detailed falls prevention and management audit on and Tendable (audit tool) and review as part of the Ward Assurance process.
4. Promote exercise and physical activity and prevent deconditioning in consequence to reduced physical activity in hospital. Early mobilization. This will involve encouraging patients to get up and move around as soon as possible after admission to the hospital can help prevent reconditioning. This can involve activities such as sitting up in bed, standing, and walking, as appropriate for the patient's condition.
5. Revise and update the Trust falls prevention and management policy and procedure: the falls prevention and management policy is currently under review by a multiagency group seeking to produce a policy that reflects national guidance and is fit for purpose.
6. Providing patients with education about the importance of staying active during their hospital stay can help motivate them to maintain their physical function. This may involve explaining the negative consequences of prolonged bedrest and providing guidance on how to stay active within the limitations of their condition.

Conclusion

Inpatient falls are a serious issue that can lead to patient morbidity and mortality. It is crucial that the Trust continue ensure preventive measures are implemented to address this issue. The QI programme summrised above requires a comprehensive and multifaceted approach. This annual report has provided an overview of the Trusts efforts to prevent and manage inpatient falls over the past year.

A range of interventions have been implemented including regular patient assessments, staff education, environmental modifications, and individualised care plans. It is anticipated that hese efforts have resulted in a significant reduction in the number of falls over the next year.

Meeting Title	Trust Board	Date: 06 July 2023
Report Title	Hospital Acquired Pressure Ulcers Annual Report	**Agenda Item Number: 15**
Lead Director	**Yvonne Christley - Chief Nurse**	
Report Author	Deepa Austin	

Introduction	*Purpose of the report e.g. Statutory/Assurance*		
Key Messages to Note	The Pressure Ulcer Annual Report highlights the prevalence, impact, prevention, and management of Hospital Acquired Pressure Ulcers (HAPU) at MKUH between April 2022 and March 2023. The Trust has seen a significant and sustained reduction in the number of HAPUs from November 2002 to the end of the reporting period in March 2023. The Trust has invested in a wide-ranging quality Improvement programme to reduce pressure ulcers. The QI programme has enabled a structured, systematic approach to identify the key problems and effect sustainable change. The QI programme is focused on: • Education • Infrastructure and Culture • Standards • Patient and Family Involvement • This report emphasises the collaborative approach involving a multidisciplinary team establishing a sustainable process in reporting and validating pressure ulcers, reviewing, and learning from incidents, resulting in a downward trend in the total number of pressure ulcers.		
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*

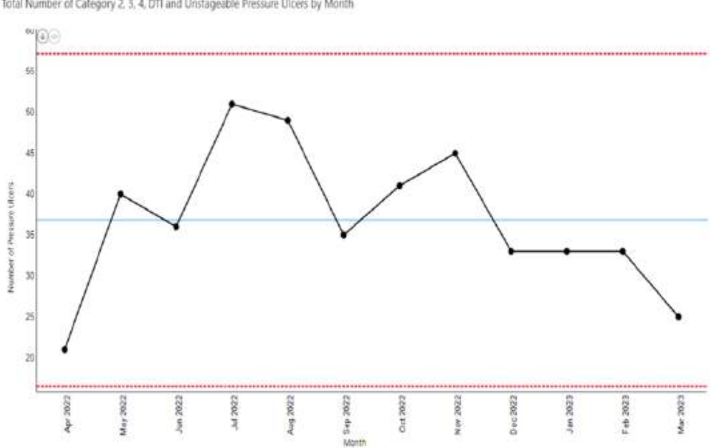
Report History	Quality and Clinical Risk Committee, June 2023
Next Steps	N/A
Appendices/Attachments	Report

Introduction

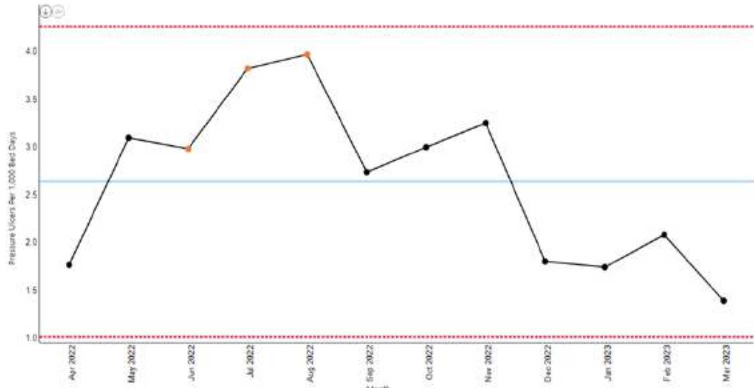
Milton Keynes university hospital is committed to providing high-quality care to patients. An essential aspect of that commitment is preventing and managing hospital-acquired pressure ulcers (HAPUs). Pressure ulcers are common in healthcare and can lead to patient morbidity and increased healthcare costs. This annual report provides an overview of the incidence of pressure ulcers at the Trust between April 2022 and March 2023. The report also highlights the progress in reducing, preventing, and managing HAPUs and outlines the Trust quality improvement programme.

Incidence of HAPU at MKUH

From April 2022 to March 2023, there were 440 reported hospital-acquired pressure ulcers (HAPUs) across all categories, including categories 2, 3, and 4, Deep Tissue Injury (DTI), and unstageable ulcers. Of these cases, 290 occurred in the medical division and 150 in the surgical division. The graph below demonstrates the total number of hospitals acquired pressure ulcers by month. As the chart shows, the Trust has seen a steady decline in the incidence of HAPU over the past six months. Since November 2022, the number of HAPUs has reduced from 45 a month to 25 in March 2023.



The Trust has also seen a decline in the number of HAPUs per 1000-bed days. Reporting pressure ulcers per 1000 bed days is a standard method of tracking the incidence of HAPUs despite fluctuations in the number of escalation beds. This allows for more accurate comparisons and benchmarking of performance. The graph below demonstrates the steady decline from 4 HAPUs per 1000 bed day in August 2022 to 1.5 HAPUs per 1000 bed day in March 2023.



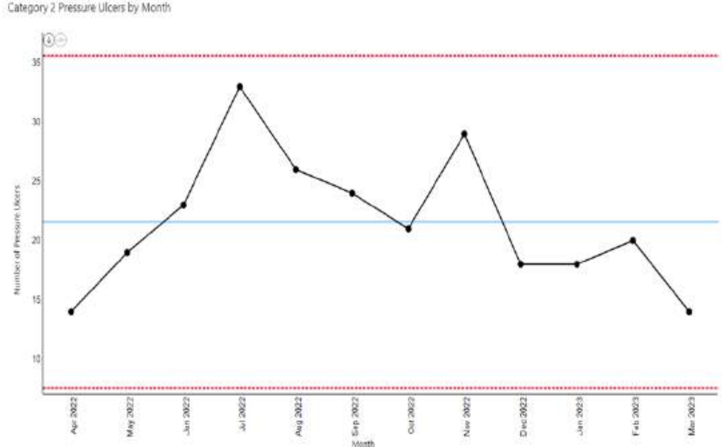
Incidence of Hospital-Acquired Pressure Ulcer by Category

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

Category 2

Category 2 pressure ulcers are the most frequently reported pressure damage. There were 259 category 2 pressure ulcers out of which 172 were in the medical division, and 85 were in the surgical division. Category 2 pressure ulcers have also steadily declined during the reporting period from the highest level of 35 in July 2022 to 15 in March 2023.

Category 2 Pressure Ulcers by Month



Category 3 Pressure Ulcers

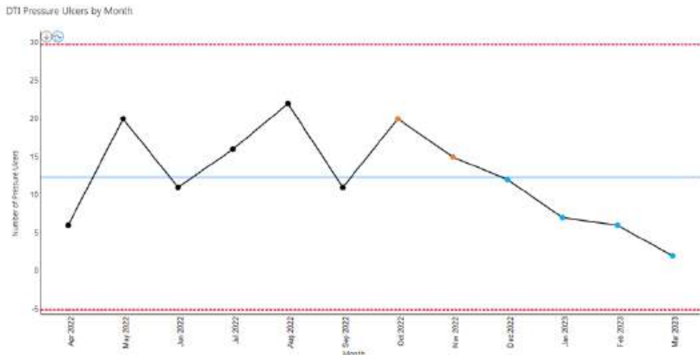
Category 3 pressure ulcer is pressure damage with full-thickness tissue loss. There were 14 category 3 pressure ulcers during the reporting period, of which 6 were in the medical division, and 8 incidences were in Surgery.

Category 4 Pressure Ulcers

There were two category 4 pressure ulcers reported this year. One was a device-associated (Anti Embolic Stockings) in the medical division, and the other incident was a deterioration of a community-acquired Category 3 pressure ulcer in the surgical division.

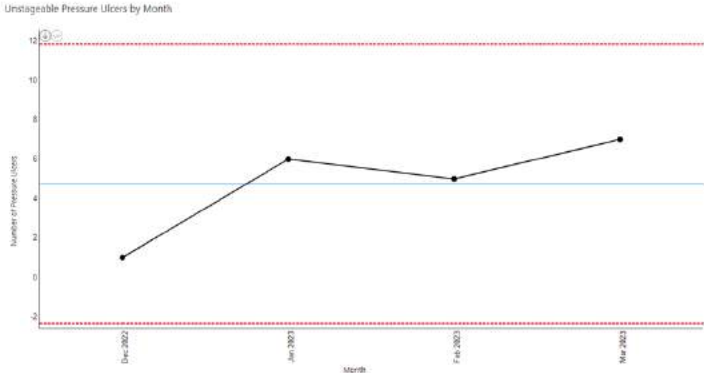
Deep Tissue Injury (DTI)

Deep tissue injury is a pressure ulcer that begins under the skin's surface and progresses to the skin's surface. It may appear purple or maroon. There were 148 DTIs reported this year, of which 98 were in the medical division, and 50 were in the surgical division. These also have steadily declined from 28 in November 2023 to 2 in March 2023.



Unstageable Pressure Ulcers

Unstageable pressure ulcers occur when the wound's depth cannot be determined. The Trust started the process of categorising unstageable pressure ulcers in December 2022. Since December, there were 19 unstageable pressure ulcers, of which 13 were in the medical division, and 6 were in the Surgical division.



HAPU Quality Improvement Programme

A Trust-wide quality improvement programme commenced in December 2022 to reduce hospital-acquired pressure ulcers. The QI programme summarised below provides a structured, systematic approach to identifying improvements and producing sustainable change.

Education and Training

- **Wound Care Education**

A revised e-learning programme was introduced to support the knowledge and skills required for appropriate wound care based on the National Wound Care Capabilities Framework. The sessions in this wound care program support the development of knowledge and skills related to pressure ulcer prevention and management. At the time, reporting 77% of Registered Nurses had completed the training. Staff are required to undertake training to comply with a target of 90%.

- **Pressure Ulcer Prevention and Management Programme for Ward Leaders (Band 6 and Band 7)**

A weekly programme for Ward Leaders has been introduced to support the clinical teams with additional pressure ulcer prevention and management training. This training commenced in February and provided focused support on the leadership and management of pressure ulcer care and prevention. To date, 46 Ward Leaders have attended the training. All areas have at least one ward leader with formal training in pressure ulcer management. This is also supported by bite-size training provided by the Tissue viability team.

A master class for all registered and unregistered staff on pressure ulcer prevention and management was provided by the National Wound Care strategy lead for NHS England in May 2023.

- **Medstrom Aria Flex Bed Training**

A training program has commenced on managing and using Aria Flex Bed and the advanced semi-dynamic support for all staff. To date, 666 staff have been trained. There are proposals to include training on Medstrom beds as part of the manual handling, as profiling and positioning on beds support pressure ulcer prevention.

Infrastructure and Culture

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

Tissue Viability Specialist Nurses now validate all HAPUs to ensure consistent and reliable categorisation and early intervention and treatment. The Radar incident reporting system has also been adapted to record the pressure ulcer category after validation.

- **Care Review and Learning Panel**

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

- **HAPU Data Collection and Measurement**

Weekly and monthly data is now available on the Trust information portal, and it is reported on the Trust Board scorecard as the number of pressure ulcers per 1000 bed days. This facilitates more accurate benchmarking and comparison with peer organisations. All clinical

areas receive a weekly update on the number and category of HAPUs. These reports provide information on trends and a weekly SPC chart indicating deterioration and improvement.

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

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

- **Pressure Ulcer Prevention and Management Policy**

A revised and updated Pressure Ulcer Prevention and Care Policy has been developed and is going through consultation with an implementation plan for July 2023.

Care Delivery and Standards

- **eCARE**

Patients with a high Waterlow score on their risk assessment now have a recommendation to initiate a care plan. Th

- **e wound and pressure**

ulcer care plan has been reviewed and adapted to be more user-friendly, and a new section has been developed for accurate documentation of repositioning. This will be added to the problem list for patients with a visual symbol aid.

- **Incontinence Management**

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

- **Patient and Family Involvement**

Appreciative Inquiry (AI) was used to understand the impact of pressure ulcers on the patient and their families. This information was used to co-design a patient information booklet with advice and guidance on preventing pressure damage in the hospital. The team is also exploring how information can be shared with patients, relatives, and care providers before hospital admission. All information will be developed to meet individual patients' needs and EDI requirements.

Improved Tissue Viability Service

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

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

The Trust has invested additional resources to strengthen the leadership within the tissue viability service. This included a Band 7 Specialist Nurse and a Tissue Viability Nurse Consultant.

Conclusion

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

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

Meeting Title	**Trust Board**	**Date: 06 July 2023**
Report Title	**Freedom To Speak Up (FTSU)**	**Agenda Item Number: 16**
Lead Director	Danielle Petch, Director of Workforce	
Report Author	Danielle Petch, Director of Workforce	

Introduction	FTSU – Annual report and refreshed vision		
Key Messages to Note			
Recommendation *(Tick the relevant box(es))*	**For Information** x	**For Approval** ☐	**For Review** ☐

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

Report History	*The attachments have been presented to Workforce Development and Assurance Committee, May 2023*
Next Steps	
Appendices/Attachments	

2023 MKUH Vision for FTSU

We are committed to promoting an open and transparent culture where all members of staff feel safe and confident to speak up in support of patient safety, staff experience and continuous improvement.

Freedom to Speak Up Guardian Annual Report 2022

Executive Summary

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

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

Overview of Case work

In the year under consideration, **41** concerns have been raised, categorised under the 5 headings set by the NGO.

- 15 were reported as having some element of bullying and harassment involved – mainly through incivility when dealing with colleagues, in their own or other departments, or a line manager.
- 11 were reported as other inappropriate attitudes or behaviours, e.g., racism, homophobia, slow locking of bank shifts, 'gossiping', inappropriate advances.
- 3 were reported as detriment – where when the witness has already spoken about an issue, and they feel they have an experience they describe as detrimental.
- 5 were about patient safety – two were about the pressures on teams and groups of staff where low numbers and low morale were having an impact, another concerned patient related data quality.
- 7 were reported as having concerns about worker safety and wellbeing, e.g., expectations to carry out a physical task when not fit.

At the time of writing most cases were dealt with through intervention with line managers or workforce department assistance. Some witnesses took their own action, and others decided that no further action was required. Currently no ongoing investigations have been required. In addition, all 5 current Guardians have acted to support witnesses and quarterly data submissions are made to the NGO as required.

The increase in reported concerns is noted, there were 21 last year. It is hoped that this indicates increasing confidence in the FTSU service. When provided, the feedback about the service has been positive. During 2022 it was agreed to purchase an App for Freedom to Speak Up that staff could add to their personal devices. It is hoped to be in place in spring 2023. Use of the App will eliminate manual recording of data and cases which is currently time consuming for Guardians. An online form is available through use of QR code however, the link to the reported incidents stopped working in late 2022 which led to a short delay in contacting some witnesses. The Lead Guardian contacted all concerned and the cases were picked up as required, whilst others had been settled and did not require further action.

Current Freedom to Speak Up Team.

The Lead Guardian, Philip Ball, is supported by 4 current Guardians; Angela Legate, Lizzie Taylor, Hafsa Omar and Karen Phillips. These are supported by Champions who act as first points of contact and signpost to Guardians where required. The Champions and Guardians have met throughout 2022 to keep in touch with developments.

Protected time for Guardians is addressed through the Protected Working Time policy. During 2022 the Lead Guardian was able to work in a paid capacity and by the end of 2022 was working 15 hours per week. This is an Annual Report. The draft was shared for comments with the Guardians.

Developing the Role and profile of the Freedom to Speak Up Guardian in MKUH

The Freedom to Speak Up Guardian is not part of the management structure of the Trust and is able to act independently in response to the concerns being raised. The Guardian reports directly to the Chief Executive, and this gives them access to the executive directors of the Trust. The Guardian is supported by an Executive (Danielle Petch, Director of Workforce) and Non-Executive Director (Alison Davis, Trust Chair). There are two key elements to the role:

- To give independent, safe, and confidential advice and support to members of staff who wish to raise concerns that could have an impact on patient safety and experience.
- To promote a culture where members of staff feel safe to raise concerns and do not fear adverse repercussions as consequence.

There is a dedicated email address freedomtospeakup@mkuh.nhs.uk for staff to contact the Guardians, and there is a mobile phone number 07779 986470 that is a direct route to contact a Guardian. This way of contacting the Guardians is particularly useful for staff who do not normally use email. This has a drawback in that the caller can be anonymous, making feedback and changes difficult. There is also a web-based form to report concerns.

The NGO has encouraged the development of the FTSU Champion role – mainly as a way of signposting staff either to the Guardians, or to other support systems within the organisation, where their concerns may be more appropriately addressed, and 6 Champions were identified. This willingness to become engaged in FTSU activity is a testament to the openness of the Trust. The Lead Guardian would like to see an increase in the number of Champions through a recruitment campaign to run in 2023.

Freedom to Speak Up activities in the Trust – working on listening and following up.

Philip Ball has been participating in East of England Guardians network meetings and attending web-based events put on by the NGO. In September 2022 Jayne Chidgey-Clark, National FTSU Guardian was a speaker at the MKUH Event in the Tent. October is Speak Up Month and in 2022 a number of activities took place including a competition for the most Speak Up pledges, which was won by the Theatre team. Operational pressures and a clash with black history month limited the resources available for communications in 2022. Much more is planned for 2023.

As noted earlier in this paper, one of the aims of Sir Robert Francis' recommendation was to help establish a culture of openness within the NHS. The MKUH Guardian, supported by the Director of Workforce as executive lead, is helping to achieve this in several ways including:

Raising awareness: All new staff are to be given information in a presentation about Freedom to Speak Up as part of corporate induction and presentations have been given to student nurses and medical students. The NGO provided a short web-based training package that all staff can access, via https://www.e-lfh.org.uk/programmes/freedom-to-speak-up/ and this is embedded in mandatory training requirements. Training packages for Managers and Executives at Board level were also rolled out during 2022. The postcard which was developed is featured at the start and end of this report.

An improved intranet page is in place and posters with details of FTSU service and reminders of ways to speak up are kept up to date. Communications about staff support include references to FTSU.

The Guardians and or Champions attend team meetings to deliver short presentations to promote FTSU. The Guardians have been invited to attend meetings of the staff networks and be involved in meetings about staff health and well-being. This helps triangulate data over sickness rates and divisions that have higher rates of sickness absence, for example.

Staff Development: Unregistered care staff can often find it harder to raise concerns but spend most time in direct contact with patients. There is a need to develop opportunities to engage with professional groups and within leadership development training to empower staff to feel confident about speaking up, and to prepare managers to receive feedback from their staff when they have concerns. The development of the Nursing and Midwifery Strategy provided an opportunity to encourage speaking up and speaking out, through the work of Ambition 1.

Influencing cultural change: There needs to be continued collaborative working with HR and the EDI team to raise awareness about bullying and harassment and how to address and combat this behaviour.

Plans for 2023 -

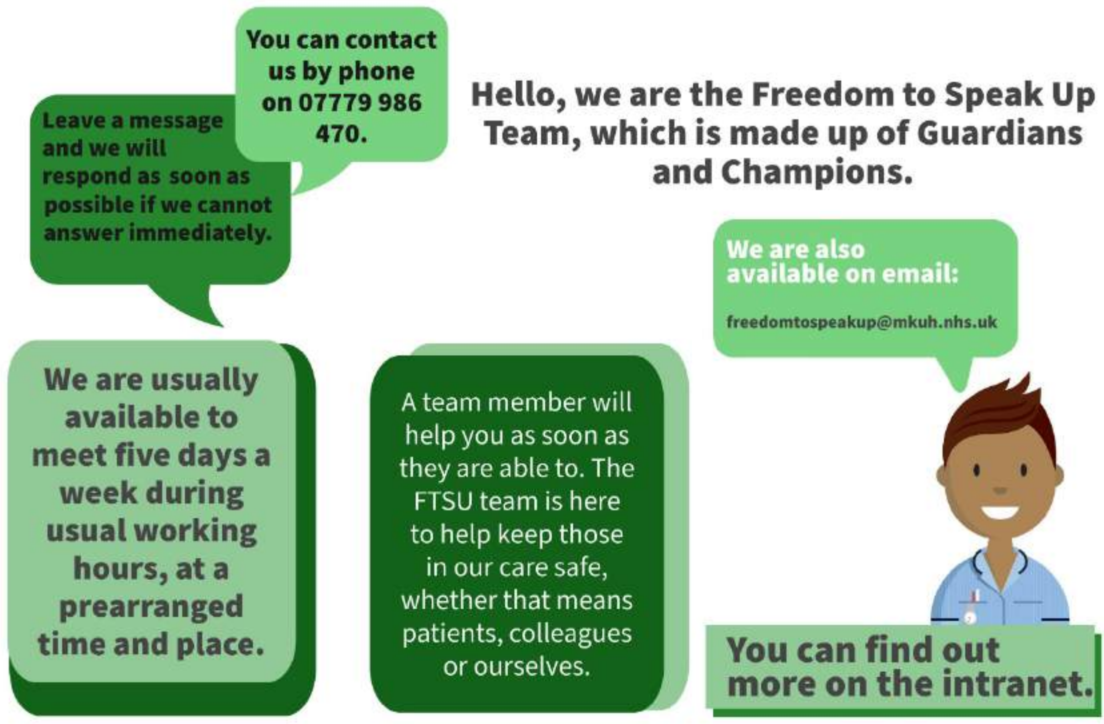
- The approach to FTSU to have greater focus on listening and following up during 2023,
- Promote FTSU widely with increased in October 2023, as it is the 'Speak Up' month.
- Use NHS Staff survey data to highlight and address areas of concern, such as comfort at speaking up and confidence in the Trust to respond to concerns.
- To participate in the development of the role of the Freedom to Speak Up Guardian and continue to be active in the East of England regional group, through the quarterly meetings and WhatsApp.
- Evaluation of the effectiveness of the Freedom to Speak Up Guardian role in the Trust through use of feedback to the Guardian about how well use of the service has worked.

- Regular contributors to team, departmental and divisional meetings; engage with networks such as the Ability and BAME that are developing at MKUH.
- Implement the web-based form that can be accessed by MKUH staffs to report concerns.
- Implement and embed the FTSU App.
- Use the postcards developed about the FTSU service that is given to all new starters as well as current staff, with a version available in the Trust Intranet.

Recommendation

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

Philip Ball, FTSU Guardian, 22nd March 2023



Meeting Title	Public Board Meeting	Date: 6th July 2023
Report Title	Risk Register Report	Agenda Item Number: 17
Lead Director	*Kate Jarman, Director of Corporate Affairs*	
Report Author	*Paul Ewers, Risk Manager*	

Introduction	The report provides an analysis of all risks on the Risk Register, as of 29th June 2023
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 *(Tick the relevant box(es))*	For Information ☐	For Approval ☐	For Review √

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	*Objective 1: Keeping you safe in our hospital* *Objective 2: Improving your experience of care* *Objective 3: Ensuring you get the most effective treatment* *Objective 4: Giving you access to timely care* *Objective 7: Spending money well on the care you receive* *Objective 8: Employ the best people to care for you* *Objective 10: Innovating and investing in the future of your hospital*

Report History	The Risk Report is an ongoing agenda item
Next Steps	
Appendices/Attachments	Appendix 1: Corporate Risk Register Appendix 2: Significant Risk Register

Risk Report

1. INTRODUCTION

This report shows the risk profile of the Trust, the aim of providing the Committee with assurance that the Risk Management process is being effectively managed and highlighting key areas of concern.

2. RISK PROFILE

2.1 Overdue Risks

At the time of reporting, there were a total of 18 risks out of 254 risks (7%) overdue their review date.

2.1.1 Total Overdue Risks by CSU/Corporate Department

CSU/Corporate Department	Overdue Risks
Specialty Medicine	5
Diagnostic & Screening	4
Directorate of Patient Care	3
Child's Health	2
Emergency Department	2
Anaesthetics & Theatres	1
Musculoskeletal	1

2.1.2 Risks Overdue Review > 1 month = 6. This is a decrease of 6 since the last report.

2.2 New Risks = 5

RSK-455 IF there is a lack of knowledge and familiarity with the use of e-prescribing within the Neonatal Unit (NNU) & Paediatric Unit, by medical and nursing staff THEN this could result in prescribing and administration errors
Risk Register: Child's Health **Risk Owner:** Kate Bulbeck
Current Risk Score: 12 (Consequence 4, Likelihood 3)

RSK-456 IF there is an increasing demand on the Blood Sciences service and staffing levels are no longer sufficient to provide a robust 24/7 service THEN staff will be unable to continue to meet service demands
Risk Register: Pathology / Diagnostic & Screening **Risk Owner:** Jessica Dixon
Current Risk Score: 20 (Consequence 4, Likelihood 5)

RSK-457 If there are insufficient staffing levels (radiographers) THEN there will be reduced capacity in the department resulting in closure of the 3rd CT Scanner
Risk Register: Imaging / Diagnostic & Screening **Risk Owner:** Mike Pashler
Current Risk Score: 20 (Consequence 4, Likelihood 5)

RSK-458 IF there are delayed waiting times for patients requiring CT Coronary Angiogram. THEN there will be a delay in the diagnosis and treatment of patients.
Risk Register: Medicine / Specialty Medicine **Risk Owner:** Estelle Cawley
Current Risk Score: 12 (Consequence 3, Likelihood 4)

RSK-459 IF there is insufficient capacity to maintain a core team of trained radiographers THEN there will be a decreasing number of trained CT staff within the department
Risk Register: Imaging / Diagnostic & Screening **Risk Owner:** Mike Pashler
Current Risk Score: 15 (Consequence 5, Likelihood 3)

2.3 Closed Risks = 10

RSK-087 – Potential Mammography Equipment Failure **Closure Reason:** Replacement kit as part of Phase 2 Breast re-design
RSK-148 – Staffing in Chemical Pathology **Closure Reason:** Risk merged with wider staffing risk (RSK-456)
RSK-163 – Inadequate working office environment in Stroke Unit **Closure Reason:** Renovation work in Ward 7 gym complete, including IT equipment
RSK-184 – Lack of space/equip & increased Mammography demand **Closure Reason:** Building works complete. Third mammo room built- equipment installed.
RSK-198 – Potential Mammography Equipment Failure in Mobile Unit **Closure Reason:** Mammogaphy kit installed
RSK-316 – Staffing in Cellular Pathology **Closure Reason:** Risk merged with duplicate staffing risk (RSK-176)
RSK-349 – Lack of support contract – Unisoft Endoscopy Reporting **Closure Reason:** Implementation of HD Clinical Solus endoscopy reporting complete
RSK-350 – Lack of link between Unisoft and eCARE **Closure Reason:** Implementation of HD Clinical Solus endoscopy reporting complete
RSK-398 – Medication Storage – including segregatig different drugs **Closure Reason:** New storage has reduced likelihood of occurrence
RSK-419 – Lack of FFN Test stock **Closure Reason:** FFN tests now ordered.

2.4 Risks for escalation onto the Corporate Risk Register = 0

3. Risks where the Current Risk Score has changed this month:

3.1 Increasing Risks = 3

RSK-374 IF patients on the cancer pathway wait longer than 62 days THEN there is the risk treatment has been delayed,
Increase: 15 to 20 **Reason for Increase:** Reason for increase has not been provided on Radar.

RSK-079 IF Therapies are unable to clear the post pandemic backlog THEN we will be unable to meet response times in line protocol requirements
Increase: 9 to 12 **Reason for Increase:** Reason for increase has not been provided on Radar.

RSK-427 IF there is an increase in demand for inpatient and ED CT scans THEN some scans will be routinely waiting a number of days to be performed.
Increase: 16 to 20 **Reason for Increase:** Reason for increase has not been provided on Radar.

3.2 Decreasing Risks = 10

RSK-203 IF the current capacity problems with breast clinics are not improved; lack of space, lack of equipment and organisation of appointments THEN there may be problems appointing breast care service patients and symptomatic patients within the government target of 2 weeks. This is currently exacerbated by social distancing measures and fluctuations in capacity and demand for 2ww patients. **Decrease:** 8 to 4
Reason for Decrease: Risk Reviewed at General Surgery SDU Meeting - The situation has slightly improved. Rooms are back and being monitored weekly with no breaches at present. Risk can be downgraded to its target level for monitoring. DB to inform risk manager of this decision.

RSK-214 IF there is insufficient nursing staffing THEN there is a risk that the number of patients requiring nutritional assistance at meal times exceeds staff availability **Decrease:** 12 to 9
Reason for Decrease: Staff escalate at the daily huddle number of patients on red tray to enable us to determine where help is needed at mealtimes.

RSK-018 IF patients attending the ED with diabetes are not assessed and escalated promptly and therefore will not receive timely/ongoing care to manage their diabetes due to a lack of knowledge/appreciation by staff of the importance of timely assessment/escalation of concerns THEN the patients may deteriorate. **Decrease:** 9 to 6
Reason for Decrease: Practice development Band 7 focusing on training with Band 6 presentation on DKA. Diabetes nursing service now available seven days a week.

RSK-359 IF there are insufficient staffing levels to support the continued service of PSU due to significant turnover of staff THEN there could be pressure on existing staff to repeatedly train and maintain the service, and significant pressure on management with the recruitment process and pre/post employment administration **Decrease:** 9 to 6
Reason for Decrease: Staffing levels are looking healthy and training is progressing well for new recruits. To review in 1 month with view to close if sustained

RSK-449 IF an investment is not made in Transfusion Practitioner(TP) team staffing THEN there is a risk that essential and mandated transfusion practitioner

tasks will be delayed or incomplete. **Decrease:** 9 to 6
Reason for Decrease: Discussed at POT and Haem/BT meeting. Agreed to downgrade risk to 9.

RSK-115 IF annual and quarterly test reports for Autoclaves and Washer Disinfectors used for critical processes are not being received in a timely manner from the Estates department and there is no Authorised Person (D) to maintain the day to day operational aspects of the role THEN the Trust will be unable to prove control, monitoring and validation of the sterilisation process as a control measure. Both units are reviewed only 1 day per month - a bulk of this time is spent checking records and the other aspects of the role do not get the sufficient time required to review and follow up. **Decrease:** 12 to 6
Reason for Decrease: An internal AP(D) has been assigned for HSDU this significantly reduces the risk grading. There is currently no AP(D) for Endoscopy decontamination so the risk has been downgraded but needs to remain open.

RSK-163 If there are inadequate computer facilities and working environment are not adequate to support the office needs for clinical staff located on the Stroke Unit. Then there is potential for staff to suffer musculoskeletal injuries and reduced efficiency of working when writing clinical notes and reports. Reduced patient experience from receiving rehabilitation in an unsuitable environment. **Decrease:** 8 to 2
Reason for Decrease: Renovation works of the ward 7 gym are complete, waiting for storage units and IT equipment to arrive. Once these are in place this risk should be able to be closed.

RSK-453 IF – the changing facilities for hydrotherapy and access to the pool are not reorganised THEN – we are less able to monitor patients health should they become unwell; are unable to navigate a hospital trolley to the poolside when dealing with an emergency situation; are unable to maintain the privacy and dignity of patients whilst changing; are unable to provide disabled access for some patients; are unable to provide secure changing facilities and are unable to meet EDI requirements. **Decrease:** 16 to 8
Reason for Decrease: Reason for decrease has not been provided on Radar.

RSK-331 If current demands on the therapies admin service continues without the capacity to meet the volume of work Then clinicians diary slots will be left unfilled and patients won't be contacted in a timely manner. **Decrease:** 12 to 2
Reason for Decrease: Risk score reduced due to employment of temporary staff

RSK-008 IF the Trust does not have an appropriate system to record mortality and morbidity data; THEN the Trust will not be able to record and/or provide accurate reports for governance or the Trust Board. **Decrease:** 8 to 2
Reason for Decrease: The CORS website reporting system has been commissioned, and is being demonstrated to the M+M Leads for the purposes of troubleshooting. Training will be rolled out over the next few weeks. This should lead to a functioning system within 3 months, when hopefully the risk can be closed.

4. Risk Management Training Update

The new 'Risk Management, Simply' training programme for managers started during March/April 2023. To date, 105 members of staff have attended the face-to-face training session. There are further sessions scheduled through the rest of the year.

Risk Management Training is being recorded through the Radar Workforce Compliance module and staff will be recommended to attend 3-yearly refresher sessions, as scheduled into the Radar system.

5. RECOMMENDATION

The Committee is asked to review and discuss this paper.

6. DEFINITIONS

Scope: Scope will either be Organisation or Region. Risks that are on the Corporate Risk Register are assigned the Organisation scope. Risks that are on the local CSU/Division/Corporate Department Risk Registers are assigned the Region scope.

Original Score: **This is the level of risk without any control in place.** If the controls in place are not effective and fail, then this is the level of risk the Trust could potentially face, should the risk occur. The score should be used to support the prioritisation of risk activities. Where two Current Risk Scores are the same, the risk with a higher Original Score should be managed first as it has the potential to cause a higher risk, should the controls fail.

Current Score: **This is the level of risk taking into consideration all implemented controls**. This is the level of risk the Trust is currently exposed to if the risk was to occur now. You should also consider how effective your controls are. The Current Score is the key risk score used for prioritising risks. However, if you do not have assurance your controls are effective and/or you have two risks with the same Current Score, you should also consider the Original Score.

Target Score: **This is the level of risk that is deemed acceptable, bearing in mind it is not always possible to eliminate risk entirely.** I.e. what is will the level of risk be once all suitable and appropriate controls have been implemented? The Target Score should take into account the Trust Risk Appetite Statement (see the Risk Management Framework) which guides the level of risk the Trust is willing to accepted, based on the type of risk. For example, the Trust has a low-risk appetite to risks that could result in harm (these should be managed to as low as reasonably practicable).

Risk Appetite: The Risk Appetite should be reflective of the level of risk the Trust is willing to accept in pursuit of its objectives. Please see further details regarding the Trust Risk Appetite Statement in the Risk Management Framework.

Risk Response: Risks that are being managed and are at their Target Risk Score, will be listed as Tolerate. This means that no further action is required, other than ongoing review of the risk. Risks that require further controls to the implemented to bring the score to the Target Risk Score, will be listed as Treat.

Corporate Risk Register

Reference	Created on	Description	Impact of risk	Scope	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-134	04-Nov-2021	If there is insufficient funding, then the Trust may be unable to meet financial plans and targets or deliver its strategic aims,	Leading to service failure and regulatory intervention THEN the Trust will be unable to meet its financial performance obligations or achieve financial sustainability	Organisation	Karan Hotchkin	09-Jun-2023	12-Jul-2023	Planned	20	20	8	Internal budgetary review/financial performance oversight processes to manage/mitigate cost pressures. Financial efficiency programme identifies headroom for improvement in cost base. Close monitoring/challenge of inflationary price rises (13-Mar-2023)	Cost and volume contracts replaced with block contracts (set nationally) for clinical income(04-Nov-2021), Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until end of March 2022)(04-Nov-2021), Budgets to be reset for FY22 based on financial regime; financial controls and oversight to be reintroduced to manage financial performance(04-Nov-2021), Cost efficiency programme to be reset to target focus on areas of greatest opportunity to deliver(04-Nov-2021), The current funding has now been clarified .The trust will work with BLMK system partners during the year to review overall BLMK performance(21-Mar-2022)	High	Treat	Risk transferred from Datix	01-Apr-2022
RSK-158	12-Nov-2021	If the escalation beds are open across the medical and surgical divisions Then the additional patients that will need to be seen will put additional demand on the Inpatient Therapy Services that are already stretched due to long term vacancies	LEADING TO: Patients deconditioning and increased Length Of Stay (LOS), high volume of patients will not be seen daily, priority will be given to new assessments, discharges and acute chests. Majority of patients may only be seen once a week for rehabilitation which is insufficient to maintain a patient's level of function. Staff morale will reduce as they will not be providing the appropriate level of assessment and treatment to their patients.	Organisation	Adam Baddeley	13-Jun-2023	21-Jul-2023	Planned	16	20	6	agency physiotherapist and occupational therapist to cover additional workload., inpatient improvement project- aiming to review patient pathways to optimise staffing	Therapy staff attend board rounds and work with the MDT to determine priority patients. The skills mix and workforce is reviewed twice weekly between Occupational Therapy and Physiotherapy to determine cover for the base wards. To work closely with community services to raise awareness and to increase discharge opportunities i.e. in reaching Therapies working with Long stay Tuesday initiative Therapies supporting new discharge pathway/process in the Trust Over recruitment of PT and OT band 5's Locum cover for vacant posts. Daily attendance at 10.30 system wide discharge call. Inpatient Therapy Service participation in MADE events. Review of staffing model across inpatient medical and frailty wards.(12-Nov-2021), Closure or Reduction in Escalation Beds(19-Apr-2022), To ensure that inpatients teams are aware of open escalation areas and patient are prioritised in line with agreed criteria(12-Apr-2023)	High	Treat	Inpatient therapy service currently has 14 WTE vacancies. OT practice contract still supporting service at 2-3 WTE a week.	27-Nov-2018
RSK-159	12-Nov-2021	Patients referred to the Occupational Therapy and Physiotherapy inpatient services covering medical and surgical wards are not being seen in a timely manner due to the number of long term vacancies and national challenges to recruit to vacant posts. THEN there will be a delay in these patients being assessed, treated and discharged.	LEADING TO deconditioning of vulnerable/complex patients requiring a short period of therapy; increased length of stay; potential readmission, increased demand for packages of care requiring double handed provision. patient experience and long term quality of life will also be impacted as patients are being discharged as more dependent on care.	Organisation	Adam Baddeley	13-Jun-2023	14-Jul-2023	Planned	20	20	6	inpatient improvement programme- to ensure optimal staffing and allocation	Daily prioritisation of patients cross covering and review of skill mix locum cover x1 OT and x1 PT in place Ward book for escalation wards setup and band 7 reviews the caseload on the ward daily Monday- Friday and requests the most urgent are reviewed. Recruitment process ongoing but vacancies have reduced slightly. Over recruitment of band 5 OT and PT roles. Non-recurrent funding application for increase in therapy assistants over winter months.(12-Nov-2021), Review of Governance Structure(19-Apr-2022), Review Model of Care(19-Apr-2022), Review Equity Tool - Safe Staffing(19-Apr-2022), Review Workforce Model and Structure(19-Apr-2022), Recruitment and Retention of staff(19-Apr-2022), Education and Training of staff(19-Apr-2022), workforce plan to improve retention(09-May-2023), use of agency staff for any gapped posts(09-May-2023), each team to review skill mix to provide resilience in team, introduce support workers where required(09-May-2023), winter proposal for therapy services- enhanced number of support workers for winter period.(09-May-2023), regular attendance at MADE (Multiagency Discharge Event) to improve flow of patients and safe timely discharge.(09-May-2023)	Low	Treat	Inpatient Therapy service remains 14 WTE below establishment, recruitment is ongoing and we have 12 new starters joining between now and August. OT practice contract continues to support inpatient therapy services.	04-Mar-2019
RSK-202	23-Nov-2021	IF Transformation delivery is not adequately resourced and prioritised and/or schemes are unrealistic and not well planned THEN There is a risk that the Trust is unable to achieve the required efficiency improvements through the transformation programme	LEADING TO the Trust potentially not delivering its financial targets leading to TO potential cash shortfall and non-delivery of its key targets	Organisation	Karan Hotchkin	09-Jun-2023	12-Jul-2023	Planned	20	20	9		Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partners(23-Nov-2021), Cross-cutting transformation schemes are being worked up(23-Nov-2021), Savings plan for 21/22 financial year not yet fully identified(23-Nov-2021), Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partner. There are no cross-cutting transformation schemes yet identified and savings of around £8m have been identified against the £12m target. Whilst this shortfall can be mitigated this year, the risk is around the underlying financial position.(16-Nov-2022)	Medium	Treat	Risk transferred from Datix	01-Apr-2022

Corporate Risk Register

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RSK-305	06-Dec-2021	If there is insufficient strategic capital funding available THEN the Trust will be unable to invest in the site to maintain pace with the growth of the Milton Keynes population's demand for hospital services	LEADING To financial loss and reputational damage	Organisation	Karan Hotchkin	09-Jun-2023	12-Jul-2023	Planned	16	20	9	Trust is discussing this with the regional Capital Team and with the ICB capital allocations for 23/24. 22/23 allocations are manageable (13-Mar-2023)	The trust has a process to target investment of available capital finance to manage risk and safety across the hospital(06-Dec-2021)	Medium	Treat	Risk was approved by Finance and Investment committee on 30/12/2021	01-Apr-2022
RSK-341	17-May-2022	IF there is a delay with imaging reporting for CT and MRI for patients on cancer pathways THEN there could be a delay with diagnosis and the commencement of treatment	LEADING TO potential increase in the required treatment, potential poorer prognosis for patient, poor patient experience, increase in complaints and litigation cases.	Organisation	Paula Robinson	09-Apr-2023	21-Feb-2023	Overdue	20	20	8	2x Specialist Doctors appointed on a fixed-term basis to uplift internal reporting capacity (09-Apr-2023), Specialist Radiology to be recruited to uplift reporting capacity (09-Apr-2023), Explore alternative outsourcing for some specialist areas (e.g. lung) (09-Apr-2023), Imaging Business Case for substantive Radiologists and Radiographers (09-Apr-2023)	PTL tracking to escalate to imaging leads(18-May-2022), Agency Locum Consultant appointed 2 days a week to uplift internal reporting capacity(14-Jun-2022), Temporary reduction in double reporting for Quality Assurance to increase real-time scan reporting(14-Jun-2022), Current Radiologists doing 30% over standard reporting levels(14-Jun-2022)	Low	Treat	Risk reviewed by Claire McGillycuddy. No change to risk - review again February 2023	01-Jun-2022
RSK-001	06-Sep-2021	IF all known incidents, accidents and near misses are not reported on the Trust's incident reporting system (Radar); THEN the Trust will be unable to robustly investigate all incidents and near-misses within the required timescales;	LEADING TO an inability to learn from incidents, accidents and near-misses, an inability to stop potentially preventable incidents occurring, potential failure to comply with Duty of Candour legislation requiring the Trust to report all known incidents where the severity was moderate or higher, potential under reporting to the Learning from Patient Safety Events (LfPSE) system, and potential failure to meet Trust Key Performance	Organisation	Tina Worth	21-Mar-2023	30-Jun-2023	Pending	20	16	12	Staff competence and confidence with Radar reporting, with improved reporting rate, reduction in inaccurate reports on system and/or failure of incidents being reported (24-Oct-2022)	Incident Reporting Policy(06-Sep-2021), Incident Reporting Mandatory/Induction Training(06-Sep-2021), Incident Reporting Training Guide and adhoc training as required. Radar to provide on site & bespoke training IT drop in hub to be set up 2 days a week for staff drop ins(06-Sep-2021), Datix Incident Investigation Training sessions(06-Sep-2021), Daily review of incidents by Risk Management Team to identify potential Serious Incidents and appropriate escalation(06-Sep-2021), Serious Incident Review Group (SIRG) ensure quality of Serious Incident Investigations(06-Sep-2021), SIRG ensure appropriate reporting of Serious Incidents to Commissioners(06-Sep-2021), Standard Operating Procedure re Risk & Governance Team supporting the closure of incident investigations during unprecedented demand on service(06-Sep-2021), Implementation of new Risk Management Software to make incidents easier to report and improve engagement with staff(06-Sep-2021)	Low	Treat	With ongoing PSIRF preparation recognise that shared learning is crucial to that & current processes are not robust enough to address this. To be included in PSIRF implementation plan	06-Sep-2021
RSK-035	28-Sep-2021	IF there is a high turnover of staff due to: work pressure, not having the opportunity to work at the top of their licence, lack of capacity for development, lack of capacity for supervision / support. Also difficulty in recruiting. Loss of staff to primary care which offers more attractive working hours. THEN there will be insufficient staff in pharmacy to meet demands of the organisation and ensure patient safety in the use of medicines.	LEADING TO: 1. increased length of stay due to TTO delay 2. increase in prescribing errors not corrected 3. increase in dispensing errors 4. increase in missed doses 5. failure to meet legal requirements for safe and secure use of medicines 6. harm to the patients 7. adverse impact on mental health of Pharmacy staff All resulting in adverse patient outcomes. Lack of financial control on medicines expenditure Breach of CQC regulations	Organisation	Helen Chadwick	09-Jun-2023	09-Jul-2023	Planned	20	16	6	Actively recruiting staff (09-Jun-2023)	Business Case for additional staff(05-Apr-2022), Temporary role realignment towards patient facing roles(05-Apr-2022), Use of Agency Staff(05-Apr-2022), Prioritisation of wards(28-Jun-2022)	Low	Treat	turnover rate declined over last 3 months and will continue to monitor	07-Aug-2019
RSK-036	28-Sep-2021	If there is no capacity in the Pharmacy Team THEN there is a risk that Pharmacy and Medicines Policies and Procedures may not be reviewed and updated in a timely manner, nor new policies developed	Leading to: Potential for Policies & Procedures to be out of date Potential for staff to follow out of date Policies & Procedures Failure to meet CQC requirements Lack of guidance for staff Potential harm to patients	Organisation	Helen Chadwick	09-Jun-2023	09-Jul-2023	Planned	16	16	6	Recruitment of staff (09-Jun-2023)	Use of remote bank staff to update policies(28-Sep-2021), Business Case for additional Pharmacy staff(19-Apr-2022)	Low	Treat	significant staffing gaps remain, using bank resource to mitigate risk where possible	01-Oct-2021
RSK-126	04-Nov-2021	IF cot spacing in the Neonatal Unit does not comply with BAPM guidance or the latest PHE guidance for COVID-19 (the Unit is seeking to increase both total cot spacing and cot numbers by 4 HDU/ITU cots in line with Network 5 year projections of acuity and demand, and spacing in line with National Recommendations) THEN there will be overcrowding and insufficient space in the Neonatal Unit, exacerbated by need for social distancing due to COVID-19. The milk kitchen was condemned due to this	LEADING TO an inability to meet patient needs or network requirements. We will now also be unable to meet PHE recommendations for social distancing This may result in a removal of Level 2 status if we continue to have insufficient space to adequately fulfil our Network responsibilities and deliver care in line with national requirements. This may also impact on our ability to protect babies and their families during COVID	Organisation	Lazarus Anguvaa	12-Jun-2023	05-Jun-2023	Overdue	25	16	9	Business Case for Refurnishing Milk Kitchen and Sluice	Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards(04-Nov-2021), Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID(04-Nov-2021), Added to capital plan(04-Nov-2021), Feasibility study completed(04-Nov-2021)	Low	Treat	Risk reviewed by triumvirate ,No change to risk or risk scoring	19-Dec-2022

Corporate Risk Register

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RSK-142	04-Nov-2021	IF there is insufficient capacity and ongoing unsustainable demand for dietetic input for Paediatric patients (both inpatient and outpatient) . IF Home Enterally Fed Paediatrics patients continue to be seen our outpatient structure which is not adequate to meet their demands and needs. This means that these high risk groups of Children and Young People are not accessing the necessary specialist nutritional support at the appropriate time in their development THEN staff may be unable to cover a service that has not been serviced correctly, and the paediatric team cannot provide a full dietetic service to children and young people in the Milton Keynes area	LEADING TO patient care and patient safety may be at risk, vulnerable children may become nutritionally compromised, the service may be unable to assess and advise new patients and review existing patients in a timely manner, and there may be an impact on patients nutritional status and longer term dietary management on what is a very vulnerable group of patients. The majority of our caseload is infants or tube fed infants and children where there nutrition and growth is a priority.	Organisation	Elizabeth Pryke	20-Jun-2023	09-Jul-2023	Planned	15	16	3	In contact with commissioners to discuss service provision Collecting additional data (feedback from stakeholders, benchmarking etc) to support business case (11-Apr-2023), Business Case for paediatric Home enteral feeding service	Existing staff are working some additional hours but this remains insufficient to meet the needs of the service(04-Nov-2021)	Low	Treat	Insufficient time to take forward business case, to prioritise in the next month	01-Nov-2021
RSK-016	22-Sep-2021	IF there is a lack of flow in the organisation THEN there may be an unsafe environment for patients	LEADING TO a potentially impact on bed space capacity, ambulance queues, missed Emergency Access Targets and overcrowding into ED/radiology corridors creating Health & Safety hazard and continued pressure, leading to poor patient care/treatment, nursing patients outside of cubicles in corridors and the middle of majors,and delays in discharge/transfer and the potential for an increase of incidents being reported regarding assessment/care/treatment, and or significant number of patients with a high acuity/ dependency being cared for in areas that are not suitable for safe care	Organisation	Kirsty McKenzie-Martin	16-Jun-2023	14-Jun-2024	Planned	25	15	6	Recruitment drive for more nurses/HCA's ongoing. Active management of Nursing/Consultant and Registrar gaps in rota daily to ensure filled. (16-Jun-2023), Walking majors and resus reconfigured. Expanded Cubicle space in Majors - extra 10 spaces, increased capacity using Acorn Suite., Internal escalation policy in place. CSU lead developing trust escalation criteria to alert trust leads to problems sooner - diverting patients to; Ambulatory care, Since Covid pandemic, phasing plan in place with red and green zones within ED., Escalation plan for ED to mitigate patient pressures	EPIC consultant in place to aid flow within department and speed up decision making(22-Sep-2021), RAT-ing process and specialty referrals having a RAG system developed to prioritise sickest patients to be assessed.(22-Sep-2021)	Low	Treat	No change	07-Mar-2016
RSK-250	26-Nov-2021	IF staff across MKUH continue to use eCARE in the same way, that the volumes of requests made to the IT Department remain at their current rate, and the volume of change and project work continues at the current volume THEN the IT Department will become less responsive and a range of functions within eCARE will continue to be left without action	LEADING TO increased clinical risk, increased risk to performance of eCARE, potential disruption to staff, and delays in the deliver or projects and realising their benefits	Organisation	Craig York	03-May-2023	31-Aug-2023	Planned	15	15	3	Identification of staff time and resources (11-Apr-2023), Business case being written by the end of spring 2023 to identify the amount of staff time required., Review volumes against historical figures to reflect reality of challenge. Include in business case. Consider additional posts for all.	Prioritisation of workload is in place to cover the most impacting of issues or projects, however this only reduces the potential impact slightly(26-Nov-2021)	Low	Treat	Volume of work is increasing month on month without additional staff to support.	25-Jan-2023
RSK-406	09-Dec-2022	IF there is a global shortage of electronic components THEN this can impact the lead times for delivery of medical equipment	LEADING TO to inability to replace/repair aged equipment used to monitor and support patients during their hospital care.	Organisation	Ayca Ahmed	13-Mar-2023	30-Jun-2023	Pending	25	15	10	Surgery Division to carry out a risk assessment and build it in their contingency plan (23-May-2023), Medicine Division to carry out a risk assessment and build it in their contingency plan (23-May-2023), Women's & Children's Division to carry out a risk assessment and build it in their contingency plan (23-May-2023), Core Clinical Services Division to carry out a risk assessment and build it in their contingency plan (23-May-2023)	Medical Devices Manager (MDM) is in liaising with suppliers for delivery per each approved BC for medical equipment procurement and providing support/advice to each division lead(09-Dec-2022), Clinical Contingency arrangement(09-Dec-2022), Finance lead for Business Cases is reminding all attendees at each meeting to get the Business Cases ready(09-Dec-2022), Wards/depts are borrowing from another ward/dept within the Trust as a normal practice or lease, rent, arrange a loan via any other supplier(09-Dec-2022), The advice on alternative suppliers are available via the MDM(09-Dec-2022), Procurement has a list from the NHSSC route advising on delivery lead times(09-Dec-2022), Regular inspection and maintenance of current equipment(09-Dec-2022), Rolling programme of equipment replacement regularly reviewed and issues escalated at early stage(09-Dec-2022)	Low	Treat	Risk approved onto the Corporate Risk Register at RCB	11-Nov-2022
RSK-002	06-Sep-2021	IF recommendations and actions from audit are not evidenced, monitored and completed in the Trust; THEN required changes to practice may not implemented and we may not be meeting best practice criteria;	LEADING TO potential impact on the top 3 Trust objectives (patient Safety, Clinical Effectiveness, Patient Experience), potential poor quality of service and associated impact on resources and potential CQC concerns re audit activity and learning from national audits	Organisation	Tina Worth	21-Mar-2023	30-Jun-2023	Pending	15	12	3	Scheduled implementation of Radar audit module (24-Feb-2023)	Audit report templates available to identify audit action plans(06-Sep-2021), Monitoring via Clinical Audit & Effectiveness Committee (CAEB)(06-Sep-2021), Terms of Reference (ToR) for Clinical Audit & Effectiveness Board revised to include quality improvement, GIRFT etc(06-Sep-2021), Escalation/exception reporting to Management Board(06-Sep-2021), Refresh of SharePoint data base to assist with data capture, with Level 1 audit a priority(06-Sep-2021), Structure review - Staff realignment to support audit agenda(06-Sep-2021), Pilot of new governance approach to reports/CIG meetings(06-Sep-2021)	Low	Treat	With Head of QI now in post & consultation within team to enable more staff support for audit & review of processes there is expected to be some changes in direction & compliance in due course	06-Sep-2021

Corporate Risk Register

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RSK-003	06-Sep-2021	IF existing Radar governance system does not support meeting Trust/legal/stakeholder requirements and are unsupported by the Trust IT department or an external IT provider; THEN the Trust is unable to meet statutory and mandatory Good Governance requirements and accreditations;	LEADING TO potential delays in care, inappropriate/incorrect/sub-optimal treatment; potential increase in incidents, complaints and claims; reduced CQC rating and potential enforcement actions	Organisation	Tina Worth	21-Mar-2023	30-Jun-2023	Pending	25	12	4	Implementation of Radar Documentation Module (27-Jun-2023), Implementation of Radar Audit Module (24-Feb-2023)	SharePoint and Q-Pulse in place(06-Sep-2021), Scheduled implementation of new system Radar(06-Sep-2021)	Low	Treat	Ongoing discussions with NHSE & Radar Director of Corporate Affairs has written to Radar re concerns Awaiting move from 2 to one reporting form which its is hoped will improve reporting rate due to ease for user Ongoing PSIRF Radar reviews as part of implementation	06-Sep-2021
RSK-093	22-Oct-2021	IF there is insufficient staffing within the dietetics department in paediatrics THEN they will be unable to assess and advise new outpatients and review existing outpatients in a timely manner.	LEADING TO an impact on patients nutritional status and longer term dietary management on what is a very vulnerable group of patients. The majority of our caseload is infants or tube fed infants and children where there nutrition and growth is a priority	Organisation	Elizabeth Pryke	20-Jun-2023	24-Jul-2023	Planned	16	12	6	review of patient pathways to reduce need for outpatient appointments	1. Dietetic manager has been given approval to source a band 6 experienced locum paediatric dietitian to provide cover.(22-Oct-2021), 2. As a back up plan, a band 5 basic grade dietitian is also being sourced from the locum agency, with the expectation that senior dietetic staff can cover the complex paediatric cases.(22-Oct-2021), 2 new starters to join the team in the next few weeks will start to increase paediatric dietetic provision - to review waiting list once new starters in post(19-Apr-2022), Paediatric Dietetic Assistant Practitioner appointed - to start on 9.5.22, after induction will help to reduce risk(29-Apr-2022), additional paediatric dietitian employed on bank contract for 2 sessions / week to help with long waiting lists - monitor waiting lists on a monthly basis(05-Feb-2023)	Low	Treat	Fully staffed within paed team from 1.7.23 - will review towards end of July to assess impact of improved staffing levels	01-Oct-2021
RSK-203	23-Nov-2021	IF the are negative impacts on the supply chain following the rising fuel costs and the conflict in Ukraine THEN there is a risk that the supply of key clinical products may be disrupted	LEADING TO some unavailabilty of clinical products, delays to deliveries and services may be disrupted or reduce resulting in impact on patient care	Organisation	Lisa Johnston	09-Jun-2023	12-Jul-2023	Planned	16	12	6		Trust's top suppliers have been reviewed and issues with supply under constant review(23-Nov-2021), Procurement business partners use the NHS Spend Comparison Site and local knowledge supported by the clinical procurement nurse to source alternative products(23-Nov-2021), Clinical Procurement nurse to join the NHSI/E Supply Resilience Forum(15-Aug-2022), Clinical Procurement nurse is part of the NHSI/E Supply Resilience Forum created in August 2022.Trust's top suppliers have been reviewed and issues with supply under constant review, Procurement business partners use the NHS Spend Comparison Site and local knowledge supported by the clinical procurement nurse to source alternative products(16-Nov-2022)	Medium	Treat	Still ongoing risk	01-Jun-2022
RSK-219	25-Nov-2021	IF metal butterfly needles are used for administering subcutaneous infusions via syringe drivers, and bolus subcutaneous injections, particularly in palliative and end-of-life care THEN there is a risk that the member of staff (hospital or community) may sustain a needle stick injury as they are withdrawing the needle when the infusion is stopped	LEADING TO the staff being at risk of coming into contact with contaminated blood	Organisation	Yvonne Christley	02-Jun-2023	31-Jul-2023	Planned	4	12	12		MKUH Sharps Management Policy ICM/GL/34 – advises use of safer needle alternatives wherever practical. Alerting ward staffs to be careful when inserting and removing the butterfly needles.(25-Nov-2021)	Low	Tolerate	This needs to move under corporate nursing for approval	25-Nov-2021
RSK-230	25-Nov-2021	IF a major incident was to occur requiring the trust to respond above service levels THEN there could be an impact to normal service. Eg/elective and inpatient care.	LEADING TO changes in routine working processes and procedures across the Trust for the duration of the major incident response and recovery phases.	Organisation	Adam Biggs	08-Jun-2023	07-Nov-2023	Planned	16	12	8		Major incident response plan (IRP)(25-Nov-2021), Action Cards have been removed from the Major Incident Response Plan and are held as a separate annex(25-Nov-2021), CBRN arrangements outlined within the IRP(25-Nov-2021), Mass casualty response outlined within the IRP(25-Nov-2021), Regional casualty dispersal process in place(25-Nov-2021), Local resilience Forum working group meetings attended, with tactical and strategic levels represented by CCG and NHSE&I(25-Nov-2021), Training and Exercise programme in place to ensure the Trust meets national best practice and statutory obligations(25-Nov-2021), EPRR annual work plan in place and agreed with Accountable Emergency Officer (AEO) that is scrutinised and reviewed through the Emergency Planning Steering Committee on a quarterly basis attended by senior and key staff(25-Nov-2021), Annual NHSE&I EPRR Core Standards review conducted by BLMK CCG to ensure MKUH is meeting its statutory obligations, with internal report sent to Managing Board and Trust Public Board for sign-off(25-Nov-2021)	Low	Treat	No current change in risk scoring as this remains an open risk due to nature of Major Incident response	25-Nov-2021

Corporate Risk Register

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RSK-232	25-Nov-2021	IF there is an extreme prolonged weather conditions (heat/cold) THEN there is potential for wards/departments to be unable to maintain/provide effective service provision at required standards during prolonged extreme weather conditions	LEADING TO Service disruption/delays, Staff health & wellbeing, Patient safety, Adverse media publicity Breaches of Health & Safety at Work Act, Management of Health & Safety at Work Regulations, Workplace Health, Safety & Welfare Regulations	Organisation	Adam Biggs	24-Apr-2023	02-Oct-2023	Planned	12	12	6		Business continuity plans in some areas(25-Nov-2021), Heat wave plan(25-Nov-2021), Extreme weather policy(25-Nov-2021), Cold Weather Plan(25-Nov-2021)	Low	Tolerate	No change to risk rating	10-Apr-2022
RSK-254	26-Nov-2021	If Nursing staff accidently select the incorrect prescription chart within eCARE THEN patients could receive medication which is prescribed for another patient.	LEADING TO potential harm to patients	Organisation	Craig York	03-May-2023	31-Aug-2023	Planned	12	12	9	CareAware Connect going live by August 2023	eCARE alert if mismatch between wrist band & electronic drug chart. Correct workflow taught in eCARE training. Monthly scanning compliance report(26-Nov-2021)	Low	Treat	Use of the CareAware Connect app, once live, will make it easier/more accessible to scan the patient wristband to highlight this potential risk and avoid impact.	25-Jan-2023
RSK-262	29-Nov-2021	IF the Trust Fire Dampers are not surveyed and remedial works funded THEN remedial work not being completed	LEADING TO the travel of fire between compartments causing risk to life, greater damage to the estate, poor public image and subsequent interventions from the Fire Brigade with potential enforcement notices.	Organisation	Michael Stark	22-Jun-2023	31-Jul-2023	Planned	20	12	8		A combination of fire door maintenance, fire alarm system, compartmentation inspections and remedials, fire damper inspections and remedials, automatically closing fire doors, emergency lighting, fire extinguishers and other elements of the fire strategy mitigates the reliance on any one component of fire safety(29-Nov-2021), Mandatory fire training(29-Nov-2021), Fire wardens(29-Nov-2021), Authorised Engineer (AE)appointed March 2020(29-Nov-2021), Annual inspections(29-Nov-2021), Funded annual remedial programme(29-Nov-2021), Site wide Damper annual audit, risk based approach to any remedials(29-Nov-2021), £10K of repair work ordered and new inspection(29-Nov-2021), Changed Theatre 5 Damper, remaining 6 faults to be replaced 2022/2023(03-Mar-2022)	Low	Tolerate	Reviewed by Associate Director of Estates, Estates Manager, and Compliance Officer - changed to Tolerate.	25-Aug-2021
RSK-263	29-Nov-2021	IF the Trust Fire Compartmentation are not surveyed and remedial works funded THEN remedial work not being completed	LEADING TO the travel of fire between compartments causing risk to life, greater damage to the estate, poor public image and subsequent interventions from the Fire Brigade with potential enforcement notices	Organisation	Michael Stark	22-Jun-2023	31-Jul-2023	Planned	20	12	8	Outstanding items for last survey to be prioritised on risk basis (26-Jun-2023)	fire door maintenance, fire alarm system, compartmentation inspections and remedials, fire damper inspections and remedials, automatically closing fire doors, emergency lighting, fire extinguishers and other elements of the fire strategy mitigates the reliance on any one component of fire safety(29-Nov-2021), Mandatory fire training(29-Nov-2021), Fire wardens(29-Nov-2021), Annual Capital bids rolling program(29-Nov-2021), Annual audit regime in place(29-Nov-2021), Authorised Engineer (AE)appointment made March 2020(29-Nov-2021), Annual audit in place(29-Nov-2021), Annual Remedial programme in place, risk based priority(29-Nov-2021), Identified remedials were completed Jan 2021(29-Nov-2021), 21/22 programme approved at May 2021 Trust Exec Group(29-Nov-2021), Audit completed June 2021, included all plant room spaces(29-Nov-2021), 20% of Hospital streets audited annually on a rolling program(29-Nov-2021), Works identified including 140 fire doors to be fitted on electrical cupboards. Prioritisation on risk basis,	Low	Treat	Reviewed by Associate Director of Estates, Estates Manager, and Compliance Officer - No change to rating.	25-Aug-2021

Corporate Risk Register

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RSK-264	29-Nov-2021	IF the Trust Fire Doors are not regularly surveyed and remedial works funded THEN remedial work not being completed	LEADING TO the travel of fire between compartments causing risk to life, greater damage to the estate, poor public image and subsequent interventions from the Fire Brigade with potential enforcement notices.	Organisation	Michael Stark	22-Jun-2023	31-Jul-2023	Planned	20	12	8		A combination of fire door maintenance, fire alarm system, compartmentation inspections and remedials, fire damper inspections and remedials, automatically closing fire doors, emergency lighting, fire extinguishers and other elements of the fire strategy mitigates the reliance on any one component of fire safety(29-Nov-2021), Mandatory fire training(29-Nov-2021), Fire wardens(29-Nov-2021), Pre commitment to continual rolling program of updates and refurbishment. BAU funding.(29-Nov-2021), Plant Room Doors surveyed(29-Nov-2021), Guaranteed Capital agreed brought service in house January 2020(29-Nov-2021), Authorised Engineer (AE) appointed April 2023(29-Nov-2021), Many Fire Doors have been replaced since Jan 2020 as part of the prioritisation programme(29-Nov-2021), Rolling programme with backlog to overcome issues(29-Nov-2021), 21/22 programme approved at May 2021 Trust Exec Group(29-Nov-2021), Options for new AE, out to tender(29-Nov-2021)	Low	Tolerate	Reviewed by Associate Director of Estates, Estates Manager, and Compliance Officer - updated to tolerate. All control actions implemented	29-Nov-2021
RSK-269	30-Nov-2021	IF the Trust fails to comply fully with current DoH HTM 04-01 Parts A&B, Addendum relating to Water Systems and HTM 00 as identified in the Water Risk assessment THEN The Trust will be unable to provide assurance of a fully compliant water safety system	LEADING TO Increased risk to patients and staff, loss of reputation, financial loss to the Trust.	Organisation	Ben Hazell	22-Jun-2023	31-Jul-2023	Planned	16	12	8	Controls and action recommendations being reviewed by Compliance Officer (24-Apr-2023), Cleaning of Phase 1 Cylinders and Calorifiers, and descaling of phase 1 calorifiers	A Water Services Management Group operates quarterly, with agreed membership and agenda items(30-Nov-2021), Audit document and action plan has been circulated to the Group for discussion and progression at the next meeting(30-Nov-2021), Independent contractor commissioned to regularly test water outlets. Controls and testing regimes in place(30-Nov-2021), Review and Water Services Management Group membership includes independent contractor and Authorising Engineer(30-Nov-2021), Whole site risk assessments are current and risk reviewed at each meeting(30-Nov-2021), Risk assessment undertaken of augmented care areas(30-Nov-2021), House keepers are flushing water out lets in clinical areas and return flushing sheets to estates, Hotel Services Audit manager to track progress and compliance(30-Nov-2021), Tender awarded to Evolution, 2 year contract commenced 1st July 2019. extended for 6 months. New tender to be drafted(30-Nov-2021), Phase 1 and Cancer Centre risk assessments completed(30-Nov-2021), Phase 2 Risk Assessment completed June 2021, actions underway(30-Nov-2021),	Low	Treat	Reviewed by Associate Director of Estates, Estates Manager, and Compliance Officer - No change to rating.	21-Dec-2022
RSK-274	30-Nov-2021	IF the Trust worn flooring is not replaced THEN there is a risk of failure of flooring	LEADING TO trip hazard & infection control issues	Organisation	Paul Sherratt	22-Jun-2023	31-Jul-2023	Planned	15	12	6	3 year + 1 +1 . contract awarded. Annual audit of Common areas, corridors and circulation, includes repairs (26-Jun-2023)	Capital bid to be placed annually(30-Nov-2021), Ward 6 and Ward 1 full floor replacement completed(30-Nov-2021), Business Case written, funded 21/22(30-Nov-2021), Adhoc floor repairs made with temporary taping of any failures occurring(30-Nov-2021), Going to the market for new contractor, out to tender(30-Nov-2021), Crown Industrial flooring making small repairs(30-Nov-2021)	Low	Treat	Reviewed by Associate Director of Estates, Estates Manager, and Compliance Officer - No change to rating.	25-Aug-2021

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RSK-281	30-Nov-2021	If the lift located in Outpatients (servicing levels 3, 4 of yellow zone, and Staff Health & Wellbeing) fails THEN disabled & mobility reduced/sight impaired individuals unable to access workplace or services – unable to fulfil contractual obligations. Persons entrapped in lift unable to exit. Delayed access/treatment of an individual taken ill whilst trapped. Claustrophobia, panic attacks, psychological harm, deterioration of condition	LEADING TO Reduced availability of staff, unable to carry out duties, reduced clinical input/unable to see clients (internal/external) in a timely manner – increased workload for other staff leading to increased work pressure/stress Loss of income of external clients who cannot be seen due to absence of clinician Service user dissatisfaction – complaints/reputation of service and organisation affected Adverse publicity if unavailability of service reported to local press/reputation of organisation and service affected The organisation would be in breach of statutory duties under Health & Safety At Work etc Act 1974, Equality Act 2010 – failure to provide safe access/egress/safe place of work – potentially leading to enforcement action/further interest of Health & Safety Executive Inspectorate	Organisation	Mark Brown	22-Jun-2023	31-Jul-2023	Planned	12	12	9	Luing Cowley Lift awaiting upgrades, difficult as no alternative when lift not in service. (14-Nov-2022) (04-Apr-2023)	There is an SLA is place that states that the lift will be repaired within 4 hours, normally 1-2hours(30-Nov-2021), ResQmat are on the landings on floors 3 & 4 and should be used in the event disabled persons and those with limited mobility, are unable to leave their respective floors, although staff are not trained in their use(30-Nov-2021), Call bell/telephone in lift to call for assistance(30-Nov-2021), Monthly lift inspections in place(30-Nov-2021), 6 Monthly PPM in place(30-Nov-2021), Annual insurance inspections in place(30-Nov-2021), ResQmat training video in place created by Manual Handling adviser(30-Nov-2021), Refurbishment of ward 14 lift carried out(30-Nov-2021), On the Capital Programme(30-Nov-2021), Outpatients Business Case approved for M&E study, with any identified anticipated to be completed end of FY 2022(30-Nov-2021), M&E study completed. Business Case written to install a second lifting platform in outpatients.(03-Mar-2022)	Low	Treat	Reviewed by Associate Director of Estates, Estates Manager, and Compliance Officer - No change to rating.	25-Aug-2021
RSK-402	01-Dec-2022	IF there is a lack of Orthopaedic Therapy staff to provide rehabilitation, discharge planning and equipment to patients in the trauma and elective orthopaedic pathways. THEN fractured NOF patients may not be able to be offered daily mobilisation; may not have a functional OT assessment within 7 days; elective Orthopaedic patients may not be seen twice a day	LEADING TO potential for length of stay for both trauma and elective patients to increase and reduce patient experience.	Organisation	Adam Baddeley	13-Jun-2023	19-Jul-2023	Planned	15	12	6	Recruitment of vacant posts (13-Jun-2023), Pathway review (13-Jun-2023)	Recruitment(01-Dec-2022)	Medium	Treat	OT establishment is down by 1.6 WTE due to LTS and a vacancy. Using OT practice to support the ward. PT rotational staff have been delayed in rotating to maintain PT establishment in T&O.	01-Dec-2022
RSK-423	24-Jan-2023	IF specific enteral feeds are not available due to national supply issues THEN patients will not receive the correct feed to meet their nutritional needs	LEADING TO impact on patients' nutritional status and dietary management, also increased workload for dietetic and stores staff arranging for different feeds to be ordered and prescribed.	Organisation	Elizabeth Pryke	27-Jun-2023	31-Jul-2023	Planned	12	12	6		Weekly updates provided by feed suppliers, which dietitians are acting on Patients gradually changed to feeds that are less likely to be affected(05-Feb-2023)	Medium	Treat	No change to national supply issue - managing shortages as previously described	24-Jan-2023
RSK-424	25-Jan-2023	IF the new information standard regarding SDEC is released without significant operational and technical changes to the way the relevant information is collected THEN MKUH may not be able to submit the dataset in the required format with the required content LEADING TO a potential financial and reputational impact to MKUH	Potential financial, reputational, contractual, or operational impacts.	Organisation	Craig York	03-May-2023	31-Aug-2023	Planned	12	12	4	Review of data needs, implications on workflow in eCARE, needs to be undertaken before any known work can be scoped.		Medium	Treat		25-Jan-2023
RSK-007	06-Sep-2021	IF the team Fire Warden is not adequately trained or they are not present during a related emergency; THEN there would be no focal point for fire safety matters for local staff and supporting line managers on fire safety issues, and the team may not be represented in Fire Safety Committee meetings, and they will not be able to organise and assist in the fire safety regime within their local area	LEADING TO staff and other individuals visiting level 1 in Oak House potentially not being evacuate in a timely manner due to the lack of oversight. The lack of single focused oversight could cause confusion, delays in evacuation and people being left behind. This could lead to smoke inhalation, burns, death. Fire checking and prevention procedures may not be robust enough to identify potential hazards and prevent a fire from happening. Breach of statutory regulations	Organisation	Tina Worth	27-Mar-2023	30-Jun-2023	Pending	15	10	5	There was a recommendation that in light of the working from home arrangements, it might be appropriate for everyone to have the training so that there is adequate cover. (24-Oct-2022)	Fire Warden advised to work within current knowledge and skill gained through mandatory fire training(06-Sep-2021), No team member to attempt to fight fires with equipment untrained to use(06-Sep-2021), Risk assessment shared with team / Staff awareness(06-Sep-2021), Quarterly fire safety audits completed(06-Sep-2021), Good housekeeping practicalities - reiterated at team huddle(06-Sep-2021), Fire safety signage displayed -action cards and assembly points identified, clearly visible to team members and others visiting corridor(06-Sep-2021), Fire alarm system checked regularly in line with Trust policy and is audible in corridor(06-Sep-2021), Team members have undertaken and are up to date with mandatory training (compliance checked monthly)(06-Sep-2021), Team risk assessment for lone working on back of Covid changes which covers fire(06-Sep-2021), Risk & Clinical Governance Team Fire Warden to attend Fire Warden Training(06-Sep-2021), There was a suggestion that posters were put up for staff to follow when Kevin is not in.(21-Dec-2021)	Low	Treat	Raised at Health & Safety Committee given flexible working & as such staff fire warden trained not on site every day. Proposed building rota plan required	06-Sep-2021

Corporate Risk Register

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RSK-125	04-Nov-2021	IF there is a surge of COVID-19 patients impacting on Trust ability to maintain patient care and clinical services, or loss of staff to support clinical and non-clinical services due to high levels of absence, or a loss of national stockpile in PPE or medical devices (ventilators) resulting in the Trust not receiving deliveries to preserve the safety of patients and staff THEN there is a risk of reduced capabilities in responding to a Novel Coronavirus (COVID-19) impacting on patient care within clinical and non-clinical services, with the inability to maintain safety for staff and patients due to national pressures on supplies and infrastructure	LEADING TO Loss of clinical and non-clinical services, risk to patient care, risk to staff wellbeing and financial impacts	Organisation	Adam Biggs	24-Apr-2023	25-Sep-2023	Planned	25	10	4		COVID-19 operational and contingency plans in place(04-Nov-2021), PPE logged daily covering delivery and current stock(04-Nov-2021), National COVID Vaccine Roll Out Programme(24-Apr-2023), National COVID Vaccine Roll Out Programme(24-Apr-2023)	Low	Tolerate	No current change to risk scoring with watching brief concerning current COVID surge against national guidance and comms.	29-Apr-2020
RSK-242	26-Nov-2021	IF a chemical, biological, radiological, nuclear (CBRN/HAZMAT) incident was to occur through either intentional or unintentional means THEN the Trust would require specialised response through national guidelines and expert advice	LEADING TO potential impact on Trust services and site safety to patients and staff; Possible impact on closing or disrupting ED operations, with further risk to all operations on how the Trust operate depending on the nature of the incident (e.g., Novichok incident at Salisbury)	Organisation	Adam Biggs	08-Jun-2023	22-Nov-2023	Planned	10	10	10			Low	Treat	No change to risk score against NRSA and remains an open risk due to nature of the potential incident	26-Nov-2021
RSK-260	29-Nov-2021	IF people working at height are not correctly trained THEN there is a risk from fall from height	LEADING TO staff/contractor injuries, potential claims, non compliance with statutory regulations and loss of reputation	Organisation	Paul Sherratt	23-Jun-2023	31-Jul-2023	Planned	15	10	5	Refresher Ladder Training to be arranged and delivered	Staff training. Ladder/equipment inspections(29-Nov-2021), Written processes and Working at Height Policy reviewed regularly(29-Nov-2021), New lifting equipment purchased(29-Nov-2021), General H&S training conducted(29-Nov-2021), Cherry Picker obtained- staff trained(29-Nov-2021), RAMS from contractors reviewed by Compliance Manager(29-Nov-2021), Edge protection in place in all locations where plant or PV panels exist(29-Nov-2021), On going Contract in place for Edge Protection and Latchways systems Inspections and Maintenance.(29-Nov-2021), Trained RP in August 2021(29-Nov-2021), RP has been appointed by Alan Hambridge(29-Nov-2021)	Low	Treat	Reviewed by Associate Director of Estates & Compliance Officer. No change to current risk rating.	25-Aug-2021
RSK-010	06-Sep-2021	IF the Radar Risk Management System does not meet the needs to the Trust and of legal reporting requirements THEN the Trust will not have an appropriate system to manage incidents, complaints, claims, compliments, safety alerts and risks	LEADING TO an inability for the Trust to defend itself against future claims/litigation leading to potential financial penalties, improvement notices, PFD notices from HM Coroner, adverse publicity etc., an inability to evidence compliance with CQC regulations and freedom of information requests, and potential for an increase in incidents, complaints and claims due to lack of learning from incidents.	Organisation	Paul Ewers	08-Jun-2023	14-Jul-2023	Planned	20	9	6	Redesign of Analytics to meet the needs of the Trust, System redesign to meet the needs of the new Patient Safety Incident Response Framework (PSIRF)	Project Manager identified along with 3 members of staff to provide cover and support to the project where necessary(06-Sep-2021), Radar Project Plan in place(06-Sep-2021), Radar Risk Assessment in place(06-Sep-2021), Working Groups identified to support design/build of system in line with Trust's requirements(06-Sep-2021), Radar Healthcare have a dedicated Project Manager and team in place to support MKUH with implementation(06-Sep-2021), Clearly defined roles added to the Project Plan(06-Sep-2021), Escalation process in place to Exec Sponsor(06-Sep-2021), Communication Strategy Developed(06-Sep-2021), Enhancements / Developments to Radar System required to support staff in reporting incidents.(23-Dec-2022), Radar moving server from Windows to Linux to provide more stable analytics system, with improved speed and functionality(23-Dec-2022)	Low	Treat	Risk reviewed. New incident form implemented to make it quicker and easier to report. Next step to work with Radar to redesign Analytics Dashboards to support better reporting and trend analysis.	28-Apr-2021
RSK-206	23-Nov-2021	IF the Trust is unable to recruit staff of the appropriate skills and experience; there continues to be unplanned escalation facilities; There are higher than expected levels of enhanced observation nursing; and there is poor planning for peak periods / inadequate rostering for annual/other leave. THEN the Trust may be unable to keep to affordable levels of agency and locum staffing	LEADING TO Adverse financial effect of using more expensive agency staff and potential quality impact of using temporary staff	Organisation	Karan Hotchkin	09-Jun-2023	12-Jul-2023	Planned	16	9	9		Weekly vacancy control panel review agency requests(23-Nov-2021), Control of staffing costs identified as a key transformation work stream(23-Nov-2021), Capacity planning(23-Nov-2021), Robust rostering and leave planning(23-Nov-2021), Escalation policy in place to sign-off breach of agency rates(23-Nov-2021), Fort-nightly executive led agency reduction group meeting with aim of delivering reduction in both quantity and cost of agency used(23-Nov-2021), Agency cap breaches are reported to Divisions and the FIC(23-Nov-2021), Divisional understanding of how to reduce spend on temporary staffing to be developed(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix	01-Apr-2022
RSK-214	24-Nov-2021	IF there is insufficient nursing staffing THEN there is a risk that the number of patients requiring nutritional assistance at meal times exceeds staff availability	LEADING TO patients nutritional needs potentially not being met, impacting on poor outcomes, patient experience and length of stay	Organisation	Elizabeth Winter	01-May-2023	01-Jul-2023	Pending	15	9	8		Protected meal times(24-Nov-2021), Red trays/jugs(24-Nov-2021), Meal time assistants(24-Nov-2021), Dining Companions Launched May 2018(24-Nov-2021), Senior Sister highlighting patients who require assistance at daily safety huddle(24-Nov-2021)	Low	Tolerate	Staff escalate at the daily huddle number of patients on red tray to enable us to determine where help is needed at mealtimes.	24-Nov-2021

Corporate Risk Register

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RSK-233	25-Nov-2021	IF we are unable to recruit sufficient staff THEN we may no have safe staffing levels in the hospital	LEADING to reduced service delivery, reduction in patient experience and care.	Organisation	Louise Clayton	11-May-2023	31-Aug-2023	Planned	16	9	3	International Recruitment of 100 Nurses in 2023 (31-Oct-2022)	Apprenticeship routes for nursing(25-Nov-2021), System in place to recruit student nurses from placements at MKUH(25-Nov-2021), Enhanced adverts, social media and recruitment open day tool kit for Divisions to use(25-Nov-2021), NHS People Plan strengthens action on education and new roles(25-Nov-2021), National NHS England recruitment publicity(25-Nov-2021), Recruitment and retention premia or certain specialties(11-May-2023), Advanced Nurse Practitioner development and integration in progress(11-May-2023), New SAS grade established(11-May-2023), New publication for International Medical Graduates developed(11-May-2023), Action down policy in place(11-May-2023), Routine/Regular evidence based trends inform early recruitment activity(11-May-2023)	Low	Tolerate	Risk merged with RSK-233.	01-Nov-2021
RSK-236	25-Nov-2021	IF there is inability to retain staff employed in critical posts THEN we may not be able to provide safe workforce cover	LEADING TO clinical risk. Increasing temporary staffing usage and expenditure Increased turnover Decreased stability rates Increased stress levels within trust Reduced morale	Organisation	Louise Clayton	10-May-2023	31-Jul-2023	Planned	16	9	9		Variety of Organisational Development and Reward initiatives, including Event in the Tent, P2P, Schwartz Rounds, Living our Values, Annual Staff Awards and feedback from staff being acted upon(25-Nov-2021), Monitoring via staff survey feedback and local action plan based outcomes(25-Nov-2021), Health and Wellbeing promotion, education and prevention via Staff Health and Wellbeing(25-Nov-2021), Online onboarding and exit interview process in place(25-Nov-2021), Flexible working and Agile Working policies in place(25-Nov-2021), MK Managers Way in place(25-Nov-2021), Recruitment and retention premia in place, including Golden Hello for Midwives(25-Nov-2021), Enhanced social media engagement in place and ongoing(25-Nov-2021), Annual funding initiatives to upskill staff and retain them through ongoing education e.g. Chief Nurse Fellowships, PGCE and Rotary Club Bursary fund(25-Nov-2021), Refer a Friend Scheme introduced in 2022 to improve retention and recruitment.(10-May-2022), International Recruitment ongoing to recruit 125 nurses	Low	Tolerate	Risk Reviewed - Controls updated. No change to Risk Score	02-Jan-2023
RSK-276	30-Nov-2021	If the flat roofs identified in the Langley Roof report and 6 facet survey as requiring replacement or upgrading, are not replaced THEN there is a risk of roof failure in relation to flat roofs across the Trust	LEADING TO Water ingress - Potential damage to equipment, disruption to service, damage to reputation	Organisation	Anthony Marsh	23-Jun-2023	30-Sep-2023	Planned	15	9	3	Replacement/upgrade of flat roofs identified in the 6 facet survey (26-Jun-2023)	Inspections and repairs as needed(30-Nov-2021), Updated annual 6 facet survey by Oakleaf(30-Nov-2021), Large patch repairs undertaken as emergency business cases(30-Nov-2021), 1 x Post Grad roof fully replaced 19/20(30-Nov-2021), Ward 10 - 50% of roof patch repairs completed 19/20(30-Nov-2021), Phase 1, Phase 2 and Community Hospital survey completed.(52 roof leaks noted in 12 months Jan 19 -Aug 20) 16 leaks in 1st week of October 2020(30-Nov-2021), Pharmacy small roof replaced September 20(30-Nov-2021), Business Case approved for 4 to 5 year rolling programme(30-Nov-2021), Community Hospital work completed July 2021(30-Nov-2021), Phase 1 and Phase 2 of the hospital works outstanding. Funding to be approved(30-Nov-2021), Funding for phase 2 included in carbon zero funds to be announced Jan 2022(30-Nov-2021)	Low	Treat	Reviewed by Associate Director of Estates, Estates Manager, and Compliance Officer - No change to rating. Phase 2 Hospital unfunded	21-Dec-2022
RSK-279	30-Nov-2021	IF pedestrians in the hospital grounds walk over the verges, grassed areas, mounds, slopes, sloped/high curbs and do not stick to the designated pathways THEN Patients, visitors and staff could slip, trip or fall causing injury including fractures, sprains, strains	LEADING TO legal and enforcement action against individuals/and or the Trust leading to fines/compensation/exposure in local press leading to adverse publicity	Organisation	Michael Stark	30-Mar-2023	30-Sep-2024	Planned	12	9	6	Ongoing review of grounds to control access (23-Mar-2023), Areas suitable to install knee high fencing identified. To be prioritised and installed in future years. (26-Jun-2023)	Sloping curbs painted yellow where they may be crossed(30-Nov-2021), Fencing or railings in some areas to deter access(30-Nov-2021), Rolling Paths annual program to repair paths and roads(30-Nov-2021), Grass kept cut by grounds team(30-Nov-2021), Keep off the Grass signage in place(30-Nov-2021)	Low	Treat	Reviewed by Associate Director of Estates & Compliance Officer. No change to current risk rating. Risk response updated to tolerate	25-Aug-2021

Corporate Risk Register

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RSK-282	30-Nov-2021	IF there is a lack of on-site appointed person for decontamination - AP (D) THEN the Trust will not be able to implement and operate the Management's safety policy and procedures relating to the engineering aspects of decontamination equipment	LEADING TO non-compliant machines – working but not correctly; machine Failures – suddenly unusable, loss of production, out-sourcing; equipment released that is not disinfected or sterile – risk to staff; equipment released that contains endotoxins – risk to patients / SSI's	Organisation	Michael Stark	23-Jun-2023	31-Jul-2023	Planned	12	9	6	An Estates Officer is to be appointed as AP(D) following training and approval. (26-Jun-2023), An external AP(D) will be needed for Endoscopy, however the AE(D) is currently covering this responsibility. Senior Mechanical Estates Officer will continue to provide estates operational management to service. All testing now undertaken by external expert contractor. (21-Nov-2022)	We are unable to employ or sub-contract and independent AP (D), the AE(D) is covering this role currently working with our internal, trained but yet to be appointed Estates Officer(30-Nov-2021), The AE(D) is coming to site once a month and spends his time validating servicing reports and giving feedback(30-Nov-2021)	Low	Treat	Reviewed by Associate Director of Estates, Estates Manager, and Compliance Officer - No change to rating.	25-Aug-2021
RSK-283	30-Nov-2021	IF medical equipment is damaged due to misuse, inappropriate use, storage, transportation, and/or inappropriate cleaning THEN the medical equipment may be unavailable due to damage	LEADING TO delay in patient care and treatment; cost of parts; cost of repairs; purchasing replacement	Organisation	Ayca Ahmed	13-Mar-2023	30-Jun-2023	Pending	12	9	6	Training in the use of medical equipment (20-Mar-2023), Auditing PPMs (20-Mar-2023), Medical Devices Management policy- following processes (20-Mar-2023)		Low	Treat	Reviewed by Medical Devices Manager, no change to risk rating.	16-Oct-2018
RSK-284	30-Nov-2021	IF staff members do not adhere to the Medical Devices Management Policy THEN they may not follow the correct procurement procedures for Capital and Revenue medical equipment purchases	LEADING TO them being not fit for purpose equipment being purchase; more costly; non-standardised; lack maintenance contract; lack of training for staff; incompatible/lack of consumables and accessory; additional IT integration costs	Organisation	Ayca Ahmed	13-Mar-2023	30-Jun-2023	Pending	12	9	6	Medical Devices Group meetings are held monthly to discuss procurement (20-Mar-2023)		Low	Treat	Reviewed by Medical Devices Manager, no change to risk rating.	16-Oct-2018
RSK-300	30-Nov-2021	IF the call bell system is not replaced/upgraded THEN the call bell system could fail as parts obsolete for some systems to obtain	LEADING TO increased risk to patients and possible service disruption and poor patient experience	Organisation	Mark Brown	23-Jun-2023	30-Sep-2023	Planned	9	9	3	Wards with obsolete equipment require replacement. Upgrade programme to be included in rolling Capital bid (03-May-2023)	An emergency back up system of 30 units has been purchased in the event of current system failing. There is also an additional spare unit(30-Nov-2021), Ward 4, 5 and Milton Mouse & A&E Majors were replaced in FY18/19(30-Nov-2021), ADAU replaced as emergency business case October 2019(30-Nov-2021), Endo replaced in Jan 2020(30-Nov-2021), Vizcall no longer in business, plan to replace all Vizcall systems in 20/21 - Vizcall test equipment and spares purchased for in house support(30-Nov-2021), Above the line funding for 2 x wards and ED agreed for 2021 with Ascom(30-Nov-2021)	Low	Treat	Reviewed by Associate Director of Estates, Estates Manager, and Compliance Officer - No change to rating.	25-Aug-2021
RSK-364	15-Jul-2022	If SBS are not able to respond to supplier and finance queries in a timely way THEN there is risk that there will be a delay in paying suppliers leading to suppliers putting the Trust on stop and not delivering key supplies	LEADING TO impact on patient care through non supply of goods	Organisation	Karan Hotchkin	09-Jun-2023	12-Jul-2023	Planned	16	9	6		On going monthly meetings with Senior SBS Client Relationship team to discuss issues and outline their plan on resolving this issue(15-Jul-2022), Additional Bank resource for Finance and Procurement staff(15-Jul-2022), Finance team reviewing supplier on stop notifications(15-Jul-2022), The Trust is meeting on a monthly basis with senior SBS client relationship team to discuss the issues and get a plan from SBS of how the situation can improve, In addition extra temporary resources are being employed to support the finance and procurement team to deal with the additional supplier queries. The Finance team are reviewing any suppliers who are providing stop notifications and arranging urgent payment if required(16-Nov-2022)	Low	Treat		15-Jul-2022
RSK-425	25-Jan-2023	IF the current mechanisms used for reporting on RTT status continue, along with the current use of the tools to populate PTL reporting THEN the data available for submission will continue to require significant overhead to review and improve (i.e. veracity etc.) LEADING TO an inability to submit with short turnarounds, continued challenges in seeing patient pathways, prioritizing care etc.	Potential impact to patient care due to an inability to see patient pathways at a system level.	Organisation	Craig York	03-May-2023	31-Aug-2023	Planned	9	9	6	Business Case being submitted by late spring to implement RTT functionality.		Medium	Treat		25-Jan-2023
RSK-431	10-Feb-2023	IF Medical Record's microfiche machine is not operational THEN staff have to take photos using a mobile phone from the microfiche roll in a blackened room	LEADING TO an inability to access archived patient records, an inability to print records; trip hazard for staff when using blackened room	Organisation	Tasmane Thorp	30-May-2023	28-Sep-2023	Planned	9	9	6	Purchase and installation of new Microfiche Reader, Purchasing iPad to enable photos		Low	Treat	RISK 431 General Comment Update - Parts are not available to purchase through EBAY as suggested. Comment requested by Jessica Goodger, approved by Felicity Medina @ Patient Access Managers meeting of 15 May 2023	16-Jan-2023
RSK-432	10-Feb-2023	IF the Trust does not effectively communicate with its patients (e.g. for visually or hearing impaired patients/family members or those where English is not their first language etc) THEN some patients will not be able to access information relating to their care and treatment	LEADING TO patients/families not being effectively included in decisions relating to their care; the Trust not being compliant with the Accessible Information Standards	Organisation	Tasmane Thorp	27-Mar-2023	28-Sep-2023	Planned	9	9	6		Clear Face Masks used where appropriate(10-Feb-2023), Hearing Loops(10-Feb-2023), Interpreters used where required(10-Feb-2023), Badges available to identify anyone with hearing loss to request additional support(10-Feb-2023), Placement of screens to allow a visual view showing when patients can go into their appointment and where(10-Feb-2023), Purchase and installation of Synertec to improve accessibility of patient information(10-Feb-2023)	Low	Treat	To be reviewed in 6 months to monitor progress	07-Feb-2023

Corporate Risk Register

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RSK-434	10-Feb-2023	IF there is insufficient capacity of outpatient appointments THEN Patient Access will be unable to provide patients within designated timescales	LEADING TO a delay in diagnosing and treating patients; cancellation of appointments to ensure patients are appropriately prioritised; increasing waiting lists; breach in national appointment timescales; patients being moved in clinics without clinical validation.	Organisation	Emma Hunt-Smith	30-May-2023	31-Mar-2024	Planned	9	9	6	Capacity & Demand planning for all services to be completed, Cleanse of the Patient Tracking Lists for the following services to be undertaken, utilising additional non-recurrent resource - Ophthalmology; ENT; Urology; Trauma & Orthopaedics; Gynaecology	Fortnightly ASI reports are produced and circulated at a senior level identifying polling ranges and patients waiting on e-Referral worklists.(10-Feb-2023), Divisions reviewing capacity & demand planning.(10-Feb-2023), WLIs are being held in services to expedite long waiting patients.(10-Feb-2023), Patients are booked according to referrals priority and wait time(10-Feb-2023), Many services have referral assessment services in order to clinically triage referrals(10-Feb-2023), All services have been requested to ensure that there are firebreaks within their clinic templates to mitigate disruption due to clinic cancellations(10-Feb-2023), Daily 78+ week report circulated to monitor longest waiting patients.(10-Feb-2023)	Low	Treat	Impact of Risk - Update added (Patients being moved in clinics without clinical validation), requested by Jessica Goodger, approved by Felicity Medina @ Patient Access Managers meeting 15 May 2023	06-Feb-2023
RSK-448	17-Apr-2023	IF the GE Voulson E10 obstetric ultrasound machines are more than 5 years old THEN there may be reduced accuracy in imaging and reduction in image quality; ongoing further costing to replace probes and complete maintenance; higher risk of equipment breakdown	LEADING TO potential unnecessary further testing and patient stress; potential withdrawal from service and cancelation of lists; breach of Public health England's Fetal anomaly screening programme (FASP) guidance	Organisation	Alexandra Godfrey	15-May-2023	01-Aug-2023	Planned	9	9	6	Replacement obstetric ultrasound machines	Regular servicing and QA programming to ensure accuracy and functionality(17-Apr-2023), Ensuring probes are repaired and maintained.(17-Apr-2023), Switch older machine with newer machine for those undertaking the 12 and 20 week screening scans(17-Apr-2023)	Low	Treat	Risk approved onto the Risk Register at Imaging CIG on 21/03/23	21-Mar-2023
RSK-211	23-Nov-2021	IF infection / colonisation with pseudomonas aeruginosa from contaminated water occurs within the Cancer Centre THEN there is a risk of infection and complications this could cause to immuno-suppressed cancer patients. Mitigations in place to avoid risk to patients and staff in Cancer Centre	LEADING TO susceptible patients within augmented care units such as Ward 25 and chemotherapy Suite potentially coming to harm	Organisation	Angela Legate	26-Jun-2023	26-Jul-2023	Planned	16	8	8		For direct contact with patients water where testing has shown absence of P.aeruginosa(23-Nov-2021), For direct contact with patients water supplied through a point of use (POU) filter(23-Nov-2021), For direct contact with patients sterile water (for wound washing if required)(23-Nov-2021), Signs at all taps alerting people to refrain from drinking or brushing teeth with water(23-Nov-2021), Bottled water available(23-Nov-2021), Correct installation and commissioning of water systems in line with HTM 04-01 is adhered to. Schematic drawings are available for water systems(23-Nov-2021), Flushing of water outlets is carried out daily and documented (07:00 – 09:00 HCA)(23-Nov-2021), Plans for sampling and microbiological testing of water is in place(23-Nov-2021), replacement of pipework to hand wash basins in patient bays(27-Feb-2023), pipework completed(17-Apr-2023), close monitoring of cleaning by domestic team (taps) and water sampling by external authorised company. pt. information includes safe use of drinking water(17-Apr-2023)	Low	Tolerate	monitoring continues to show good quality water with low or zero contamination	16-Mar-2021
RSK-257	26-Nov-2021	IF the server MKH-CRIS-01 continues to run Red Hat Linux Enterprise Version 6, Version 6 currently has >337 vulnerabilities THEN the server will be extremely vulnerable to being exploited by a third-party threat actor	LEADING TO negative impact on patient care due to lack of the service	Organisation	Craig York	03-May-2023	31-Aug-2023	Planned	15	8	6	Extended support to mitigate the security risk	The server is currently on the clinical VLAN, leading to security benefits.(26-Nov-2021), Additional support procured to mitigate the security risk(26-Nov-2021)	Low	Treat	The supplier have not made an upgrade available yet - they are still validating their system on the new version of the operating system.	25-Jan-2023
RSK-265	30-Nov-2021	IF there is local power failure and failure of emergency lights, due to age of existing fittings and lack of previous investment THEN there may be a failure to protect persons allowing a safe evacuation of the area	LEADING TO poor patient experience and safety, non-compliance with regulation, loss of reputation	Organisation	Mark Brown	23-Jun-2023	30-Sep-2023	Planned	20	8	8		Future investment requirements identified by PPM , reactive maintenance and Estates Specialist Officer(30-Nov-2021), PPM checks in place with regular testing by direct labour(30-Nov-2021), Rolling program of capital investment(30-Nov-2021), Rolling PPM program PPM 3 hour E-light testing program in place(30-Nov-2021), List of known remedials to be completed and prioritised(30-Nov-2021)	Low	Tolerate	Reviewed by Associate Director of Estates, Estates Manager, and Compliance Officer - No change to rating.	25-Aug-2021

Corporate Risk Register

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RSK-266	30-Nov-2021	IF the Trust are unable to take up the New Hospital Plan THEN The Trust would have to fund all future developments from either internally generated funding defined for backlog investment or borrow the money	LEADING TO the Trust being unable to meet the needs of the future MK population with regard to the size and quality of the estate	Organisation	Rebecca Grindley	06-Apr-2023	15-Mar-2024	Planned	16	8	8		Seed funding approved by DHSC to support the development of a Strategic Outline Case (SOC)(30-Nov-2021), SOC has been formally completed(30-Nov-2021), Regular monthly meetings on a formal basis with NHSE/I and DHSC(30-Nov-2021), Regular dialogue taking place with NHSE/I Strategic Estates Advisor(30-Nov-2021), Regular dialogue taking place at Board level(30-Nov-2021), Monthly reporting structure in place with NHSE/I(30-Nov-2021), Programme Board chaired by CEO set-up with agreed ToR(30-Nov-2021), Wider engagement with MK Council(30-Nov-2021), Wider engagement with senior colleagues in the Trust commenced(30-Nov-2021), Engagement with CCG undertaken(30-Nov-2021), SOC Submitted to NHSEI, OBC to be progressed in quarter 4(30-Nov-2021), Funding for Outline Business Case (OBC) agreed in Jan '22. Due for completion by March 2023.(04-Mar-2022)	Medium	Tolerate	Trust have team in place to deliver OBC as national programme proceeds. The delay in the national programme increases pressure on the trusts bed capacity. We are unlikely to miss the opportunity to access funding should the programme proceed.	30-Nov-2021
RSK-285	30-Nov-2021	IF footpaths and roadways are not maintained and inspected sufficiently and regularly THEN this could lead to trips and falls if not correctly maintained	LEADING TO harm to patients, staff and the general public, and damage to vehicles and other road users	Organisation	Paul Sherratt	23-Mar-2023	31-Mar-2024	Planned	12	8	4	Annual Capital bid placed on the capital program FY23 (01-Jul-2022)	Inspections and ad-hoc repairs(30-Nov-2021), Annual Inspection Audit completed by Estates Officer(30-Nov-2021), Some remedial captured by capital works at Cancer Centre(30-Nov-2021), Remedial works completed. Further improvements identified and action plan developed to address on a rolling program.(04-Mar-2022)	Low	Treat	Reviewed by Associate Director of Estates & Compliance Officer. No change to current risk rating.	25-Aug-2021
RSK-291	30-Nov-2021	IF the existing surface water drainage system is not suitably maintained or repaired THEN the surface water drainage system could fail	LEADING TO flooding and contamination and loss of service	Organisation	Michael Stark	23-Mar-2023	31-Mar-2024	Planned	12	8	4	Annual drain survey scheduled to identify remedial works (31-Mar-2023)	Reactive maintenance repairs(30-Nov-2021), CCTV works has indicated areas of root re-growth with pipe damage to storm water pipes, works being undertaken during summer/autumn 2021(30-Nov-2021), BDP created scope for full site survey under the HIP program to identify shortfall in current data and future plan requirements. A new link is likely to be required as part of South Site development(30-Nov-2021), Road Gulley on PPM(30-Nov-2021)	Low	Treat	Reviewed by Associate Director of Estates & Compliance Officer. No change to current risk rating.	25-Aug-2021
RSK-293	30-Nov-2021	IF the current fuse boards are not updated to miniature circuit breakers THEN existing fuse-boards could fail	LEADING to delays in repairs/replacement resulting in possible service disruption and poor patient experience	Organisation	Mark Brown	23-Mar-2023	31-Mar-2024	Planned	12	8	4	Ongoing rolling program of refurbishment, subject to funding in Trust Capital programme (23-Mar-2023)	PPM testing and repairs(30-Nov-2021), Fixed electrical testing program in place to identify any potential risks and actions required(30-Nov-2021), Replaced Circuit breakers/fuses FY 20/21(30-Nov-2021), Ward 1 completed 2021(30-Nov-2021), Wards 15 & 16 have replacement circuit boards fitted as part of ward refurbishment in 2022(21-Dec-2022)	Low	Treat	Reviewed by Associate Director of Estates & Compliance Officer. No change to current risk rating.	25-Aug-2021
RSK-301	30-Nov-2021	IF the existing foul water drainage system is not suitably maintained or repaired THEN the system could fail	LEADING TO cause flooding, contamination and loss of service	Organisation	Michael Stark	23-Mar-2023	31-Mar-2024	Planned	8	8	4	Multiple areas descaled ongoing programme (31-Mar-2023)	Reactive maintenance repairs(30-Nov-2021), Wards 1-5 identified as risk areas(30-Nov-2021), Some CCTV inspection has been completed(30-Nov-2021), Proactive maintenance commitment(30-Nov-2021)	Low	Treat	Reviewed by Associate Director of Estates & Compliance Officer. No change to current risk rating.	25-Aug-2021
RSK-005	06-Sep-2021	IF policies, guidelines and patient information are not reviewed and amended in a timely manner; THEN staff will be working with out of date information	LEADING TO potential error in patient care, non-compliance with legislative, national requirements, potential litigation and potential loss of reputation to Trust	Organisation	Tina Worth	27-Mar-2023	30-Jun-2023	Pending	12	6	3		Trust Documentation Policy(06-Sep-2021), Library resource to source current references(06-Sep-2021), Governance Leads provide support to staff reviewing guidelines and policies(06-Sep-2021), Monthly trust documentation report shared with Governance Leads(06-Sep-2021), New process via Trust Documentation Committee for 'removal' of significantly breached documents(06-Sep-2021), Work plan in place to check approval of documents/links to national leaflets(06-Sep-2021), Implementation of Radar Document Management System to improve engagement and access to the documentation process(06-Sep-2021)	Low	Treat	Risk unchanged. Noted trust wide comms via corporate meetings on the importance of updating policies	06-Sep-2021

Corporate Risk Register

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RSK-020	22-Sep-2021	IF there are ligature point areas in ED for Adult and C&YP in all areas of department THEN ED patients may use ligature points to self harm. There has been an incident where a mental health patient used a door closer as a ligature point.	LEADING TO increased safety risk to patients, safe and adverse publicity	Organisation	Patricia Flynn	09-Feb-2023	22-Jun-2023	Overdue	9	6	2	Mental Health pathway to be reviewed by the Corporate Team (23-Nov-2022), E-Care Risk Assessment Tool to be reviewed/adapted (06-Jun-2023)	Patients assessed and those at risk of self harming are placed in an area they can easily be observed.(22-Sep-2021), New mental health room has been ligature and risk assessed by CNWL team(22-Sep-2021), Remind all staff about keeping swipe doors closed so they don't access rooms where they are not observeble Last ligature audit was April 2019 and actioned.(22-Sep-2021), Risk Assessment of adult and C&YP areas reviewed April 2019(22-Sep-2021), Check list in place to risk asses each Adults and C&YP attending with MH/DSH issues to identify personalised action plan(22-Sep-2021), Follow up ligature RA completed as advised by H&S lead for trust Risk Assesment completed - identified need for collapsible clothes hangers in public toilets - request to estates to install and completed; x1 non-compliant cord pull also in toilet - changed(22-Sep-2021), Repeat Ligature Risk Assessment for 2020 required(22-Sep-2021), ensure all staff are aware of the new Policy - "Ligature Risk Awareness"(22-Sep-2021)	Low	Treat	discussed with safeguarding BJ.. noting a small number of identified pt with known MH issues who are high risk who are frequent attenders to ED.	05-Aug-2014
RSK-033	27-Sep-2021	If the laundry contractor (Elis) can not provide an efficient and effective service. Then there may be: Delayed deliveries from Elis 2. Shortage deliveries from Elis 3. Lack of contingency stock	Leading to: 1. Delayed linen distribution throughout the trust. 2. Delayed personal care – negative impact on patient experience. 3. Delayed clinics and surgical lists (theatres). 4. Staff health and wellbeing – stress. 5. Waste of staffing resources – staff without linen to distribute. 6. In case of a Major Incident there would not be enough laundry to provide a good level of patient care.	Organisation	Steven Hall	28-Feb-2023	31-Aug-2023	Planned	8	6	6		1. Escalated issue internally and externally.(27-Sep-2021), In daily contact with laundry company to ascertain their position.(11-Feb-2022), There is a lock on the dirty linen store to prevent employees/patients/ visitors entering.(11-Feb-2022), Contract review meetings with Elis every quarter.(15-Dec-2022), MKUH has a contract with Elis which has contingency plans in place.(15-Dec-2022)	Low	Tolerate	Regular meeting with the Laundry provider - re-established. Contract extension for two years approved including extra-ordinary price increase.	01-Dec-2022
RSK-115	29-Oct-2021	IF annual and quarterly test reports for Autoclaves and Washer Disinfectors used for critical processes are not being received in a timely manner from the Estates department and there is no Authorised Person (D) to maintain the day to day operational aspects of the role THEN the Trust will be unable to prove control, monitoring and validation of the sterilisation process as a control measure. Both units are reviewed only 1 day per month - a bulk of this time is spent checking records and the other aspects of the role do not get the sufficient time required to review and follow up.	LEADING TO possible loss of ISO 13485 accreditation due to non-compliance to national standards. Inconsistent checks or lack of scheduled tests for the steam plant also increase the risk.	Organisation	Mark Brown	23-Jun-2023	12-Jul-2023	Planned	20	6	4	A meeting took place in January with estates managers, where HSDU were seeking assurance that the service would be covered. Estates have agreed to look for a plan to mitigate the risk and to keep HSDU fully informed. HSDU have informed the AE(D), so he is now aware that the site will not have any day to day operational AP(D) cover. Estates nominated person AP is undergoing training and awaiting final sign off and official appointment to role. (31-Mar-2023), Mechanical Engineer is being trained as AP, and currently being assessed ready for official appointment. (30-May-2023)	Estates management informed and plans in place to receive reports on time and to standard. Independent monitoring system in place monitoring machine performance. Weekly PPM carried out on machinery. An action plan has been created by estates, to include training the specialist estates officer so he can gain the recognised qualification he needs to carry out the role of the Authorised person for decontamination (AP(D)) and for additional training of the estates competent persons (CP(D) who test the decontamination equipment.(29-Oct-2021)	Low	Treat	Reviewed by Associate Director of Estates, Estates Manager, and Compliance Officer - No change to rating.	25-Aug-2021
RSK-204	23-Nov-2021	IF data sent to external agencies (such as NHS Digital, Advise Inc and tenders) from the Procurement ordering system contain patient details THEN there is a risk that a data breach may occur with reference to GDPR and Data Protection Act as the procurement department deals with large volumes of data.	LEADING TO a data breach and potential significant fine	Organisation	Lisa Johnston	12-Jun-2023	12-Jan-2024	Planned	16	6	6		All staff attend an annual mandatory training course on Information Governance(23-Nov-2021), Staff are encouraged to use catalogues which reduces the requirements for free text(23-Nov-2021), Data sent out to external agencies is checked for any patient details before submitting(23-Nov-2021)	Medium	Tolerate	Ongoing risk	01-Apr-2022
RSK-205	23-Nov-2021	IF there is Incorrect processing through human error or system errors on the Procurement systems THEN there is risk that there may be issues with data quality within the procurement systems	LEADING TO Incorrect ordering resulting in a lack of stock and impacting on patient safety	Organisation	Lisa Johnston	09-Jun-2023	12-Jul-2023	Planned	12	6	6		Monthly reviews on data quality and corrections(23-Nov-2021), Mechanisms are in place to learn and change processes(23-Nov-2021), Data validation activities occur on monthly basis(23-Nov-2021), A desire to put qualifying suppliers in catalogue(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix	01-Apr-2022
RSK-207	23-Nov-2021	IF there is major IT failure internally or from external providers THEN there is a risk that key Finance and Procurement systems are unavailable	LEADING TO 1. No Purchase to pay functions available ie no electronic requisitions, ordering, receipting or payment of invoices creating delays for delivery of goods. 2. No electronic tenders being issued. 3. No electronic raising of orders or receipting of income	Organisation	Karan Hotchkin	09-Jun-2023	12-Jul-2023	Planned	12	6	6		If its an external issue, SBS the service provider of the purchase to pay and order and invoicing has a business continuity plan in place(23-Nov-2021), If its an internal issue. The Trust has arrangements with the CCG who also use SBS to use their SBS platform(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix	01-Apr-2022
RSK-209	23-Nov-2021	IF staff members falsely represent themselves, abuse their position, or fail to disclosure information for personal gain THEN the Trust/Service Users/Stakeholders may be defrauded	LEADING TO financial loss and reputational damage	Organisation	Karan Hotchkin	09-Jun-2023	12-Jul-2023	Planned	12	6	6		Anti-Fraud and Anti-Bribery Policy(23-Nov-2021), Standards of Business Conduct Policy including Q&A section(23-Nov-2021), Standing Orders(23-Nov-2021), Local Counter Fraud Specialist in place and delivery of an annual plan(23-Nov-2021), Proactive reviews also undertaken by Internal Audit(23-Nov-2021), Register of Gifts and Hospitality(23-Nov-2021), Register of Declarations(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix	01-Apr-2022

Corporate Risk Register

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RSK-216	24-Nov-2021	If agreed processes for multi agency working are not appropriately managed THEN the information and shared working agreements may fail.	LEADING TO potential failures in care provision which may have a detrimental effect on patients and their families, members of staff and the Trust. The complexities of multi agency working especially within safeguarding requires sharing of information between multiple agencies and within agencies. Currently there are multiple pathways for sharing of information within and externally from the Trust. This carries a potential legal and financial cost to the Trust if not appropriately managed within agreed legal frameworks.	Organisation	Lesley-Anne Johnson	28-Nov-2022	31-Mar-2023	Overdue	9	6	6		Memorandum of understanding for the MK Safeguarding adult and children's board and for the subgroups that feed into this multi agency board, of which the Trust is a signatory(24-Nov-2021), There are electronic safeguarding forms available to staff to raise safeguarding concerns to the relevant external safeguarding adult or children's teams, SABR1, MARF. MARF now go to what is known as the Multi-Agency Hub and that has POLICE, EDUCATION, HEALTH AND SOCIAL SERVICES(24-Nov-2021), The Safeguarding Leads attend MARAC AND MARM COMMITEES which are Multi-Agency(24-Nov-2021), Safeguarding has an electric promoting welfare tab on EDM to identify individuals at risk(24-Nov-2021), Safeguarding children have a sharing information electronic form to help identify to school nurses and health visitors children who have attended or may be at risk due to the child behind the adult(24-Nov-2021), Maternity services use confidential communique on the Amalga system This has been widened to include children's and also the safe storage and collection of the MARF forms(24-Nov-2021), Trust Safeguarding Committee is multi agency(24-Nov-2021), MKHFT sits on the Milton Keynes Safeguarding Adults	Low	Tolerate	Risk under control. Annual Review	24-Nov-2021
RSK-229	25-Nov-2021	If there is poor quality of data input into the eCare system THEN there could be consequential impact on the data flow into the Trust data warehouse and reporting for both performance management and contracting (commissioners) data	LEADING TO Impacts all performance reporting. Impacts "Contracts" reporting leading to a loss of income for the Trust	Organisation	Ian Fabbro	03-May-2023	31-Aug-2023	Planned	12	6	4	Ongoing review of quality of data in eCARE, Data Quality team within the Information team are working regularly with the PTL team to review the quality of outpatient referral data.	Extensive list of data quality reports to identify poor data quality(25-Nov-2021), Data Quality team is in place, who undertake a compliance function to review sample records to ensure early capture of data quality issues(25-Nov-2021), Control scripts to identify data quality issues when the data is loaded into the Data Warehouse(25-Nov-2021), On-going review of the quality of data(11-Apr-2023)	Medium	Tolerate	No significant improvement on staffing	25-Jan-2023
RSK-252	26-Nov-2021	IF eCARE does not prevent non-prescribers from prescribing medication which could then be administered to a patient THEN there could be limitations in restricting access to individual Smart Card holders permissions or individuals do not adhere to the correct workflow	LEADING TO Medications could be prescribed and administered to a patient that are not clinically required & could be contraindicated	Organisation	Craig York	03-May-2023	31-Aug-2023	Planned	9	6	6	Excepted risk & continue to do as a monthly audit, with assistance identified and acted on	eCARE training of correct process -eCARE training includes advice on only performing tasks related to professional registration and job role(26-Nov-2021), Code of conduct - NMC -eCARE pop up requires staff to state who advised them to prescribe medication & how (verbally/written)(26-Nov-2021), Monthly audit of in place a mechanism where medications prescribed by non-physicians are audited monthly against the known list of Non-Medical Prescribers/pharmacists/Midwives. Inconsistencies will be escalated to CNIO for investigation(15-Dec-2021), SOP to be produced to support monthly audit.(16-Feb-2022)	Low	Tolerate	No progress made since prior review	25-Jan-2023
RSK-258	29-Nov-2021	IF the Switchboard resources cannot manage the service activity THEN this may result in poor performance	LEADING TO failure To meet KPI's and Emergency Response Units will put Patients, Staff and Visitors at risk and Communication with Users will give poor perception of the We Care action initiative	Organisation	Anthony Marsh	23-Jun-2023	10-Sep-2023	Planned	20	6	3		Re-profiled staff rotas(29-Nov-2021), Trained Bank staff employed where possible(29-Nov-2021), IT Department implemented IVR to assist in reducing the volume of calls through the switchboard(29-Nov-2021), Contingency trained staff available to assist(29-Nov-2021), Two additional workstations/consoles created in Estates Information office and Security office to allow for remote working(29-Nov-2021), Review of staff rota profile(04-Mar-2022)	Low	Tolerate	Reviewed by Associate Director of Estates, Estates Manager, and Compliance Officer - updated actions, changed to tolerate, no further actions required	25-Aug-2021
RSK-272	30-Nov-2021	IF the Passenger Lifts are not maintained THEN there is a risk of failure of components	LEADING to malfunction. Patients or visitors could get stuck in the lift, this could potentially cause panic or delay treatment. The public image of the trust could be affected.	Organisation	Mark Brown	23-Jun-2023	30-Sep-2023	Planned	15	6	3		Maintenance Contracts are in place(30-Nov-2021), Insurance inspections are place(30-Nov-2021), Lift modernisation inspection has been completed and 5 year plan underway since FY17/18(30-Nov-2021), Eaglestone lift upgraded and some remedial and safety upgrades during FY19-20(30-Nov-2021), W14 upgraded 2020(30-Nov-2021), Luing Cowley Lift awaiting upgrades, difficult as no alternative when lift not in service.(30-Nov-2021), Maintenance contract awarded.(30-Nov-2021), AE (Authorising Engineer) to be identified.(01-Jul-2022)	Low	Tolerate	Reviewed by Associate Director of Estates, Estates Manager, and Compliance Officer - changed to tolerate. reduced current risk 6, likelihood of not being maintained is reduced	25-Aug-2021

Corporate Risk Register

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RSK-273	30-Nov-2021	If the Trust Wards and Departments fail to demonstrate their medical equipment is maintained to correct standards THEN there is a risk of the Trust not complying with CQC Regulation 15 Premises and Equipment and risk to patient care	LEADING TO non-compliance and negative impact on the reputation of the Trust	Organisation	Ayca Ahmed	13-Mar-2023	30-Jun-2023	Pending	15	6	3	Contract KPI's agreed as part of new contract (20-Jun-2023)	Robust PPM maintenance schedule in place, audits of the rolling programme(30-Nov-2021), Audits monitored at Medical Devices Committee(30-Nov-2021), Escalation process in place to respond to 'unfound items'(30-Nov-2021), September 2018 , 6 Years contract approved(30-Nov-2021), Annual review of asset base and contract base reset linked to Capital Programme(30-Nov-2021)	Medium	Treat	Reviewed by Medical Devices Manager, no change to risk rating.	16-Oct-2018
RSK-299	30-Nov-2021	IF the Summary Record of Estates 5 year and Prioritised Backlog Maintenance risk based priority programme is not fully implemented THEN plant and equipment may fail in various areas of the hospital	LEADING TO infection control, financial implications, loss of services and reputation damage	Organisation	Anthony Marsh	23-Mar-2023	31-Mar-2024	Planned	9	6	4	Ongoing reviews, identified backlog issues driving Capital Plan. Outstanding funding of Capital works required. Operational impact of significant works to be considered. (26-Jun-2023), New Hospital Programme guidance indicates funding to clear CIR backlog programme to be included as part of the project. (26-Jun-2023)	All areas are reviewed on a monthly basis by Estates Service Manager, or sooner if equipment/plant breakdown demands(30-Nov-2021), Business cases for plant replacement to be put forward FY21/22(30-Nov-2021), Compliance Officer reviewing to identify significant costs(30-Nov-2021), Annual review of recent 6 Facet Survey to identify future funding requirements e.g. Roof, Ventilation, Plant, HV, drainage(30-Nov-2021), n/a(30-Nov-2021), Annual Physical 20% of site 6 facet survey undertaken, remainder of site updated with desktop exercise(03-Mar-2022)	Low	Treat	Reviewed by Associate Director of Estates & Compliance Officer. No change to current risk rating.	25-Aug-2021
RSK-217	24-Nov-2021	IF patients are unable to meet their nutritional requirements orally nasogastric tube feeding may be required to meet their nutritional needs; staff may not be confident or competent passing Nasogastric Tubes (NG Tubes) or correctly confirming the position of the Nasogastric tube tip THEN there is a risk that Nasogastric (NG) Feeding Tubes are not inserted and/or positioned correctly	LEADING TO 1) A Never event if feed/medication or water are inserted into the nasogastric tube and it is incorrectly positioned in the lung. This could result in death. 2) Patients would experience a delay in feeding if staff are not competent placing nasogastric tubes and checking the position of the tube tip.	Organisation	Jane Radice	02-Jun-2023	30-Jun-2023	Pending	15	5	5		All NPSA recommendations were acted upon in 2011 in the Trust as per NPSA requirements by the ANP for Nutrition(24-Nov-2021), Nutrition Committee overseeing this alert and is standard item on agenda from Dec 16. Clinical Medical and Nutritional ANP leading on the action plan(24-Nov-2021), Policies, protocols and bedside documentation reviewed to ensure compliance(24-Nov-2021), Ongoing programme of audit. Previous audit data presented to NMB Spring 2016(24-Nov-2021), Dietetic Amalga database identifies patients who require Nasogastric feeding(24-Nov-2021), Trust declared compliance with 2016 Nasogastric Tube Misplacement: Continuing Risk of Death or Severe Harm Patient Safety Alert (NHS/PSA/RE/2016006)(24-Nov-2021), The NG tube used by the trust was changed in 2020 to a tube that is more radiopaque and is therefore easier to interpret on X-ray(24-Nov-2021), pH strips are purchased from one supplier to avoid confusion with colour interpretation(24-Nov-2021), Two nutrition nurses available to place NG tubes if there are no trained clinical staff available(24-Nov-2021), Radiographers trained to interpret x-rays for confirmation of NG tube tip position. This speeds up reporting and avoids junior medical staff having to assess	Low	Tolerate	Risk reviewed at Therapies CIG - No change to risk	23-Apr-2014
RSK-031	27-Sep-2021	IF patients/staff/visitors use un-maintained wheelchairs THEN there is a risk of injury: 1. The steering mechanism may not be working correctly. 2. The lifting mechanism may not be working correctly. 3. The back rest may be broken meaning that patients may not be able sit up or the mechanism may be faulty.	LEADING TO: 1. Patient/Staff back injuries. 2. Collisions between staff/visitors/patients. 3. Staffing being off long term sick. 4. Service interruption and delays. 5. Litigation claims.	Organisation	Steven Hall	27-Feb-2023	31-Aug-2023	Planned	9	4	4		Ongoing maintenance programme for wheelchairs - with authorised supplier(27-Sep-2021)	Low	Tolerate	Contract in Place - Wheelchairs have been serviced and repaired. Current contractor slow to repair & obtain parts. Aiden Ralph Support Services Manager to investigate alternative suppliers.	01-Dec-2022

Corporate Risk Register

Reference	Created on	Description	Impact of risk	Scope	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-120	29-Oct-2021	IF medical devices are not correctly cleaned/disinfected/decontaminated/sterilised THEN the devices will not be sufficiently cleaned	LEADING TO possible patient and staff safety issues and cross contamination	Organisation	Marea Lawford	14-Mar-2023	03-Jan-2024	Planned	9	4	4	monitor and increase score should it be required to do so. this is not seen as a likely risk (05-Jan-2023)	The trust has a decontamination policy which states how equipment can be risk assessed to ensure that the correct methods of cleaning are used.This is on the hospital intranet and can be accessed by all staff. The hospital has two departments HSDU and Endoscopy Decontamination both of which are accredited to ISO 13485 and these units process a vast majority of the medical devices used on a patient. Low risk items are usually dealt with on the wards and the Decontamination policy covers this. Any specialist equipment used in wards and departments is identified at the point of purchase using the PPQ to determine what methods of decontamination are required. If this equipment is unsuitable for reprocessing through HSDU or Endo Decon then a individual risk assessment will need to be completed. Guidance on this can be gained from IPCT, the Decontamination Lead, EBME and the Medical equipment manager. A decontamination group meets quarterly and ward managers/HOD's are requested that any items decontaminated on the wards are bought to the attention of the group in order to ensure that the correct methods are being used.(29-Oct-2021)	Low	Tolerate	risk is low and deemed acceptable.	05-Jan-2023
RSK-160	12-Nov-2021	IF the existing Bag Valve Masks (BVM) look similar to the Lung Volume Recruitment (LVR) bags that the department want to introduce as a Physiotherapy treatment modality for airway clearance THEN they could be used in error during resuscitation procedures	LEADING TO patient requiring resuscitation with a BVG could have resuscitation attempted with a LVR bag and could suffer consequences of incorrect treatment initially and delay to correct treatment procedures	Organisation	Adam Baddeley	09-May-2023	03-Jun-2024	Planned	15	4	4		•The bag has "not for resuscitation purposes" printed on the bag by the manufacturers and also comes with a yellow "not for resuscitation purposes" tag attached to it. •There are clear differences in the two bags appearances All staff that work in the ward environments will have completed BLS training at least so will be familiar with the BVM equipment. They will have seen and used the BVM in practice during resus training and therefore would know that it has an oxygen reservoir bag and tubing that connects to an oxygen flow meter which an LVR bag does not have. •BVM is kept in its packaging hung on the resus trolley. When an LVR bag is provided to a patient it would be kept in their bedside locker in the navy blue drawstring bag it comes from the manufacturer in. •The resus trolley is checked daily by ward staff so if the LVR bag mistakenly was put in the resus trolley by nursing staff that would be recognised. •All physio staff that would be issuing this equipment out would have specific training before being able to use with patients. •The patient would be seen daily by Physio who would recognise if the LVR bag was missing from that patients locker. •If an LVR bag was issued to a patient then the nurse involved in that patients care would be informed of the equipment being kept in the patients locker (but not	Medium	Tolerate	No changes to risk score, continue to review 3 monthly. No incidents identified.	17-Jan-2020
RSK-215	24-Nov-2021	IF Child Protection (CP) Medicals are not completed THEN there is potential for delay in proceedings for Child Protection and could mean the children remain in care longer than they should	LEADING TO the police and Social Services having to return to get the medicals completed, an increased risk to the child's safety and potential litigation against the Trust	Organisation	Lesley-Anne Johnson	28-Nov-2022	03-Apr-2023	Overdue	9	4	4	Ongoing discussions are being held with CCG and Designated Doctor to progress an agreeable pathway	Named Doctor to review the process of booking the patients in(24-Nov-2021), Social Service made aware that the earlier we know about CP Medicals the easier it is to get them in and out(24-Nov-2021), A interim process has been agreed that SW requesting CP Medical contacts the SGC Lead who will coordinate booking through ward 4 and discuss with on call consultant(24-Nov-2021)	Low	Tolerate	No change to risk. Outside control of the Trust. Annual Review.	24-Nov-2021
RSK-237	25-Nov-2021	IF the Trust is unable to spend the full amount of the Apprenticeship Levy each month THEN money which could have been used to develop our staff will be forfeit	LEADING failure to maximise taxpayers money. The Trust may not be able to use the apprenticeship levy to fund staff education, training and development. Inability to maximise the new apprenticeship standards may impact on recruitment, retention and career development	Organisation	Louise Clayton	08-Jun-2023	31-Aug-2023	Planned	15	4	4	Review of the Nurse Apprenticeship pathway is underway with newly appointed Head of Practice Education (06-Jan-2023), Creation of Apprenticeship Strategy (08-Jun-2023)	Apprenticeship Manager attends the Nursing, Midwifery and Therapies Education Forum to promote apprenticeship benefits(25-Nov-2021), NHS People Plan commitment to support apprenticeships and other key national entry routes(25-Nov-2021), There is a national tender for the radiography apprenticeships underway led by HEE(25-Nov-2021), Apprenticeship strategy approved, maximising Levy use going forwards(25-Nov-2021), Medical apprenticeship consultation ongoing(25-Nov-2021), New apprenticeships have been created for IT, Data Analyst roles and HR.(10-May-2022), Increase in advertising of apprenticeships across the Trust and through the network through widening participation.(10-May-2022)	Low	Treat	Risk reviewed - Additional controls identified. No change to risk scoring.	25-Nov-2021
RSK-261	29-Nov-2021	IF adequate PAT testing is not carried out in a systematic and timely manner THEN untested faulty equipment could be used	LEADING TO poor patient and staff safety and increased claims against the Trust	Organisation	Mark Brown	23-Mar-2023	31-Mar-2024	Planned	8	4	4		Visual checks carried out by user(29-Nov-2021), 100% PAT testing of all available devices at time of testing annually by contractor(29-Nov-2021)	Low	Tolerate	Reviewed by Associate Director of Estates & Compliance Officer. No change to current risk rating.	29-Nov-2021

Corporate Risk Register

Reference	Created on	Description	Impact of risk	Scope	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-288	30-Nov-2021	IF the medical oxygen supply fails to function or becomes non-compliant with HTM requirements THEN the oxygen plant may not be available	LEADING TO potential loss of service, reduced patient safety and substandard care	Organisation	Michael Stark	23-Jun-2023	31-Mar-2024	Planned	12	4	4		PPM Schedule, and reactive repairs as required(30-Nov-2021), Robust contingency plan is in place with liquid O2(30-Nov-2021), Steve Goddard has been appointed as Authorised Engineer(30-Nov-2021), Estates Officer has been appointed as AP(30-Nov-2021), SHJ appointed as maintenance contractor(30-Nov-2021), AP training booked for and additional estates officer and estates service manager(30-Nov-2021), VIE capacity upgrade 2021(30-Nov-2021), Draft feasibility to achieve second VIE, and conversion of site to ring main, linked to HIP programme(30-Nov-2021)	Low	Tolerate	Reviewed by Associate Director of Estates, Estates Manager, and Compliance Officer - No change to rating.	25-Aug-2021
RSK-294	30-Nov-2021	IF staff do not carry out either informal (i.e. experience-based) or formal risk assessments before attempting a work task THEN there is a risk of personal injury to staff carrying out routine work	LEADING TO poor staff safety, injury and financial loss	Organisation	Michael Stark	23-Mar-2023	31-Mar-2024	Planned	12	4	4		All staff receive formal risk assessment training, and are competency assessed for their roles. Independent External Advisor contractor commissioned to review estates risk assessments and arrangements regularly.(30-Nov-2021), Risk awareness training is performed annually along with asbestos awareness training for all workshop staff as part of the H&S training package(30-Nov-2021), Training plan updated and implemented(30-Nov-2021), Risk Assessments by task type pop up on MICAD PPM tasks for workshop staff.(30-Nov-2021), Weekly huddle meeting with maintenance staff to include H&S(30-Nov-2021)	Low	Tolerate	Reviewed by Associate Director of Estates & Compliance Officer. No change to current risk rating.	30-Nov-2021
RSK-295	30-Nov-2021	IF there is a lack of knowledge on use or poor condition of ladder THEN there is a risk of fall from height from ladders	LEADING TO risk of harm to staff, poor public image, a potential investigation by HSE	Organisation	Paul Sherratt	23-Mar-2023	31-Mar-2024	Planned	12	4	4		Staff issued with safe use of ladder guidance(30-Nov-2021), Ladder inspections PPM schedule in place to check(30-Nov-2021), New replacement ladders have been installed, tagged and registered(30-Nov-2021), A competent training person needs to be identified to provide continual training(30-Nov-2021), RP Appointed(30-Nov-2021)	Low	Tolerate	Reviewed by Associate Director of Estates & Compliance Officer. No change to current risk rating.	30-Nov-2021
RSK-390	28-Oct-2022	IF the current Amber alert for Blood stock escalated to a Red Alert, THEN the Trust may be unable to provide required red cell components to patients in need	LEADING TO patients that do not fulfil the criteria of transfusion in a red alert situation may be denied red cell transfusions and potential shortening of the patient's life	Organisation	Grant Barker	05-May-2023	06-Jul-2023	Pending	12	3	2		Emergency Blood Management Arrangements (EBMA): Review of elective surgery. Defer all patients who have a greater than 20% chance of requiring transfusion of 2 units or more. Communicated to stakeholder hospitals. Top up transfusion threshold moved from 80g/L to 70g/L with and request over threshold being challenged by BMS staff and possibly referred to Haem clinicians for review.(28-Oct-2022), Top up transfusion requests with an Hb higher than 70 g/L will be challenged and referred to a consultant if required(28-Oct-2022), EBMA: Consider limiting transfusion to 2 units where Hb falls below trigger levels.(28-Oct-2022), Red cells for transport currently limited to 2 units(28-Oct-2022), Clinical area required to check Hb after single unit transfusions to determine whether more units are required(28-Oct-2022), Communication has been shared with Trust directors, Silver Command, HTC members, Stakeholder hospitals and managers in medicine, surgery, W&C and Oncology.(28-Oct-2022), As part of the Massive Haemorrhage Protocol (MHP) process, the designated communicator should inform the lab to stand down.(28-Oct-2022),	Low	Tolerate	Continue with current practices and review stock levels periodically. Alerts from NHSBT advise in pre-amber.	11-Oct-2022
RSK-008	06-Sep-2021	IF the Trust does not have an appropriate system to record mortality and morbidity data; THEN the Trust will not be able to record and/or provide accurate reports for governance or the Trust Board	LEADING TO non-compliance with the National Mortality & Morbidity 'Learning from Death' Framework	Organisation	Nikolaos Makris	17-May-2023	10-Aug-2023	Planned	15	2	1		Governance Team putting forward deaths for Structured Judgement Reviews (SJRs) based on previously agreed clinical criteria e.g. sepsis related(06-Sep-2021), Learning from Deaths policy as a tool to indicate required processes and cases that require review(06-Sep-2021), Implementation of the new system - CORs(06-Sep-2021), M&M review meetings on a regular basis with all required SJRs completed(01-Apr-2022)	Medium	Treat	The CORS website reporting system has been commissioned, and is being demonstrated to the M+M Leads for the purposes of troubleshooting. Training will be rolled out over the next few weeks. This should lead to a functioning system within 3 months, when hopefully the risk can be closed.	06-Sep-2021

Significant Risk Register

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RSK-131	04-Nov-2021	IF the demand for CT and MRI increases and there is continued requirement to reduce scan turnaround times THEN there will be a delay in patient management, an inability to manage patients privacy and dignity, an increased risk of infection due to overcrowding of facilities, and there will be a lack of capacity for appropriate management of CT and MRI within KPI and DM01 timescales	LEADING TO financial targets being missed, negative impact on reputation due to long waiting times Reputation, and financial due to increased infection rates, and staff leaving due to poor working conditions.	Region	Diagnostic & Screening	Paula Robinson	17-May-2023	21-Jun-2023	Overdue	20	20	8	Business Case to be developed for Radiographers, Review of Radiologists - demand and capacity, New CT Machine to be implemented, Recruitment of staff	Extended working hours and days(04-Nov-2021), Some scans sent off site to manage demand(04-Nov-2021), Reduced appointment times to optimise service(04-Nov-2021)	Medium	Treat	Risk reviewed by Risk Manager. Target risk is score that the Trust aims to reduce the risk down to. Target is set too high (n=16). Reduced to 8, to reflect that the Trust would want this risk to be unlikely to occur.	01-Jun-2021
RSK-134	04-Nov-2021	If there is insufficient funding, then the Trust may be unable to meet financial plans and targets or deliver its strategic aims,	Leading to service failure and regulatory intervention THEN the Trust will be unable to meet its financial performance obligations or achieve financial sustainability	Organisation		Karan Hotchkin	09-Jun-2023	12-Jul-2023	Planned	20	20	8	Internal budgetary review/financial performance oversight processes to manage/mitigate cost pressures. Financial efficiency programme identifies headroom for improvement in cost base. Close monitoring/challenge of inflationary price rises (13-Mar-2023)	Cost and volume contracts replaced with block contracts (set nationally) for clinical income(04-Nov-2021), Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until end of March 2022)(04-Nov-2021), Budgets to be reset for FY22 based on financial regime; financial controls and oversight to be reintroduced to manage financial performance(04-Nov-2021), Cost efficiency programme to be reset to target focus on areas of greatest opportunity to deliver(04-Nov-2021), The current funding has now been clarified .The trust will work with BLMK system partners during the year to review overall BLMK performance(21-Mar-2022)	High	Treat	Risk transferred from Datix	01-Apr-2022
RSK-158	12-Nov-2021	If the escalation beds are open across the medical and surgical divisions Then the additional patients that will need to be seen will put additional demand on the Inpatient Therapy Services that are already stretched due to long term vacancies	LEADING TO: Patients deconditioning and increased Length Of Stay (LOS), high volume of patients will not be seen daily, priority will be given to new assessments, discharges and acute chests. Majority of patients may only be seen once a week for rehabilitation which is insufficient to maintain a patient's level of function. Staff morale will reduce as they will not be providing the appropriate level of assessment and treatment to their patients.	Organisation		Adam Baddeley	13-Jun-2023	21-Jul-2023	Planned	16	20	6	agency physiotherapist and occupational therapist to cover additional workload., inpatient improvement project- aiming to review patient pathways to optimise staffing	Therapy staff attend board rounds and work with the MDT to determine priority patients. The skills mix and workforce is reviewed twice weekly between Occupational Therapy and Physiotherapy to determine cover for the base wards. To work closely with community services to raise awareness and to increase discharge opportunities i.e. in reaching Therapies working with Long stay Tuesday initiative Therapies supporting new discharge pathway/process in the Trust Over recruitment of PT and OT band 5's Locum cover for vacant posts. Daily attendance at 10.30 system wide discharge call. Inpatient Therapy Service participation in MADE events. Review of staffing model across inpatient medical and frailty wards.(12-Nov-2021), Closure or Reduction in Escalation Beds(19-Apr-2022), To ensure that inpatients teams are aware of open escalation areas and patient are prioritised in line with agreed criteria(12-Apr-2023)	High	Treat	Inpatient therapy service currently has 14 WTE vacancies. OT practice contract still supporting service at 2-3 WTE a week.	27-Nov-2018
RSK-159	12-Nov-2021	Patients referred to the Occupational Therapy and Physiotherapy inpatient services covering medical and surgical wards are not being seen in a timely manner due to the number of long term vacancies and national challenges to recruit to vacant posts. THEN there will be a delay in these patients being assessed, treated and discharged.	LEADING TO deconditioning of vulnerable/complex patients requiring a short period of therapy; increased length of stay; potential readmission, increased demand for packages of care requiring double handed provision. patient experience and long term quality of life will also be impacted as patients are being discharged as more dependent on care.	Organisation		Adam Baddeley	13-Jun-2023	14-Jul-2023	Planned	20	20	6	inpatient improvement programme- to ensure optimal staffing and allocation	Daily prioritisation of patients cross covering and review of skill mix locum cover x1 OT and x1 PT in place Ward book for escalation wards setup and band 7 reviews the caseload on the ward daily Monday-Friday and requests the most urgent are reviewed. Recruitment process ongoing but vacancies have reduced slightly. Over recruitment of band 5 OT and PT roles. Non-recurrent funding application for increase in therapy assistants over winter months.(12-Nov-2021), Review of Governance Structure(19-Apr-2022), Review Model of Care(19-Apr-2022), Review Equity Tool - Safe Staffing(19-Apr-2022), Review Workforce Model and Structure(19-Apr-2022), Recruitment and Retention of staff(19-Apr-2022), Education and Training of staff(19-Apr-2022), workforce plan to improve retention(09-May-2023), use of agency staff for any gapped posts(09-May-2023), each team to review skill mix to provide resilience in team, introduce support workers where required(09-May-2023), winter proposal for therapy services- enhanced	Low	Treat	Inpatient Therapy service remains 14 WTE below establishment, recruitment is ongoing and we have 12 new starters joining between now and August. OT practice contract continues to support inpatient therapy services.	04-Mar-2019

Significant Risk Register

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RSK-202	23-Nov-2021	IF Transformation delivery is not adequately resourced and prioritised and/or schemes are unrealistic and not well planned THEN There is a risk that the Trust is unable to achieve the required efficiency improvements through the transformation programme	LEADING TO the Trust potentially not delivering its financial targets leading to TO potential cash shortfall and non-delivery of its key targets	Organisation		Karan Hotchkin	09-Jun-2023	12-Jul-2023	Planned	20	20	9		Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partners(23-Nov-2021), Cross-cutting transformation schemes are being worked up(23-Nov-2021), Savings plan for 21/22 financial year not yet fully identified(23-Nov-2021), Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partner. There are no cross-cutting transformation schemes yet identified and savings of around £8m have been identified against the £12m target. Whilst this shortfall can be mitigated this year, the risk is around the underlying financial position.(16-Nov-2022)	Medium	Treat	Risk transferred from Datix	01-Apr-2022
RSK-305	06-Dec-2021	If there is insufficient strategic capital funding available THEN the Trust will be unable to invest in the site to maintain pace with the growth of the Milton Keynes population's demand for hospital services	LEADING To financial loss and reputational damage	Organisation		Karan Hotchkin	09-Jun-2023	12-Jul-2023	Planned	16	20	9	Trust is discussing this with the regional Capital Team and with the ICB capital allocations for 23/24. 22/23 allocations are manageable (13-Mar-2023)	The trust has a process to target investment of available capital finance to manage risk and safety across the hospital(06-Dec-2021)	Medium	Treat	Risk was approved by Finance and Investment committee on 30/12/2021	01-Apr-2022
RSK-341	17-May-2022	IF there is a delay with imaging reporting for CT and MRI for patients on cancer pathways THEN there could be a delay with diagnosis and the commencement of treatment	LEADING TO potential increase in the required treatment, potential poorer prognosis for patient, poor patient experience, increase in complaints and litigation cases.	Organisation		Paula Robinson	09-Apr-2023	21-Feb-2023	Overdue	20	20	8	2x Specialist Doctors appointed on a fixed-term basis to uplift internal reporting capacity (09-Apr-2023), Specialist Radiology to be recruited to uplift reporting capacity (09-Apr-2023), Explore alternative outsourcing for some specialist areas (e.g. lung) (09-Apr-2023), Imaging Business Case for substantive Radiologists and Radiographers (09-Apr-2023)	PTL tracking to escalate to imaging leads(18-May-2022), Agency Locum Consultant appointed 2 days a week to uplift internal reporting capacity(14-Jun-2022), Temporary reduction in double reporting for Quality Assurance to increase real-time scan reporting(14-Jun-2022), Current Radiologists doing 30% over standard reporting levels(14-Jun-2022)	Low	Treat	Risk reviewed by Claire McGillycuddy. No change to risk - review again February 2023	01-Jun-2022
RSK-374	23-Aug-2022	IF patients on the cancer pathway wait longer than 62 days THEN there is the risk treatment has been delayed,	LEADING TO potential harm a risk of potential harm physical or psychological or both	Region	Haematology & Oncology	Sally Burnie	02-Jun-2023	31-Jul-2023	Planned	12	20	20	weekly restore and recovery clinical meetings and weekly operational meetings (13-Jun-2023)		Medium	Treat	Risk continues as high due to current cancer performance and harm review processes in place, ADOs and Execs aware and performance reports produced for TEC	05-Aug-2022
RSK-411	20-Dec-2022	IF child protection medical assessments continue to be undertaken with current workforce arrangements within the Paediatric Assessment unit (PAU) as part of the current consultant and junior doctor and nursing workload . THEN there will be issues regarding the current workflow and clinical risk within a busy acute/emergency area.	LEADING TO delays and avoidable risk in being able to complete the medical assessments as per RCPCH guidelines and completion of medicolegal child protection reports for multiagency partners and court with the subsequent impact of children suffering further abuse/neglect or death.	Region	Child's Health	Keya Ali	26-Jun-2023	31-Jul-2023	Planned	20	20	10	Junior doctor rota to include allocated slots in the week for child protection medical assessments and report writing, Time for child protection medical assessments to be factored into consultant's job plans with additional consultant on the rota for child protection medical assessments and supervision as per RCPCH standards., Protected SPA time for Medical Report writing and formal peer review processes. Time for paediatric consultants to meet with junior team and deliver education on interpretation of injuries, multiagency working and child protection processes., In other areas the service is provided by community paediatricians. Trust to offer service for children under the age of two years only. Further discussions with BLMK ICB to progress this issue, To include child protection activity within the winter escalation policy with a clear process as to how this activity will be managed safely given bed pressures (PAU closed to admissions and children to be seen in PED). (08-Mar-2023), To move location to an outpatient or day care setting ensuring appropriate IT support/	Clinicians currently try and complete this work within regular workload or work additional hours without remuneration.(20-Dec-2022), Wherever possible the examinations are undertaken during the quieter times to enable an appropriate chaperone is present.(20-Dec-2022), Wherever possible cubicles are used for examinations(20-Dec-2022), The safeguarding nurses try and make themselves available. This has an impact on safeguarding team's capacity.(20-Dec-2022), HIE access on eCare SystmOne on certain computers only.(20-Dec-2022), Social worker requested to attend medical assessment(20-Dec-2022)	Low	Treat	No change	28-Sep-2022

Significant Risk Register

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RSK-417	13-Jan-2023	IF the Gastroenterology Department has an overwhelming number of new and follow up patients on their waiting list, and there is a significant demand on follow up capacity THEN there may be insufficient capacity to meet the demand on the service and recover the backlog of patients	LEADING TO Patients not being seen in a timely manner, Urgent referrals not being seen as quickly as they should, poor patient experience, competing priorities between new and follow up demand.	Region	Specialty Medicine	Katherine Denning	03-Jun-2023	24-Jun-2023	Overdue	20	20	10	Recruitment of 1WTE middle grade. (24-Apr-2023), Service review to allow clinical triage of new and follow ups (01-Jun-2023), PTL validation of all patients over 18 weeks (27-Mar-2023), Admin validation of Non-RTT (24-Apr-2023), Recruitment of nursing staff to enable more OPA capacity and implementation of IBD PIFU (24-Apr-2023), Training CBO to check for duplicate appointments before booking, when creating a referral in RPAS to book outside of eReferral, to make sure eReferral is closed and discharged. (27-Mar-2023), Monthly duplicate report to be done by patient access and duplicates removed and closed (27-Mar-2023)	Patients Expedited through WLI sessions(13-Jan-2023), Triaging of referrals where possible(13-Jan-2023), Slot utilisation report has been created and used by Patient Access and Medicine Division to ensure all slots are fully utilised and not wasted.(13-Jan-2023), Patient Pathway Coordinators ensure results are reviewed and follow up appointments booked when needed- linked to PTL validation.(13-Jan-2023), Clinical Validation of the non-RTT starting with the most overdue patients. This relies on free sessions and is slow progress at 25 patients per session.(13-Jan-2023), PIFU is implemented in Gastro, only small numbers of around 10-15 per month. Clinical triage is increasing numbers being put on PIFU.(13-Jan-2023), Patient Pathway Coordinators are now starting to review some clinics ahead of time to identify any duplicate appointments.(13-Jan-2023), One off report was run identifying over 200 duplicates, all duplicates were removed by Medicine Division.(13-Jan-2023), Recruitment into 12-month consultant and 12 month middle grade post(13-Jan-2023)	Low	Treat	Risk reviewed at Specialty Medicine CIG - No changed to risk.	21-Oct-2022
RSK-421	20-Jan-2023	Ongoing shortages of medicines with minimal notice or little warning	Possibility of cancellation of patient appointments/operations or a delay to treatment/discharge. Increased cost to the trust in sourcing medicines off of contract prices, courier charges, staff time	Region	Pharmacy	Nicholas Beason	09-Jun-2023	09-Jul-2023	Planned	10	20	4	increase capacity of pharmacy procurement team	Actively working on reducing any impact from medicines out of stock - sourcing where possible. Regional procurement, NHS England and mutual aid all being used.(20-Jan-2023)	Low	Treat	risk score increased as impact has significant financial cost. needs to be escalated as organisational risk.	27-Nov-2022
RSK-427	08-Feb-2023	IF there is an increase in demand for inpatient and ED CT scans THEN some scans will be routinely waiting a number of days to be performed.	LEADING TO potential delays to patient treatment; delays to discharge.	Region	Diagnostic & Screening	Michael Pashler	23-Jun-2023	30-Jul-2023	Planned	16	20	6	Purchase and installation of 4th CT scanner (23-Jun-2023), Recruitment of Radiographers (23-Jun-2023)	Recruitment of Imaging Assistants(08-Feb-2023), Patients are prioritised based on clinical urgency to minimise risks as best as possible(09-Feb-2023), Adopting a fluid approach to managing the workload. Adapting to changes in priority at short notice.(09-Feb-2023)	Low	Treat	Risk reviewed - no changes	20-Oct-2022
RSK-435	16-Feb-2023	IF access and egress to the MRI Unit is not appropriate, including narrow corridors/doors/changing ramp inclines etc. THEN there may be limited access for manoeuvring beds and wheelchairs ; there may be an inability for bariatric patients to access the facilities.	LEADING TO potentially delayed diagnosis and treatment; deterioration of condition and poor outcomes for patients; increase in slips, trips, falls; potential inability to evacuate patients quickly in case of fire; staff, patients and visitors could sustain strains, sprains, musculoskeletal, back, fracture, entrapment, collision injuries; increase in complaints and claims; potential investigation/formal notices from Health & Safety Executive; impact on reputation of Trust through potential media coverage re safety concerns	Region	Diagnostic & Screening	Thozama Cele	22-Jun-2023	18-Sep-2023	Planned	20	20	10	Review area and remove/relocate vending machines/chairs/wall to provide a wider and more direct route onto ramp, Development / Redesign of MRI Unit / Ramp to be undertaken	Staff vigilance and awareness of changes in incline(16-Feb-2023), All trolleys and beds to have a minimum of 2 staff pushing/ pulling- regardless if a patient is on the bed/ trolley(16-Feb-2023), Wheelchair patients to be assessed on individual basis but 2 people to push up and down ramp if patient deemed to heavy for individual- approx. guide proposed would be patient more than 75 kg to require 2 staff(16-Feb-2023), Ask all patients prior to entering ramp area to keep all arms and hands inside the bed/ trolley/ wheelchair(16-Feb-2023), Staff vigilance. Ensure limbs are out of way when negotiating ramp(16-Feb-2023), Patients to be brought from wards in wheelchairs where possible(16-Feb-2023), One bed patient at a time only(16-Feb-2023), Bed patient to be transferred to an MRI safe folding trolley in emergency(16-Feb-2023), Some bariatric patients are managed medically and not bought to the unit(16-Feb-2023), Communication with staff and patients. Ability to raise concerns with local managers, exec team and safety advisors(16-Feb-2023), Hazard warning tape on changes of level(16-Feb-2023), Fire Evacuation plan to be documented and	Low	Treat	No update	06-Jun-2022

Significant Risk Register

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RSK-451	18-Apr-2023	IF obstetric ultrasound does not have the capacity to meet the demand for ultrasounds referral requests THEN service users will not have the required assessments	LEADING to delayed identification of growth anomalies and/or, Not meeting the SBLV2 care bundle as expected and the maternity incentive scheme requirements in respect of multiple pregnancies	Region	Women's Health	Katie Selby	21-Jun-2023	31-Aug-2023	Planned	20	20	6	Develop messaging and training based on inappropriate referral rejections	Locum staffing to cover obs ultrasound lists(18-Apr-2023), Map out obs ultrasound requests, referrals and DNA's to understand capacity and demand need(18-Apr-2023), Business case for staffing as identified by demand and capacity mapping(18-Apr-2023), Locum sonographer booked from week commencing 24/04/23 until late May.(03-May-2023), MDT triage of all rejected cases (superintendent sonographer for obstetric ultrasound) emailing Obs Consultant lead for fetal medicine, fetal surveillance midwife and Women's Health Governance and QI Lead.(03-May-2023), Updated the Obs USS guidance to align with maternity related growth guidance(03-May-2023), A referral guidance of terminology to use when referring for an USS to ensure only appropriate scans are requested.(03-May-2023)	High	Treat	No change to risk score.	18-Apr-2023
RSK-452	18-Apr-2023	IF scan does not have capacity to meet the demand for hysteroscopy one stop shop THEN service users appointments will be delayed	LEADING to a possible breach of 2 week cancer waits and/or, a potential for patient to delay receiving cancer diagnosis and treatment	Region	Women's Health	Mary Plummer	21-Jun-2023	31-Aug-2023	Planned	25	20	6	Scan capacity for one-top shop	2.5k from Cancer Alliance to support locum sonography cover(18-Apr-2023), 2.5k funding available which will cover 104 service users(03-May-2023)	Low	Treat	Decrease in 2 week wait, scan capacity is supported by bank/agency staff.	18-Apr-2023
RSK-456	17-May-2023	IF there is an increasing demand on the Blood Sciences service and staffing levels are no longer sufficient to provide a robust 24/7 service THEN staff will be unable to continue to meet service demands	LEADING TO: 1.The inability to cover 24/7 service and several gaps in the rota, which has already been evidenced 4 times in the last 3 months and this will result in no Out of hours cover which will mean the Trust will need to consider closing AE/Maternity and Theatres 2.Chief BMS having to cover shifts and calling people on sickness leave to help cover shifts due to lack of staff 3.An increasing delay in the turnaround time of results – KPI's for Biochemistry are significantly failing to meet the demands of the urgent service 4.Risk of losing limited expertise knowledge from department due to sickness 5.The inability to provide resilience cover for shifts due to having insufficient numbers enough to cover the shifts. 6.Increase in overdue governance and quality tasks 7.More samples are marked 'urgent' as clinicians hear of possible delays which exacerbates the problem. 8.A backlog of samples at the end of the day which is carried over to the following day or beyond which impacts integrity of samples from GP's 9.Senior scientific staff spend more time doing routine bench work to address the increase, compromising laboratory governance issues 10.Increasing levels of stress related sickness and turnover of staff, sickness rate is around 6%	Region	Diagnostic & Screening	Jessica Dixon	08-Jun-2023	07-Jul-2023	Planned	20	20	8	Recruitment of staff (23-Jun-2023), Recruit Haematology bank Bnd 4 resource (23-Jun-2023), Recruit Chemistry bank Bnd 6 resource (23-Jun-2023), Recruit Chemistry Agency Bnd 6 resource (23-Jun-2023)	Use of Agency, Locum and Bank Staff(17-May-2023), Currently utilising the 8a Chief BMS to cover shifts where possible.(17-May-2023), Prioritisation of urgent work(17-May-2023), Existing staff offered overtime(17-May-2023), Increase WTE staff resource in Chemistry within budget(23-Jun-2023), Recruit Haematology agency Bnd 6 resource(23-Jun-2023)	Low	Treat	Reviewed at POT - agreed to close RSK 148 Chem staffing risk and this blood sciences risk supersedes. Agree to come up with formal action plan to how to mitigate this risk.	02-Mar-2023
RSK-457	22-Jun-2023	If there are insufficient staffing levels (radiographers) THEN there will be reduced capacity in the department resulting in closure of the 3rd CT Scanner	LEADING TO delays to patient diagnosis and treatment, potential missed diagnosis; increased stress / increased sickness and potentially inability to retain staff	Region	Diagnostic & Screening	Michael Pashler	27-Jun-2023	22-Jul-2023	Planned	20	20	6	Recruitment of staff	Prioritising 2WW patients at the expense of urgent, routine and planned/cancer follow-up patients(27-Jun-2023), Signposting patients to PALS Team, where appropriate(27-Jun-2023)	Low	Treat		22-Jun-2023

Significant Risk Register

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RSK-001	06-Sep-2021	IF all known incidents, accidents and near misses are not reported on the Trust's incident reporting system (Radar); THEN the Trust will be unable to robustly investigate all incidents and near-misses within the required timescales;	LEADING TO an inability to learn from incidents, accidents and near-misses, an inability to stop potentially preventable incidents occurring, potential failure to comply with Duty of Candour legislation requiring the Trust to report all known incidents where the severity was moderate or higher, potential under reporting to the Learning from Patient Safety Events (LfPSE) system, and potential failure to meet Trust Key Performance	Organisation		Tina Worth	21-Mar-2023	30-Jun-2023	Pending	20	16	12	Staff competence and confidence with Radar reporting, with improved reporting rate, reduction in inaccurate reports on system and/or failure of incidents being reported (24-Oct-2022)	Incident Reporting Policy(06-Sep-2021), Incident Reporting Mandatory/Induction Training(06-Sep-2021), Incident Reporting Training Guide and adhoc training as required. Radar to provide on site & bespoke training IT drop in hub to be set up 2 days a week for staff drop ins(06-Sep-2021), Datix Incident Investigation Training sessions(06-Sep-2021), Daily review of incidents by Risk Management Team to identify potential Serious Incidents and appropriate escalation(06-Sep-2021), Serious Incident Review Group (SIRG) ensure quality of Serious Incident Investigations(06-Sep-2021), SIRG ensure appropriate reporting of Serious Incidents to Commissioners(06-Sep-2021), Standard Operating Procedure re Risk & Governance Team supporting the closure of incident investigations during unprecedented demand on service(06-Sep-2021), Implementation of new Risk Management Software to make incidents easier to report and improve engagement with staff(06-Sep-2021)	Low	Treat	With ongoing PSIRF preparation recognise that shared learning is crucial to that & current processes are not robust enough to address this. To be included in PSIRF implementation plan	06-Sep-2021
RSK-035	28-Sep-2021	IF there is a high turnover of staff due to: work pressure, not having the opportunity to work at the top of their licence, lack of capacity for development, lack of capacity for supervision / support. Also difficulty in recruiting. Loss of staff to primary care which offers more attractive working hours. THEN there will be insufficient staff in pharmacy to meet demands of the organisation and ensure patient safety in the use of medicines.	LEADING TO: 1. increased length of stay due to TTO delay 2. increase in prescribing errors not corrected 3. increase in dispensing errors 4. increase in missed doses 5. failure to meet legal requirements for safe and secure use of medicines 6. harm to the patients 7. adverse impact on mental health of Pharmacy staff All resulting in adverse patient outcomes. Lack of financial control on medicines expenditure Breach of CQC regulations	Organisation		Helen Chadwick	09-Jun-2023	09-Jul-2023	Planned	20	16	6	Actively recruiting staff (09-Jun-2023)	Business Case for additional staff(05-Apr-2022), Temporary role realignment towards patient facing roles(05-Apr-2022), Use of Agency Staff(05-Apr-2022), Prioritisation of wards(28-Jun-2022)	Low	Treat	turnover rate declined over last 3 months and will continue to monitor	07-Aug-2019
RSK-036	28-Sep-2021	If there is no capacity in the Pharmacy Team THEN there is a risk that Pharmacy and Medicines Policies and Procedures may not be reviewed and updated in a timely manner, nor new policies developed	Leading to: Potential for Policies & Procedures to be out of date Potential for staff to follow out of date Policies & Procedures Failure to meet CQC requirements Lack of guidance for staff Potential harm to patients	Organisation		Helen Chadwick	09-Jun-2023	09-Jul-2023	Planned	16	16	6	Recruitment of staff (09-Jun-2023)	Use of remote bank staff to update policies(28-Sep-2021), Business Case for additional Pharmacy staff(19-Apr-2022)	Low	Treat	significant staffing gaps remain, using bank resource to mitigate risk where possible	01-Oct-2021
RSK-053	01-Oct-2021	IF the old building management system (BMS) does not effectively regulate the temperature within orthopaedic theatres 11 & 12. THEN when the the outside temperature is warm, and the temperature in theatres increases to above 25-26 degrees theatre staff are unable to regulate this from the theatre suite, and estates are also unable to reduce the temperature. **The recommended temperature perform orthopaedic surgery is 19 -20 degrees.	LEADING TO Patients – increases the possibility of infections, performing joint replacements at higher temperatures goes against manufacturers recommendations when using bone cement as the cement sets too quickly. Cancellations in surgery, Staffing - This also has a detrimental impact of staff that could be wearing x-ray gowns and are scrubbed, wearing gowns, gloves & face masks, making the staff and clinicians feel unwell and unable to work.	Region	Anaesthetics & Theatres	Robyn Norris	03-Jun-2023	01-Feb-2024	Planned	9	16	4	Implementation of surgical block as part of new hospital build, Improved alignment with Estates to investigate issues and make plans to resolve (03-Jun-2023)	Estates department are currently investigating. We are unable to put controls into place at this time.(01-Oct-2021)	Low	Treat	Robust 3 monthly & annual AHU maintenance programme now in place Estates have recruited a Specialist Officer, who acts as lead for AHUs across the Trust	18-Jun-2021
RSK-055	01-Oct-2021	IF the staffing within theatres is not made adequate THEN the elective and emergency operating lists will not be covered	LEADING TO not achieving the required target and potentially cancelling patients, which will increase patient waiting times, reduction in income and increased costs to fulfil staffing i.e. Agency and Bank spend	Region	Anaesthetics & Theatres	Robyn Norris	03-Jun-2023	31-Oct-2023	Planned	12	16	9	Increase establishment to reduce reliance on expensive and temporary measures i.e. Agency and Bank (03-Jun-2023)	This risk is currently being mitigated by the use bank, approx. 80 /100 shifts of varying lengths per week. Agency staff approx. 300 hours per week. Even with the additional support from bank and agency staff we still struggle to provide staff for all sessions, this has recently led to cancelling lists. These risks are exacerbated when staff are off sick or absent for training / annual leave.(01-Oct-2021), GAPS: There are significant gaps in the theatre rota - 19 WTE posts are required to meet latest review of theatre staffing requirements.(01-Oct-2021), Recruited to 8x WTE(27-Apr-2022), Recruited 5x International Nurses(27-Apr-2022), Approval of Business Case for 10x additional members of staff(27-Apr-2022), 10x additional members of staff to be recruited(27-Apr-2022), Recruitment programme is underway(13-Jun-2022)	Medium	Treat	Robust rolling recruitment programme in place 17 x Agency staff in place 14 x International nurses now recruited Workforce Business Case being presented to Execs 10.02.23	24-Jun-2021

Significant Risk Register

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RSK-064	07-Oct-2021	IF the Eye Injection Clinic Capacity continues to grow and the Ophthalmology team are not be able to meet capacity demands THEN there will be an an increasing number of patients outstanding for eye injections (this is people plotted and increases every week as people are plotted from past injections).	LEADING TO a delay to sight saving treatment – time critical treatment.	Region	Head & Neck	George Belgrove	14-Jun-2023	01-Dec-2023	Planned	20	16	4	Increase Use of non medical, allied health professional injectors (21-Apr-2022), Weekend WLI clinics planned to catch up as temporary measure, Training up of Optometrists to do injections, Recruitment to SAS and fellowship roles, Team to consider an increase in nursing staff to run eye injection clinics (24-Aug-2022), Nurse in training due to start in September & 2 nurses on ophthalmology course, CDC verbally approved waiting more details this will provide more capacity	Planning for second injection room - lack of space and need to need funding to convert room(07-Oct-2021), Introduction of further Injection Clinics all day Friday (staff permitting)(21-Apr-2022), One stop clinics were introduced - increase 2 sessions to 4 - consultant led(21-Apr-2022)	Low	Treat	Updated controls	11-Nov-2019
RSK-080	15-Oct-2021	IF the pathway unit is not in place THEN moderate to severe head injury patients will not be appropriately cared for and will not be treated in accordance with NICE guidance (CG176: Head injury: assessment and early management, updated September 2019) These patients may frequently fall under the remit of the T&O Team or be nursed on a surgical ward when they should be under a neurological team.	LEADING TO Potential reduction in patient safety - T&O surgeons and nursing teams may be unaware of how to care for patients with moderate to severe head injuries especially patient who are anticoagulated. Clinicians may have to wait for an opinion from the Tertiary Centre staff training, competency and experience Serious incidents Reduced patient experience	Region	Musculoskeletal	Emma Budd	23-Jun-2023	21-Jul-2023	Planned	12	16	8		- On going discussions with Senior Medical Team - CSU Lead to escalate via trauma network - Alert process is in place for escalation within T&O & externally. - Resources available at tertiary site for advice/support(15-Oct-2021), 1, 2 c& 3. mitigating controls - Policy for management of head injuries has been developed - Awaiting appointment of head injury liaison Nurse - Long term plan for observation block to be built.(15-Oct-2021), GAPS: - Trust is not in line with other trauma units - Regional trauma centre advises head injury should not be managed by trauma and orthopaedics and after 24 hours the patient should be referred to neurosurgery. - Potential delay in opinion from Tertiary Centre(15-Oct-2021), Implementation of Pathway Unit(27-Apr-2022)	Low	Treat	Risks graded 8 or above must be reviewed at least monthly. Therefore Risk Review Due changed to 21st July 2023	14-Jul-2011
RSK-088	15-Oct-2021	IF there is overcrowding and insufficient space in the Neonatal Unit. THEN we will be unable to meet patient needs or network requirements (without the increase in cot numbers and corresponding cot spacing).	LEADING TO potential removal of Level 2 status if we continue to have insufficient space to adequately fulfil our Network responsibilities and deliver care in line with national requirements.	Region	Child's Health	Lazarus Anguvaa	12-Jun-2023	05-Jun-2023	Overdue	25	16	9	New Women's & Children's hospital build, x1 cubicle has been removed to provide workspace for staff (09-Mar-2023), Discussions with network to ensure appropriate admission/transfers into unit wherever possible Increase in accommodation added to capital plan (09-Mar-2023), Overcrowding at bedside - ensure prompt removal of equipment when not required. Wall mounted equipment to allow access at cotside Ultimately will not be resolved until new build has been completed and NNU moves across (09-Mar-2023)	1. Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards(15-Oct-2021), Business Case for Refurnishing Milk Kitchen and Sluice(15-Oct-2021), 2. Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID(15-Oct-2021), 3. Added to capital plan(15-Oct-2021)	Low	Treat	Risk reviewed by triumvirate , no changes to risk and scoring	19-Dec-2022
RSK-100	25-Oct-2021	IF there is a delay with reviewing our Avoiding Term Admissions into Neonatal Units (ATAIN) cases. THEN Women's Health CSU will not be able to complete ATAIN-related incident investigations on Radar in a timely manner	LEADING TO a delay in incident investigations being closed on Radar, in breach of the Trust's Incident Reporting Policy; non-compliance with Clinical Negligence Scheme for Trusts (CNST); incidents requiring immediate system or process learning will not been reviewed thus potentially impacting on the safety within maternity and neonatal services; negative impact on Trust reputation	Region	Women's Health	Melissa Davis	21-Jun-2023	31-Aug-2023	Planned	20	16	8	Extended ATAIN sessions to be facilitated.	1.ATAIN meetings still taking place when possible/ quorate.(25-Oct-2021), Completing Datix retrospectively(25-Oct-2021), Shadowing opportunities at other trusts to review ways in which to manage ATAIN to increase the effectiveness of the group.(25-Oct-2021), Allocation of appropriate MDT time within roles to attend ATAIN meetings(25-Oct-2021)	High	Treat	Re instated due to delays in reviews	20-Jun-2023
RSK-126	04-Nov-2021	IF cot spacing in the Neonatal Unit does not comply with BAPM guidance or the latest PHE guidance for COVID-19 (the Unit is seeking to increase both total cot spacing and cot numbers by 4 HDU/ITU cots in line with Network 5 year projections of acuity and demand, and spacing in line with National Recommendations) THEN there will be overcrowding and insufficient space in the Neonatal Unit, exacerbated by need for social distancing due to COVID-19. The milk kitchen was condemned due to this	LEADING TO an inability to meet patient needs or network requirements. We will now also be unable to meet PHE recommendations for social distancing This may result in a removal of Level 2 status if we continue to have insufficient space to adequately fulfil our Network responsibilities and deliver care in line with national requirements. This may also impact on our ability to protect babies and their families during COVID	Organisation		Lazarus Anguvaa	12-Jun-2023	05-Jun-2023	Overdue	25	16	9	Business Case for Refurnishing Milk Kitchen and Sluice	Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards(04-Nov-2021), Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID(04-Nov-2021), Added to capital plan(04-Nov-2021), Feasibility study completed(04-Nov-2021)	Low	Treat	Risk reviewed by triumvirate ,No change to risk or risk scoring	19-Dec-2022

Significant Risk Register

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RSK-135	04-Nov-2021	IF the Pathology LIMS system is no longer sufficient for the needs of the department, due to being outdated with a limited time remaining on its contract THEN the system is at risk of failure, virus infiltration and being unsupported by the supplier	LEADING TO the Pathology service being halted and contingency plans would have to be implemented. Sensitive information could lost or security of the information could be breached.	Region	Diagnostic & Screening	Jessica Dixon	08-Jun-2023	07-Jul-2023	Planned	16	16	4	Low Level Design to be completed (08-Jun-2023)	Systems manager regularly liaises with Clinysis to rectify IT failures(04-Nov-2021), Meetings with S4 to establish joint procurement take place periodically(04-Nov-2021), Project Manager role identified to lead project for MKUH(04-Nov-2021), High Level Design Completed(01-Dec-2021)	Low	Treat	Continues to be high risk. LLD nearly complete and sections sent to STS for testing. Forward planning BC has been drafted for this financial year funding. Staffing resources is a consideration and considered a risk to the project. S4 Quality lead in discussion around UAT testing which will be next phase following STS.	01-Sep-2019
RSK-142	04-Nov-2021	IF there is insufficient capacity and ongoing unsustainable demand for dietetic input for Paediatric patients (both inpatient and outpatient) . IF Home Enterally Fed Paediatrics patients continue to be seen our outpatient structure which is not adequate to meet their demands and needs. This means that these high risk groups of Children and Young People are not accessing the necessary specialist nutritional support at the appropriate time in their development THEN staff may be unable to cover a service that has not been serviced correctly, and the paediatric team cannot provide a full dietetic service to children and young people in the Milton Keynes area	LEADING TO patient care and patient safety may be at risk, vulnerable children may become nutritionally compromised, the service may be unable to assess and advise new patients and review existing patients in a timely manner, and there may be an impact on patients nutritional status and longer term dietary management on what is a very vulnerable group of patients. The majority of our caseload is infants or tube fed infants and children where there nutrition and growth is a priority.	Organisation		Elizabeth Pryke	20-Jun-2023	09-Jul-2023	Planned	15	16	3	In contact with commissioners to discuss service provision Collecting additional data (feedback from stakeholders, benchmarking etc) to support business case (11-Apr-2023), Business Case for paediatric Home enteral feeding service	Existing staff are working some additional hours but this remains insufficient to meet the needs of the service(04-Nov-2021)	Low	Treat	Insufficient time to take forward business case, to prioritise in the next month	01-Nov-2021
RSK-157	12-Nov-2021	IF There is insufficient Speech and Language Therapy capacity to meet referrals demands	LEADING TO patients not receiving input in line with Sentinel Stroke Audit National Programme (SSNAP) (communication and and timely input to support patient discharges Delayed discharges, poor patient experience and increased length of staff	Region	Therapies	Jamie Stamp	19-Jun-2023	11-Jul-2023	Planned	16	16	4	To update SLA for Speech and language Therapy, to update on new template, to reflect current provision and to capture activity date for discussion at quarterly review meetings	Daily updates are provided by the SLT to confirm outstanding referrals and priority patients for that day.(12-Nov-2021), To review opportunities to skill mix current workforce in light of recruitment challenges. For example, meetings to take place with community services to consider increasing therapy assistant time to improve input on the Stroke Unit.(11-Apr-2022), Team Leader is now in post - to ensure that regular meetings are taking place to look at recruitment and training. Band 3 Therapy Assistant (FTC) interviews are scheduled. SSNAP actions plan has been updated to reflect this.(24-Jun-2022), To create Quality Scheduled to capture data relating to Speech and language Therapy activity for discussing at quarterly meetings with the provider. Head of Therapy has met with the Operational lead for medicine to start initial discussion about what data they want captured from a stroke point of view.(24-Jun-2022), To meet with medicine division to understand areas of improvement needed to achieve the SSNAP data for Speech and language Therapy(14-Dec-2022), Arrange meeting with CNWL to discuss current staffing levels and mitigation(14-Dec-2022)	Medium	Treat	Risk score remains the same. Currently working on reviewing the Service Level Agreement (SLA) with community services. Draft verbally discussed verbally with community services on 15.06.23 along with quality schedule to capture activity. Quality schedule has also been shared internally for comments.	12-Nov-2021
RSK-377	30-Aug-2022	IF Microbiology does not have a Quality Management System and is unable to provide quality assurance THEN the department may not able to achieve accreditation for the range of tests performed in the department	LEADING TO potential for patients to receive incorrect results or delays in receiving results, diagnosis and treatment, impact on Trust's reputation, financial penalties, loss of Service User Contracts, loss of ICB commissioning, loss of staff, difficulties recruiting staff, inability to manage incidents, audit, Trust policies and equipment records in a timely manner	Region	Diagnostic & Screening	Jessica Dixon	08-Jun-2023	07-Jul-2023	Planned	16	16	8	Review rota Management (11-Apr-2023), Improve training and competency programme (08-Jun-2023), Lean process review of all bench areas - led by OUH staff (08-Jun-2023)	Quality Manager and Quality Associate Practitioner in post(30-Aug-2022), Monthly KPI's to monitor progression(30-Aug-2022), Additional support utilising bank staff as required(30-Aug-2022), Quality Management System in place that is robust in 5 other disciplines within Pathology(30-Aug-2022), Additional training for staff in utilising the QMS and understanding(30-Aug-2022), Monthly departmental and clinical meetings to review, communicate and action decisions(30-Aug-2022), EQA and IQC participation(30-Aug-2022), Audit Programme(30-Aug-2022), Training and Competency programme(30-Aug-2022), Mock UKAS inspection(30-Aug-2022), 1-1's with Senior staff to establish training gaps(30-Aug-2022), Increase formal training within departments for all staff to use Q-Pulse as required(30-Aug-2022), Improved clarity of roles and responsibilities(30-Aug-2022), Implement stock management system(30-Aug-2022), 2x Band 7 acting as Chief from OUH to support for	Low	Treat	Ongoing - continue to progress slowly through improvement actions. Some struggles with skill mix, annual leave and sickness absence. Mock inspection to be delayed due to departmental workforce resilience. To review service and activity to look to alleviate pressures.	01-Jul-2022

Significant Risk Register

Reference	Created on	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-379	01-Sep-2022	IF there is no Specialist HIV Pharmacist THEN the Trust will not be compliant with standards and guidance, potential inability to identify prescribing errors, lack of support for the Multi-Disciplinary Team, potentially increased operational costs	LEADING TO potential decommissioning of HIV service, Lack of screening of prescriptions by specialist pharmacist resulting in increased medication errors and drug wastage, negative impact on staff wellbeing, staff shortages, and difficulties retaining staff, higher operating costs for the service	Region	Specialty Medicine	Clare Woodward	03-Jun-2023	24-Jun-2023	Overdue	16	16	8	Recruitment of HIV Specialist Pharmacist (06-Jun-2023)	Utilising existing pharmacy staff who can't always meet the needs of the service(01-Sep-2022), Specialist nurses and clinicians supporting where they can(01-Sep-2022)	Low	Treat	Risk reviewed at Specialty Medicine CIG - Oxford Pharmacist assists with MDT's but not with prescriptions. Honorary contract sits under Pharmacy and requires approval	20-May-2022
RSK-399	09-Nov-2022	IF the staffing establishment within the Pharmacy Aseptic Team is not resilient and there is insufficient senior aseptic staff to complete the higher technical tasks THEN there is potential for the department to be regularly working over capacity	LEADING TO a breach in regulatory guidance, an ability to maintain the QMS work required.	Region	Pharmacy	Christopher Woodard	09-Jun-2023	09-Jul-2023	Planned	16	16	12	Review of senior staffing, including succession planning. Develop posts/time for staff to focus purely on quality tasks, not just operational. (06-Jan-2023), work with finance to understand funding streams to enable business case development., Request QA roles utilising savings made by pharmacy procurement. (09-Jun-2023)	Outsource some patient specific chemotherapy(09-Nov-2022), Discussed at monthly QMS meeting, more critical QMS tasks being prioritised for available time at present(09-Nov-2022), Review of staffing to establish what additional staffing is needed and who to improve retention and development of staff we currently have(09-Nov-2022)	Medium	Treat	remains an ongoing risk - new control added	01-Nov-2022
RSK-414	13-Jan-2023	IF The Dermatology Department does not have appropriately trained nursing staff to be able to provide a Phototherapy Service THEN the service will not be able to provide a phototherapy, which is an integral part of the Dermatology Service	LEADING to patients that are unable to access Phototherapiy being placed potentially on medication unnecessarily to try to manage their conditions in the interim	Region	Specialty Medicine	Suzanne Raven	03-Jun-2023	24-Jun-2023	Overdue	16	16	12	Recruitment of adequately trained phototherapy nurse.	List is closed to new referrals(13-Jan-2023), Patients have been reviewed and where appropriate placed on medication(13-Jan-2023)	Low	Treat	Risk reviewed at Specialty CIG meeting - Nurse in post currently being trained. Service to commence June/July. Agreed to keep open until July.	02-Nov-2022
RSK-447	13-Apr-2023	IF the previous external payroll provider has underperformed THEN there may be issues with Pension and Pay issues for staff	LEADING TO potential pension and pay quality issues that backdate significantly; Discovery of under and overpayments, pension calculation and enrolment errors; increased risk of cost to the organisation; employment tribunal claims; additional resource costs to fix issues; reputational damage to the Trust; pension issues for staff/Trust at retirement	Region	Workforce	Louise Clayton	11-May-2023	31-Jul-2023	Planned	16	16	4		Re-run of pension auto-enrolment(13-Apr-2023), Switch on of auto-enrolment fucntion on ESR from May(13-Apr-2023), Quarterly contract review meetings with new provider(13-Apr-2023), Monthly Service review meetings with new provider(13-Apr-2023), Review of retired employees who gave notice Sept - Dec 2022(13-Apr-2023)	Low	Treat		13-Apr-2023
RSK-016	22-Sep-2021	IF there is a lack of flow in the organisation THEN there may be an unsafe environment for patients	LEADING TO a potentially impact on bed space capacity, ambulance queues, missed Emergency Access Targets and overcrowding into ED/radiology corridors creating Health & Safety hazard and continued pressure, leading to poor patient care/treatment, nursing patients outside of cubicles in corridors and the middle of majors,and delays in discharge/transfer and the potential for an increase of incidents being reported regarding assessment/care/treatment, and or significant number of patients with a high acuity/ dependency being cared for in areas that are not suitable for safe care	Organisation		Kirsty McKenzie-Martin	16-Jun-2023	14-Jun-2024	Planned	25	15	6	Recruitment drive for more nurses/HCA's ongoing. Active management of Nursing/Consultant and Registrar gaps in rota daily to ensure filled. (16-Jun-2023), Walking majors and resus reconfigured. Expanded Cubicle space in Majors - extra 10 spaces, increased capacity using Acorn Suite., Internal escalation policy in place. CSU lead developing trust escalation criteria to alert trust leads to problems sooner - diverting patients to; Ambulatory care, Since Covid pandemic, phasing plan in place with red and green zones within ED., Escalation plan for ED to mitigate patient pressures	EPIC consultant in place to aid flow within department and speed up decision making(22-Sep-2021), RAT-ing process and specialty referrals having a RAG system developed to prioritise sickest patients to be assessed.(22-Sep-2021)	Low	Treat	No change	07-Mar-2016
RSK-019	22-Sep-2021	IF there is an increased number of incidents of violence and aggression in Emergency Department THEN there will be an impact on patient safety, staff mental and physical health	LEADING TO an increased risk of physical or verbal damage to staff or other patients, risk of delay in care whilst incidents resolved; potential for litigation or claims dependent on harm; Increased staff sickness rate, poor retention and recruitment of staff; negative impact on Trust reputation; poor patient experience	Region	Emergency Department	Sushant Tiwari	15-Jun-2023	10-Dec-2023	Planned	12	15	8	Police panic button in reception and majors, unacceptable behaviour posters + national abuse posters (15-Jun-2023), Security forum for Trust (22-Sep-2021), Review of Reception (15-Jun-2023)	CCTV cameras in place (dead spot remains in "Streaming")(22-Sep-2021), Conflict Resolution training(22-Sep-2021), Incidents reviewed on Datix incident reporting system(22-Sep-2021)	Low	Treat	Risk reviewed by Risk Owner. This is an ongoing risk within the department. No change to risk	09-Mar-2009

Significant Risk Register

Reference	Created on	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-061	07-Oct-2021	IF Audiology staff have to manually input patient data into Auditbase (the Patient Management System for Audiology Services) as there is no link with e- care THEN there is risk of incomplete and inaccurate patient details on the Auditbase system.	LEADING TO the potential for deceased patients being contacted for appointments. Appointment letters may be sent to incorrect addresses and therefore missed appointments Increased temporary and duplicate patient numbers on Auditbase Possible breaching as clinical time is being used for entering patient demographics Clinical governance breaches due to incorrect patient information Loss of income Adverse publicity Adverse effect on morale of all Audiology staff	Region	Head & Neck	Jane Grant	05-Jun-2023	05-Jul-2023	Pending	12	15	4	Implementation of Auditbase e-care integration	A working group is being set up with H&N to address issues within the service.(07-Oct-2021), The Auditbase upgrade had now taken place and is functioning well. - It is expected that Audiology will start diaglogue with IT to undertake work relating to the link could commence. - Ensuring datix incidents related to this risk are logged and acted upon. - Manual data input is a consequence of the failure of the PAS interface. - Not accepting medical students in Audiology - CEO advised of this in email 15.7.19 from Head of Audiology Services.(07-Oct-2021), IT Request form submitted (24.4.2022) for the development with Auditdata of an interface between Auditbase and e-care: 1. To enable demographics to be downloaded from e- care onto Auditbase when a new patient is registered on Auditbase 2. To automatically update demographics on Auditbase when there are changes to demographics on e-care 3. To download results of hearing tests from Auditbase into a results section within e-care(07-Oct-2021), Audiology staff have to manually input patient data into Auditbase(27-Apr-2022), Auditbase eCare integration(24-Nov-2022),	Low	Treat	Purchase order completed but work not due to start until end of July 2023	20-Nov-2017
RSK-067	12-Oct-2021	IF there continues to be vacancy gaps for experienced schedulers/patient pathway staff; and staff who do not have the necessary knowledge and skills required to support Ophthalmology (a specialist area) THEN there is the potential for delays, loss of income, lack of continuity to patient pathways, decreased activity and increased complaints.	LEADING to potential removal of patients from waiting lists, loss of clinical validation of screening programme patients being actioned and staff with no formal training affecting staff morale.	Region	Head & Neck	George Belgrove	26-Jun-2023	30-Jun-2023	Pending	20	15	4	Additional admin required to help with PTL validation and additional reception support to help manage the workload	Preventative & mitigating controls - Weekly meeting with PPC about bookings and highlighting of concerns from meeting. -review of patients who had been revalidated - plan to discuss issues with patient access team(12-Oct-2021), New coordinator in post.(12-Oct-2021), GAPS: 17/05/2021 although new coordinator in post team still reports some appointments are not actioned in a timely manner, staff are now receiving training on booking. 30/03/2021 team reported incidents with harm to patients therefore risk to remain at current rating and level. - Admin errors are occurring - letters sent to wrong patients, clinics over/under booked - part time staff in post insufficient to meet service needs.(12-Oct-2021), service manager for Ophthalmology starting to oversee the service more closely so will be able to pick up and highlight admin issues(24-Aug-2022)	Low	Treat	Risk Reviewed at Ophthalmology CIG meeting 27/03/2023 - Team also requests risk 067 – be increased as there are gaps in admin staff & knowledge to support the service. The level of harm should be increased to 5 due to potential loss of sight for patients.	30-Mar-2021
RSK-101	25-Oct-2021	IF the maternity service at MKUK do not have their own dedicated set of theatres. THEN maternity are left vulnerable to not having a guaranteed emergency theatre available 24hrs a day.	LEADING TO increased risk of poor outcome for mothers and babies if theatre delay; Psychological trauma for staff dealing with potentially avoidable poor outcome; Financial implication to the trust	Region	Women's Health	Melissa Davis	21-Jun-2023	30-Sep-2023	Planned	15	15	6	Hospital new build to include Maternity theatres, SOP developed to support in the incidence where two theatres are required	Escalation policy available for staff to use in situations where a 2nd theatre is needed by can not be opened(27-Apr-2022), Elective Caesarean work is completed the Theatre 1 during a booked morning session, Theatre 3 is set for obstetric emergencies.(01-Sep-2022)	Low	Treat	No change to risk.	06-Sep-2021
RSK-111	26-Oct-2021	IF there is a national shortage of midwives THEN there may be insufficient midwives to provide for the needs of MKUH patients	LEADING TO a local negative impact on delivering excellent patient care, patient experience and staff experience.	Region	Women's Health	Melissa Davis	21-Jun-2023	31-Aug-2023	Planned	16	15	6	Implement Ockenden 2 (Recalculated headroom/gap) (18-Jun-2023), Business case for future funding of birth rate+ to be developed. (18-Jun-2023), Business case to be taken to board for agreement. (18-Jun-2023), MSW project (18-Jun-2023)	There are significant efforts to recruit new midwives.(26-Oct-2021), The early recognition by GOLD and the Chief Executive to advertise for new midwives following the Ockenden report.(26-Oct-2021), Also working with NMC to achieve PIN numbers early for newly qualified staff.(26-Oct-2021), Enhanced bank rates.(26-Oct-2021), Rolling job advert for band 5/6 clinical midwives(27-Apr-2022), Review establishment birth rate+ report(27-Apr-2022), Workforce retention and recruitment plan(13-Jan-2023), Midwifery workforce plan(13-Jan-2023), Interview and offer shortened MW course places(13-Jan-2023)	Low	Treat	No change to score. Business case ready for submission.	13-Dec-2022

Significant Risk Register

Reference	Created on	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-170	12-Nov-2021	IF the Autoclave machines are not replaced THEN there is a risk that the Pathology department will be unable to sterilise bio-hazardous laboratory waste prior to discarding. Accumulation of waste potentially infective, bad odour, and consuming much needed space. External contractors can remove category 1 and 2 waste only, category 3 waste cannot be removed from the site without being processed through the autoclave.	LEADING TO Health & safety risk to the laboratory staff; Failure to meet COSHH regulations in relation to waste management and autoclave of all HG3 known and suspected biological agents/clinical materials waste; potential disruption to the service; potential to affect Trust's reputation; accumulation of waste products; limiting user of autoclave to preserve lifespan	Region	Diagnostic & Screening	Imran Sheikh	08-Jun-2023	07-Jul-2023	Planned	12	15	5	Ensure robust Autoclave contingency plan to deploy contractors to collect and manage hazardous waste is tried and tested (08-Jun-2023)	PPE; Gloves, safety goggles, ear defenders and Lab coat worn at all times, with good hand hygiene practice. Heavy duty gloves, full face visor and apron must be worn when unloading.(12-Nov-2021), Health & Safety training and competency procedures for all staff working with HG3 waste and the autoclaves.(12-Nov-2021), The autoclave maintenance is performed once per week to regularly check working order and functionality.(12-Nov-2021), Business Case Development for replacement/repair of autoclaves(11-May-2022), Autoclave thermometric tests and calibrations to ensure correct processing of load. Checking printout of every run to ensure process passed. Only authorised staff to work on autoclaves.(12-Sep-2022), 2nd autoclave being used to supply spares – these will run out(12-Sep-2022), Report deficiencies to Estates. Report incidents onto RADAR and escalate to senior management team(12-Sep-2022), Waste is being segregated in to two waste streams to ensure only HG3 waste is autoclaved to reduce	Low	Treat	Further discussion with estates have taken place around building work and planning for replacement. Latest update is that both will need to be replaced at the same time therefore risk and impact need to be considered.	10-Jul-2022
RSK-250	26-Nov-2021	IF staff across MKUH continue to use eCARE in the same way, that the volumes of requests made to the IT Department remain at their current rate, and the volume of change and project work continues at the current volume THEN the IT Department will become less responsive and a range of functions within eCARE will continue to be left without action	LEADING TO increased clinical risk, increased risk to performance of eCARE, potential disruption to staff, and delays in the deliver or projects and realising their benefits	Organisation		Craig York	03-May-2023	31-Aug-2023	Planned	15	15	3	Identification of staff time and resources (11-Apr-2023), Business case being written by the end of spring 2023 to identify the amount of staff time required., Review volumes against historical figures to reflect reality of challenge. Include in business case. Consider additional posts for all.	Prioritisation of workload is in place to cover the most impacting of issues or projects, however this only reduces the potential impact slightly(26-Nov-2021)	Low	Treat	Volume of work is increasing month on month without additional staff to support.	25-Jan-2023
RSK-271	30-Nov-2021	IF there is insufficient space within the Medical Equipment Library (MEL) THEN MEL staff will be unable to carry out the required cleaning process to comply with the appropriate guidelines set by CQC and MHRA	LEADING TO Lack of cleaning and processing space due to the growth of the MEL over the years means not keeping unprocessed and processed equipment separately, not complying with CQC Regulation 15: Premises and equipment and MHRA Documentation: Managing Medical Devices January 2021	Region	Estates	Ayca Ahmed	13-Mar-2023	30-Jun-2023	Pending	15	15	3	The MEL dept relocation is on the draft capital plan under estates (08-Jun-2023)	Staff members are taking processed equipment straight to the shelving areas as soon as it is cleaned to avoid cross contamination. This ensure equipment is kept separate, but this is not a productive method of working(30-Nov-2021), Issue has been raised at Space Committee (June 2021)(30-Nov-2021), 2019-2020 Additional office has been provided, outside of the main department for the Service Manager and the Equipment training Auditor. This has created some additional space for the Library(30-Nov-2021), 2019-2020 Additional storage provided outside of main department in the location of a storage facility within a staircase approved and provided for a number of services under an approved Business Case on the Capital Programme(30-Nov-2021)	Medium	Treat	Reviewed by Medical Devices Manager, no change to risk rating.	23-Aug-2020
RSK-324	09-Feb-2022	IF there are significant nursing vacancies within the Paediatric Unit, including Maternity Leave and Long-Term Sickness - we are currently 29% of permanent staff roles unfilled- this is being partially mitigated with use of regular Agency and Bank staff THEN there will not be sufficient/safe numbers of nursing staff to cover shifts.	LEADING TO an increased risk for children's safety due to the absence of permanent skilled staff; an increased use of agency; an increasing number of shifts that do not comply with national recommended safe staffing levels	Region	Child's Health	Helder Prata	26-Jun-2023	31-Jul-2023	Planned	15	15	9	Establishment Review to be completed (25-Apr-2023)	We are using regular Paediatric Agency and Bank staff to fill gaps wherever possible, we are planning a minimum of 50% of permanent staff on each shift. We are constantly advertising and interviewing for replacement staff- we are steadily recruiting. We are effectively managing Long term sickness in accordance with Trust guidance and with the input of HR(09-Feb-2022)	Low	Treat	Triumvirate review, score remains the same	19-Dec-2022

Significant Risk Register

Reference	Created on	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-343	23-May-2022	If there is insufficient dietetic staff in post THEN the service may be unable to meet referrals demand	Leading to patients not receiving dietetic input as needed, which could result in: - Insufficient dietetic education for adults with complex nutritional issues, including adults with diabetes, gastrointestinal disease, those either malnourished or at risk of malnutrition needing nutritional support etc. - Reduction in patient experience and poorer outcomes - MDT will not work effectively as insufficient dietetic input, increasing workload of other members of MDT - Patients with long term conditions such as Diabetes, CHD etc will not have the support to develop the skills for independence and self-management to achieve good health outcomes	Region	Therapies	Elizabeth Pryke	20-Jun-2023	24-Jul-2023	Planned	15	15	9	Recruit Band 6 Dietitian	Triaging patient referrals based on clinical need Daily team huddle to try and manage this and ensure communication is good across the team Advised ward staff so they can start first line nutritional support(23-May-2022), Setting up weekend telephone clinic(23-May-2022), Patients triaged as more urgent will be seen - reduced service communicated to senior nurses, consultants etc(14-Jun-2022), Patients triaged as more urgent will be seen - reduced service communicated to senior nurses, consultants etc(14-Jun-2022), Locum started to provide x 2 clinics / week(29-Jun-2022), Locum Dietitian working remotely To go back out to advert for B6 Dietitian(05-Feb-2023)	Low	Treat	Recruited to 1 wte B6 post, starter needs to give 3 months notice. Further post out to advert. Continuation of locum post until Sept 23.	02-May-2022
RSK-388	17-Oct-2022	IF Audiology Services do not get a second testing room equipped for the testing of younger and complex children. This area must be accessible for wide wheelchairs THEN there will be a delay in offering appointments to these children	LEADING TO delayed diagnosis, delayed treatment, delayed management and diagnostic breaches.	Region	Head & Neck	Jane Grant	22-Jun-2023	05-Jul-2023	Pending	15	15	4	Second testing room equipped for the testing of younger and complex children	Current room being used to full capacity.(17-Oct-2022), Contact Estates and external company to explore options for conversion of workshop on Level 4 to testing facility(17-Oct-2022)	Low	Treat	Quote was received and sent to Jennifer Kearney 14.2.2023 but acknowledgement or response to the email has been received.	22-Sep-2022
RSK-406	09-Dec-2022	IF there is a global shortage of electronic components THEN this can impact the lead times for delivery of medical equipment	LEADING TO to inability to replace/repair aged equipment used to monitor and support patients during their hospital care.	Organisation		Ayca Ahmed	13-Mar-2023	30-Jun-2023	Pending	25	15	10	Surgery Division to carry out a risk assessment and build it in their contingency plan (23-May-2023), Medicine Division to carry out a risk assessment and build it in their contingency plan (23-May-2023), Women's & Children's Division to carry out a risk assessment and build it in their contingency plan (23-May-2023), Core Clinical Services Division to carry out a risk assessment and build it in their contingency plan (23-May-2023)	Medical Devices Manager (MDM) is in liaising with suppliers for delivery per each approved BC for medical equipment procurement and providing support/advice to each division lead(09-Dec-2022), Clinical Contingency arrangement(09-Dec-2022), Finance lead for Business Cases is reminding all attendees at each meeting to get the Business Cases ready(09-Dec-2022), Wards/depts are borrowing from another ward/dept within the Trust as a normal practice or lease, rent, arrange a loan via any other supplier(09-Dec-2022), The advice on alternative suppliers are available via the MDM(09-Dec-2022), Procurement has a list from the NHSSC route advising on delivery lead times(09-Dec-2022), Regular inspection and maintenance of current equipment(09-Dec-2022), Rolling programme of equipment replacement regularly reviewed and issues escalated at early stage(09-Dec-2022)	Low	Treat	Risk approved onto the Corporate Risk Register at RCB	11-Nov-2022
RSK-420	17-Jan-2023	IF the ward environment of Ward 23 is not fit for purpose THEN the will be reduced visibility and observation of patients, increased risk of patient falls, reduced ability to work as a team, delays in patient care, lack of room to manoeuvre/use equipment, staff may have to escalate emergencies via telephone, delay in identifying which space call bell has been activated in, increased risk of self-harm, increased risk of confidential information being inappropriately shared, lack of sluice, increased risk of infection/cross contamination, inability to control temperature levels	LEADING TO increased risk of harm to patient, increased length of stay, compromise in medical condition / slow rehabilitation, increased risk of falls, lack of privacy/dignity, increased infection rate, negative impact on staff morale, anxiety/stress, health-related concerns, increased staff absence/turnover, increased risk of moving/handling injuries,	Region	Musculoskeletal	Patricia Flynn	07-Jun-2023	24-Jun-2023	Overdue	15	15	15	Recruitment of staff	Establishment of staff to allow for a nurse or HCA to be in a bay at any one time so far as can(17-Jan-2023), Call bells for patients to use when needing help from staff, emergency buzzers in case of emergency situation.(17-Jan-2023), Establishment of staff to ensure that two members of staff are always in bay 7(17-Jan-2023), Barriers around open area(17-Jan-2023), Staff using yellow bags to cover any bodily fluids that need to be taken to the sluice(17-Jan-2023), Small supply of continence products kept near side rooms(17-Jan-2023), Doors of side rooms kept close to reduce risk of infection(17-Jan-2023), Appointments booked to minimise amount of people waiting in corridors(17-Jan-2023), Fans in rooms however only circulating warm air(17-Jan-2023), Redevelopment / Redesign of bays and bathrooms to accommodate required equipment and suitability for patient group(17-Jan-2023), Additional sluice and storeroom(17-Jan-2023), Additional tea trolley for side room areas(17-Jan-2023), Installation of air conditioning in the side rooms(17-Jan-2023)	Low	Treat	Risk reviewed at Specialty Medicine CIG - No change to risk. Risk owner to be changed to Suzanne Raven	07-Jul-2022

Significant Risk Register

Reference	Created on	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-450	18-Apr-2023	IF the Trust cannot scan CTG traces into services user records within 1 month THEN there is a risk CTG's are not available on EDM for review if the patient presents to any maternity area and/or, CTG traces are unavailable on EDM for case review/audit/investigation/ birth reflections/ evidence/ inquest/legal and/or, CTG traces are not stored in a logical order such as Date of Birth or surname alphabetical order and/or, A loss of records	LEADING TO Service user information not being available at the time care is being provided and/or, Learning/ improvement/ complaints/ financial/legal/ reputational impacts	Region	Women's Health	Katie Selby	21-Jun-2023	30-Sep-2023	Planned	15	15	6	Purchase and implementation of a flatbed scanner with a view to increasing to two scanners (18-Jun-2023)	Flat bed scanners (2) ordered(18-Apr-2023), Increase staffing capacity to close backlog of CTGs to be scanned into EDM(18-Apr-2023), Request CTGs from medical records(03-May-2023)	Medium	Treat	Second scanner arrived - no update on scanning backlog. Risk remains the same.	11-Apr-2023
RSK-459	27-Jun-2023	IF there is insufficient capacity to maintain a core team of trained radiographers THEN there will be a decreasing number of trained CT staff within the department.	LEADING TO a potential inability to provide a 24-7 emergency CT service	Region	Diagnostic & Screening	Michael Pashler	28-Jun-2023	27-Jul-2023	Planned	15	15	4	Employ agency staff to cover substantive staff, Recruit substantive staff to increase capacity for training	Offering fast-track training to allow staff to volunteer for extra duties to facilitate training(28-Jun-2023)	Low	Treat		27-Jun-2023

Meeting Title	Trust Board of Directors	**Date:** 06 July 2023
Report Title	Board Assurance Framework	**Agenda Item Number:** 10
Lead Director	Kate Jarman, Director of Corporate Affairs and Communication	
Report Author	Kwame Mensa-Bonsu, Trust Secretary	

Introduction	Assurance Report		
Key Messages to Note	The document remain under development and the Committee is asked to review and make recommendations as appropriate. **A. Revised Risk Score** The score for **Risk 1** (page 7) – related to the 'staffing levels' – has been revised downwards from 15 to 10 due to increased staffing numbers in the Trust. **B. Updated Commentary (Highlighted)** The commentary on **Risk 5** (page 18) – related to the 'suboptimal head and neck cancer pathway' – has been updated to indicate there are ongoing delays in OUH providing a response to NHSE on the potential way forward and the suboptimal process in terms of collaboration / engagement with MIKUH on the proposed service model.		
Recommendation *(Tick the relevant box(es))*	**For Information** x	**For Approval** ☐	**For Review** x

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

Report History	None
Next Steps	Trust Board of Directors, July 2023
Appendices/Attachments	Board Assurance Framework

The Board Assurance Framework

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

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

Strategic Objectives

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

Risk treatment strategy: Terminate, treat, tolerate, transfer

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

Assurance ratings:

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

5X5 Risk Matrix:

		Consequence How severe could the outcomes be if the risk event occurred? →				
		1 Insignificant	2 Minor	3 Significant	4 Major	5 Severe
Likelihood What's the chance the of the risk occurring? ↑	5 Almost Certain	5 Medium	10 High	15 Very high	20 Extreme	25 Extreme
	4 Likely	4 Medium	8 Medium	12 High	16 Very high	20 Extreme
	3 Moderate	3 Low	6 Medium	9 Medium	12 High	15 Very high
	2 Unlikely	2 Very low	4 Low	6 Medium	8 Medium	10 High
	1 Rare	1 Very low	2 Very low	3 Low	4 Medium	5 Medium

Board Assurance Framework 2022-2023

The Board held a dedicated seminar on risk and the BAF in October 2022. This was to embed understanding among new members of the Board on the Trust's risk management processes, and to review the risks on the BAF, as part of a regular review.

In reviewing other Trust BAFs, particularly those recently evaluated through the Care Quality Commission Well Led process, recommendations to split BAF risk into immediate and medium/ long term was made and accepted by the Board to enable more robust management of immediate risk, and support risk horizon scanning.

The product of that seminar was a new set of recommended risks. These are described below. The next step for development is to work through the Committees and Executive to present a full new BAF at the January 2023 Trust Executive Group and public Board.

Next Six to 12 Month Risk Profile (2023)

The feedback from the three Board risk seminar groups (shown below) has been distilled into five key risks against the achievement of the Trust's strategic objectives in the immediate term. These are as follows:

1. **Insufficient staffing to maintain safety**
2. **Patients experience poor care or avoidable harm due to delays in planned care**
3. **Patients experience poor care or avoidable harm due to inability to manage emergency demand**
4. **Insufficient funding to meet the needs of the population we serve**
5. **Suboptimal head and neck cancer pathway**

Group feedback (six-month to 12-month risk profile):

Group 1	Group 2	Group 3
• Staffing and capacity to meet demand • Care assurance consistency under pressure • Managing demand • Environmental conditions • Potential strike action	• Strike action • Covid • Emergency experience linked to waiting times and actual experience • General staffing • Winter capacity	• Shortage of clinical staff • Strikes • Cost of living crisis • Avoidable harm due to delays • Maternity - external perspective of services • Service provision failings due to capacity and staffing

Six-Month to 12-Month Risk Profile

Likelihood (What's the chance the of the risk occurring?)	Consequence (How severe could the outcomes be if the risk event occurred?) 1 Insignificant	2 Minor	3 Significant	4 Major	5 Severe
5 Almost Certain	5 Medium	10 High	15 Very high	20 Extreme	25 Extreme
4 Likely	4 Medium	8 Medium	12 High	16 Very high	20 Extreme
3 Moderate	3 Low	6 Medium	9 Medium	12 High	15 Very high
2 Unlikely	2 Very low	4 Low	6 Medium	8 Medium	10 High
1 Rare	1 Very low	2 Very low	3 Low	4 Medium	5 Medium

	1 Insignificant	2 Minor	3 Significant	4 Major	5 Severe
5 Almost Certain					
4 Likely					
3 Moderate					
2 Unlikely					
1 Rare					

RISK 1: Insufficient staffing levels to maintain safety

Strategic Objectives

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

Strategic Risk	If staffing levels are insufficient in one or more ward or department, then patient care may be compromised, leading to an increased risk of harm						
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	Tracker 25 5 -15 April May June Score Target
Executive Lead	Director of Workforce	**Consequence**	5	5	**Risk Appetite**	Avoid	
Date of Assessment	December 2022	**Likelihood**	2	1	**Risk Treatment Strategy**	Treat	
Date of Review	06/06/2023	**Risk Rating**	10	5	**Assurance Rating**		

Cause	**Controls**	**Gaps in Controls**	**Action Required**	**Sources of Assurance**	**Gaps in Assurance**	**Action Required**
1. Increasing turnover 2. Sickness absence (short and long term) 3. Industrial action	Staffing/Roster Optimisation • Exploration and use of new roles. • Check and Confirm process	• Processes in development and review, yet to embed fully	• Complete embedding of processes	**First line of defence:** Active monitoring of workforce key performance indicators.	**First line of defence:**	

Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
4. Inability to recruit	• Safe staffing, policy, processes and tools Recruitment • Recruitment premia • International recruitment • Apprenticeships and work experience opportunities. • Use of the Trac recruitment tool to reduce time to hire and candidate experience. • Rolling programme to recruit pre- qualification students. • Use of enhanced adverts, social media and recruitment days • Rollout of a dedicated workforce website • Creation of recruitment "advertising" films • Targeted recruitment to reduce hard to fill vacancies.	• Lack of Divisional ownership and understanding of safe staffing and efficient roster practices • Monitoring Divisional processes to ensure timely recruitment • Focused Executive intervention in areas where vacancies are in excess of 20% • Increased talent management processes	• Divisional ownership of vacancies, staffing and rostering practices • Workforce team monitor vacancies to ensure recruitment taking place • Executive oversight of areas with vacancies in excess of 20% • Talent management strategy refreshed and revised			
				Second line of defence: Annual Staff Survey	**Second line of defence:**	
				Third line of defence: Internal audit	**Third line of defence:**	

Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
	Retention • Retention premia • Leadership development and talent management • Succession planning • Enhancement and increased visibility of benefits package • Schwartz Rounds and coaching collaboratives. Onboarding and turnover strategies/reporting • Learning and development programmes • Health and wellbeing initiatives, including P2P and Care First • Staff recognition - staff awards, long service awards • Review of benefits offering and assessment against peers					

RISK 2: Patients experience poor care or avoidable harm due to delays in planned care

Strategic Objectives

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

Strategic Risk	If emergency or elective care pathways are delayed, then patients will wait longer to access treatment, leading to potential risk of harm						
Lead Committee	Quality & Clinical Risk, TEC	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	**Trend: INCREASING**
Executive Lead	Chief Operating Officer	**Consequence**	5	5	**Risk Appetite**	Avoid	
Date of Assessment	December 2022	**Likelihood**	4	2	**Risk Treatment Strategy**	Treat	
Date of Review	Monthly	**Risk Rating**	20	10	**Assurance Rating**		

Cause	**Controls**	**Gaps in Controls**	**Action Required**	**Sources of Assurance**	**Gaps in Assurance**	**Action Required**
1. Overwhelming demand for emergency care	Clinically and operationally agreed internal escalation plan with surge capacity.	Staffing vacancies in different professions required to meet specific needs. Unplanned short term	Ongoing recruitment drive and review of staffing models and skill mix. International recruitment Bank and agency staffing	**First line of defence:** Internal escalation meetings with performance monitoring of key indicators.	**First line of defence:**	

	System agreed escalation plan driven by OPEL status and related actions. Emergency admission avoidance pathways, Ongoing development of SDEC and ambulatory care services. Integrated discharge team working. ED performance dashboard available on Trust intranet. Daily review of ED breach performance New clinical standards for ED.	sickness absence. Increased volume of ambulance conveyances and handover delays. Admission areas and flow management issues.	deployed Increase availability of HALO. Maximise potential of discharges with partner agency and escalate where issues.	Designated OPEL status agreed across the MK system daily. **Second line of defence:** • System escalation calls to challenge discharge. • Multi-agency Discharge Events (MaDEs) • ICB and regional scrutiny on poor performance **Third line of defence:** • MK Improving System Flow redesign project • Audit, accreditation & national benchmarking. • Regional and national intervention on poor performance. • Independent assurance		
2. Inability to treat elective (planned) patients due to emergency demand	Daily bed management of the hospital site to ensure both elective and emergency pathways are maintained in equilibrium with Executive oversight. Effective daily discharge processes to	Another COVID or equivalent pandemic. Resilience and wellbeing of staff and need for A/L and rest. Limitations to what independent sector	Due diligence in IPC procedures and uptake of national vaccination programme.		**First line of defence;** **Second line of defence:** **Third line of defence**	

	keep elective capacity protected and avoid cancellations – Board rounds. Additional WLI initiatives where there is resource and capacity to maintain reduction of the pandemic induced backlog.	providers can take. Set up time for services off site. Mutual aid via neighbouring Trusts.		• **First line of defence:** Internal escalation meetings with performance monitoring of key indicators. • Designated OPEL status agreed across the MK system daily. • **Second line of defence:** Specialty validation and weekly PTL meetings. • ICB & regional scrutiny via performance meetings. • **Third line of defence:** National		
3. Patients delayed in elective backlogs (including cancer)	Routine and diligent validation and clinical prioritisation of patient records on waiting lists. Daily/Weekly management of PTL (patient tracking list) up to Executive level. Restore and recovery weekly cancer meetings. Clinical reviews and full harm review of long	Capacity and available resource to meet the demand post pandemic. Commissioning challenges to meet the required local demand of patient needs. Capacity limitations to meet demand in other providers (health and social care).	Additional investment and capacity been sourced through alternative options outside the Trust, supported by the Cancer Alliance.			

	waiting patients, including root cause analysis (RCA). Limited diagnostic capacity to service the demand. Repatriation of outsourced capacity in 2023 – 2024.			performance profile monitoring. • External intervention from national teams via the tiering process.		
4. Inability to discharge elective patients to onward care settings.	Daily review and MK system call of all Non-Criteria to Reside patients.	Capacity limitations to meet demand in other providers (health and social care).	Spot purchase additional capacity within MK. Send patients out of area ICB support processes.			

RISK 3: Patients experience poor care or avoidable harm due to inability to manage emergency demand

Strategic Objectives

1. **Keeping you safe in our hospital**
2. **Improving your experience of care**
3. **Ensuring you get the most effective treatment**
4. **Giving you access to timely care**
5. Working with partners in MK to improve everyone's health and care
6. Increasing access to clinical research and trials
7. Spending money well on the care you receive
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Strategic Risk	If there is overwhelming demand for emergency care on successive days, then patients will not receive timely care, leading to the potential for harm						
Lead Committee	Quality & Clinical Risk Committee	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	**Trend: INCREASING**
Executive Lead	Chief Operating Officer	**Consequence**	5	5	**Risk Appetite**	Avoid	
Date of Assessment	December 2022	**Likelihood**	4	2	**Risk Treatment Strategy**	Treat	
Date of Review	Monthly	**Risk Rating**	20	10	**Assurance Rating**		

Cause	**Controls**	**Gaps in Controls**	**Action Required**	**Sources of Assurance**	**Gaps in Assurance**	**Actions Required**
1. Inadvertently high demand of emergency presentations on successive days 2. Overwhelm or service failure	Adherence to national OPEL escalation management system Clinically risk assessed escalation areas available.	Higher than normal staff absences and sickness Increased volume of ambulance conveyances and	Redeployment of staff from other areas to the ED at critical times of need. Appropriate	**First line of defence:** 1. Daily huddle /silver command and hospital site meetings in hours. 2. Out of hours on		Reduce occupancy Increase front door capacity

(for any reason) in primary care 3. Overwhelm or service failure (for any reason) in mental health (adult of child) services)	Surge plans, COVID-specific SOPs and protocols have been developed. Continued development of Emergency admission avoidance pathways, SDEC and ambulatory care services.	handover delays. Overcrowding in waiting areas at peak times. Admission areas and flow management issues. Reduction in bed capacity / configuration.	enhancement of clinical staff numbers on current rotas Services and escalation plans under continuous review in response to shrinking pandemic numbers and related non covid pressures Effective reduction in LOS and other metrics which are falling outside national benchmarking.	call management structure. 3. Major incident plan **Third line of defence:** 1. Regional or national intervention via ECIST and Tiering		Increase staffing Increase discharge profile with system partners Increase vaccine uptake in the community

RISK 4: Insufficient funding to meet the needs of population we serve

Strategic Objectives

1. **Keeping you safe in our hospital**
2. **Improving your experience of care**
3. **Ensuring you get the most effective treatment**
4. **Giving you access to timely care**
5. Working with partners in MK to improve everyone's health and care
6. Increasing access to clinical research and trials
7. **Spending money well on the care you receive**
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Strategic Risk	If there is insufficient, then the Trust may be unable to meet financial plans and targets or deliver its strategic aims, leading to service failure and regulatory intervention						
Lead Committee	Finance & Investment Committee	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	**Trend: INCREASING**
Executive Lead	Director of Finance	**Consequence**	5	5	**Risk Appetite**	Avoid	
Date of Assessment	December 2022	**Likelihood**	4	2	**Risk Treatment Strategy**	Treat	
Date of Review	01/06/23	**Risk Rating**	20	10	**Assurance Rating**		

Cause	**Controls**	**Gaps in Controls**	**Action Required**	**Sources of Assurance**	**Gaps in Assurance**	**Action Required**
The current NHS capital regime does not provide adequate certainty over the availability of strategic capital finance.	The Trust has established management processes to prioritise investment of available capital resources to manage emerging risk and safety across the hospital.	The Trust does not directly control the allocation of operational or strategic NHS capital finance.	Continued review of capital spend against available resources. Close relationship	**First line of defence:** Internal management capital oversight provided by capital scheme leads.	**First line of defence:** Limited oversight of ICS capital slippage until notified by partner organisation	Proactive monitoring of ICS partner and East of England regional capital expenditure reporting.

The capital budget available for 2023/24 is not sufficient to cover the planned depreciation requirement for operational capital investment. Consequently, it is difficult to progress investment plans in line with the needs of the local population without breaching the available capital budget.	The Trust is responsive in pursuing additional central NHSE capital programme funding as/when additional funding is available. The Trust is agile in responding to late notified capital slippage from across the ICS and wider region to take advantage of additional capital budget.	The ICS has limited control on the allocation of operational capital.	management of key external partners (NHSE).	**Second line of defence:** • Monthly Performance Board reporting • Trust Executive Committee reporting • Finance and Investment Committee reporting **Third line of defence:** • Internal Audit Reporting on the annual audit work programme. • External Audit opinion on the Annual Report and Accounts.		

RISK 5: Suboptimal head and neck cancer pathway

Strategic Objectives

1. **Keeping you safe in our hospital**
2. **Improving your experience of care**
3. **Ensuring you get the most effective treatment**
4. **Giving you access to timely care**
5. Working with partners in MK to improve everyone's health and care
6. Increasing access to clinical research and trials
7. Spending money well on the care you receive
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Strategic Risk	If the pathway for patients requiring head and neck cancer services is not improved, then users of MKUH services will continue to face disjointed care, leading to unacceptably long delays for treatment and the risk of poor clinical outcomes						
Lead Committee	Quality & Clinical Risk	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	30 20 10 0 Dec Jan Feb Mar Apr May June Score Target
Executive Lead	Medical Director	**Consequence**	5	5	**Risk Appetite**	Avoid	
Date of Assessment	December 2022	**Likelihood**	4	2	**Risk Treatment Strategy**	Treat	
Date of Review	19/06/2023	**Risk Rating**	20	10	**Assurance Rating**		

Cause	**Controls**	**Gaps in Controls**	**Action Required**	**Sources of Assurance**	**Gaps in Assurance**	**Action Required**
MKUH does not provide head and neck cancer services but acts as a spoke unit to the hub at Northampton. Northampton faces:	MKUH clinicians have escalated concerns (both generic and patient specific) to the management team at Northampton. MKUH clinicians are advocating 'mutual aid from other	No reliable medium to long term solution is yet in place (no definitive position has yet been made by commissioners)	Ongoing safety-netting for patients in current pathway	**First line of defence:** Number and nature of clinical incidents	**Third line of defence:** Regional quality team or independent review of pathway	

Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
• Increased demand related to the pandemic; • Staffing challenges in the service • Reduced capacity as a consequence of having reduced the scope of work permissible at MKUH as the spoke site.	cancer centers (Oxford, Luton) where appropriate. The issue has been raised formally at Executive level, and with East of England specialist cancer commissioners Safety-netting for patients in current pathway CEO to regional director escalation Report into cluster of serious incidents produced by Northampton and shared with commissioners	Ongoing delays in response from OUH to NHSE on the potential way forward and the suboptimal process in terms of collaboration / engagement with MKUH on the proposed service model. Continued concerns with delays in patient pathways and a failure to fully implement the recommendations of the serious incident review investigation commissioned by NHS Midlands (reported November 2022).		**Second line of defence:** Coronial inquest		

RISK 6: If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.

Strategic Objectives

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

Strategic Risk	If the NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.						
Lead Committee	Finance & Investment Committee	**Risk Rating**	**Current**	**Target**	**Risk Type**	Financial	**Trend: INCREASING**
Executive Lead	Director of Finance	**Consequence**	4	4	**Risk Appetite**	Cautious	
Date of Assessment	March 2023	**Likelihood**	5	2	**Risk Treatment Strategy**	Treat	
Date of Review	01/06/23	**Risk Rating**	20	8	**Assurance Rating**		

Cause	**Controls**	**Gaps in Controls**	**Action Required**	**Sources of Assurance**	**Gaps in Assurance**	**Action Required**
Increase in operational expenditure initially in response to COVID-19 (sickness/enhanced cleaning etc.)	Internal budgetary review/financial performance oversight processes to manage/mitigate cost pressures	Ability to influence (negotiate) and mitigate inflationary price rises is modest at local level.	Work with ICS partners and NHSE to mitigate financial risk. Closely monitor	**First line of defence:** Financial performance oversight at budget	**First line of defence:** • Systematic monitoring of inflationary price changes in non-	Establish process for oversight of inflationary price

Additional premium costs incurred to treat accumulated patient backlogs. Prolonged premium pay costs incurred in a challenging workforce environment. Increase efficiency required from NHS funding regime to support DHSC budget affordability and delivery of breakeven financial performance. Risk of unaffordable inflationary price increases on costs incurred for service delivery. Affordability of 2023/24 planning objectives (e.g., backlog recovery) in context of draft financial regime for 2023/24	Financial efficiency programme identifies headroom for improvement in cost base. Close monitoring/challenge of inflationary price rises. Medium term financial modelling commencement with ICS partners. Escalation of key risks to NHSE regional team for support.	Effective local pay control diminished in a competitive market. No direct influence national finance payment policy for 2023/24 Limited ability to mitigate cost of non-elective escalation capacity	inflationary price rises and liaise with ICS and NHS England. Timely identification and escalation of emerging risks for management decision	holder and divisional level management meetings Vacancy Control Process for management oversight/approval Controls for discretionary spending (e.g., WLIs) Financial efficiency programme 'Better Value' to oversee delivery of savings schemes. BLMK ICS monthly financial performance reporting	pay expenditure. • Limited ability to directly mitigate demand for unplanned services.	changes. Closer working with national partners/other provider collaboratives to mitigate exposure to price increases.

Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
		No details known for 2023/24 funding and beyond. Ability to influence (negotiate) and mitigate inflationary price rises is modest at local level.	management of key external partners (NHSE) Awaiting publication of multi-year revenue settlement from NHS England and work with ICS partners to forward plan. Closely monitor inflationary price rises and liaise with ICS and NHS England.			
				Second line of defence: • Monthly Performance Board reporting • Trust Executive Committee reporting • Finance and Investment Committee reporting	**Second line of defence:**	

Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
				Third line of defence: • Internal Audit Reporting on the annual audit work programme. • External Audit opinion on the Annual Report and Accounts. • Local Counter Fraud reporting to Audit Committee • NHS England regional reporting (e.g., assessment of NHS provider productivity).	**Third line of defence:**	

Meeting Title	**Trust Board in Public**	**Date: 07 July 2023**
Report Title	**Audit Committee Meeting Summary Report – 18 April 2023**	**Agenda Item Number: 19**
Chair	*Gary Marven, (Non-Executive Director)*	
Report Author	*Timi Achom, (Corporate Governance Officer)*	

Key Messages to Note

1. Matters approved by the Committee/Recommended for Trust Board approval

The Committee approved policy changes to be applied to the 2022/23 Annual Accounts and approved write offs totalling £33k.

2. Items identified for escalation to Trust Board

a. The risk scores for the Capital and Revenue-related risk entries on the BAF had increased.

b. The BAF refresh had been progressed but needed to be completed prior to the completion of the 2022/23 Annual Report.

c. Significant Provisions: In relation to bank staff, contractors and other temporary or non-permanent staff, the Trusted needed to make adequate provision to mitigate the impact of the current wage settlement.

d. The Trust was on track to be provided with a positive 'amber-green' opinion when the draft HIAO was issued.

e. The Trust had, in 2022/23, significantly improved upon the completion of Internal Audit recommendations.

3. Summary of matters considered at the meeting

a. The Committee reviewed and noted the Significant Judgements Report which formed part of the preparation of the 2022/23 Accounts.

b. The Committee reviewed and noted the 2022/23 External Planning Report Update.

c. The Committee noted the noted the update on VFM (Value for Money) Assessment.

d. The Committee reviewed the progress made against the Internal Audit 2022/23 Work Plan

4. Highlights of Board Assurance Framework Review

The Committee reviewed and noted the Board Assurance Framework.

5. Risks/concerns (Current or Emerging) identified

N/A

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

	4. Giving you access to timely care *5. Working with partners in MK to improve everyone's health and care* *6. Increasing access to clinical research and trials* *7. Spending money well on the care you receive* *8. Employ the best people to care for you* *9. Expanding and improving your environment* *10. Innovating and investing in the future of your hospital*

Meeting Title	Trust Board in Public	Date: 06 July 2023
Report Title	**Audit Committee Meeting Summary Report – 25 May 2023**	**Agenda Item Number: 19**
Chair	*Gary Marven, (Non-Executive Director)*	
Report Author	*Timi Achom, (Corporate Governance Officer)*	

Key Messages to Note
1. Matters approved by the Committee/Recommended for Trust Board approval The Committee reviewed and approved the progress on 2022/23 Annual Accounts Audit process. The Committee agreed that the proposed BLMK ICS governance audit review should be stood down as it was not in the gift of the Trust to progress any recommendations thereof.
2. Items identified for escalation to Trust Board a. The 2022/23 Annual Report and 2022/23 Quality Account were progressing but against very tight deadlines. b. The External Audit of the 2022/23 External Audit was progressing well, according to both the External Auditors and the Trust's Finance Team. c. A comprehensive Internal Audit Workplan was reviewed and, subject to an agreed revision being completed, approved by the Committee.
3. Summary of matters considered at the meeting a. The Committee reviewed and noted the draft 2022/23 HIAO (Head of Internal Audit Opinion) report and agreed with the recommendations associated with the audit reviews. b. The Committee reviewed and approved the 2023/24 Internal Audit Workplan. c. The Committee reviewed the progress made on the 2022/23 External Audit process.
4. Highlights of Board Assurance Framework Review None
5. Risks/concerns (Current or Emerging) identified N/A

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	*1. Keeping you safe in our hospital* *2. Improving your experience of care* *3. Ensuring you get the most effective treatment* *4. Giving you access to timely care* *5. Working with partners in MK to improve everyone's health and care* *6. Increasing access to clinical research and trials*

	7. Spending money well on the care you receive *8. Employ the best people to care for you* *9. Expanding and improving your environment* *10. Innovating and investing in the future of your hospital*

Meeting Title	Trust Board in Public	Date: 06 July 2023
Report Title	**Audit Committee Meeting Summary Report – 23 June 2023**	**Agenda Item Number: 19**
Chair	*Gary Marven, (Non-Executive Director)*	
Report Author	*Timi Achom, (Corporate Governance Officer)*	

Key Messages to Note
1. Matters approved by the Committee/Recommended for Trust Board approval The Committee reviewed and approved the Analytical review of the Annual Accounts for 2022/23.
2. Items identified for escalation to Trust Board a. There were no identified items for escalation.
3. Summary of matters considered at the meeting a. The Independent External Auditors' report was noted. The Committee agreed there were no adjustments to the financial statement that have resulted in a monetary adjustment to the Trust's deficit position and noted action plan around improvement areas. b. The Committee reviewed and approved the Initial management response of the 2022/23 external audit report
4. Highlights of Board Assurance Framework Review None
5. Risks/concerns (Current or Emerging) identified N/A

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

Meeting Title	Trust Board in Public	Date: 06/07/2023
Report Title	**Finance and Investment Committee Summary Report – 07 March 2023**	**Agenda Item Number: 19**
Chair	*Heidi Travis, (Non-Executive Director)*	
Report Author	*Timi Achom, (Corporate Governance Officer)*	

Key Messages to Note
1. Matters approved by the Committee/Recommended for Trust Board approval - Salix Decarbonisation capital business case reviewed and recommended.
2. Items identified for escalation to Trust Board - NHS Shared Business Services contract - Allocate contract. - Salix Decarbonisation Business Case
3. Summary of matters considered at the meeting - The Trusts operational and financial performance up to January 2023. - An update on capital investment programme and the year-end forecast. - A 5-year extension with NHS Shared Business Services to include revised contract terms incorporating flexibility in robotic process automation and system development.
4. Highlights of Board Assurance Framework Review - The BAF – was being updated to incorporate the three lines of defence and would be presented at the April 2023 meeting.
5. Risks/concerns (Current or Emerging) identified - Funding - Availability of strategic capital funding and availability of sufficient revenue funding to meet the organisation's obligations.

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

Meeting Title	Trust Board in Public	Date: 06/07/2023
Report Title	**Finance and Investment Committee Summary Report – 04 April 2023**	**Agenda Item Number: 19**
Chair	*Heidi Travis, (Non-Executive Director)*	
Report Author	*Timi Achom, (Corporate Governance Officer)*	

Key Messages to Note
1. Matters approved by the Committee/Recommended for Trust Board approval - Emergency HCI Servers capital business case reviewed and recommended.
2. Items identified for escalation to Trust Board - Capital Business Case – Emergency Capital Approval for HCI Servers - Review of Forward Agenda Planner
3. Summary of matters considered at the meeting - The Trusts operational and financial performance up to February 2023. - An update on the Trusts 'length of stay' performance needed to be implemented to improve.
4. Highlights of Board Assurance Framework Review - The major risks highlighted were due to pressures on the 'availability of strategic capital funding' and on the 'availability of sufficient revenue funding to meet the organisation's obligations.
5. Risks/concerns (Current or Emerging) identified - Capital Business Case – Emergency Capital Approval for HCI Servers - Review of Forward Agenda Planner

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

Meeting Title	Trust Board in Public	Date: 06/07/2023
Report Title	**Finance and Investment Committee Summary Report – 02 May 2023**	**Agenda Item Number: 19**
Chair	*Heidi Travis, (Non-Executive Director)*	
Report Author	*Timi Achom, (Corporate Governance Officer)*	

Key Messages to Note
1. Matters approved by the Committee/Recommended for Trust Board approval - UEC Recovery Plan Capital Funding Bid
2. Items identified for escalation to Trust Board - 2023/24 Draft Financial Plan - Contract Renewal for the Provision of an Orthotics / Appliance Service - Contract Renewal for Insight PACS - UEC Recovery Plan Capital Funding Bid
3. Summary of matters considered at the meeting - Cognitive Contract Management pilot project by KPMG to apply tool they had developed towards the monitoring the performance of the contracts the Trust had entered with providers. - Extension of current contract by 3 years with Insignia Medical Systems (Intelerad) for the Trust's Picture Archiving and Communication System (PACS) from 1 June 2023 to 31 May 2026.
4. Highlights of Board Assurance Framework Review - The BAF entries was reviewed and agreed that the commentary reflected the pressures on the funding from the NHS.
5. Risks/concerns (Current or Emerging) identified - None

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

Meeting Title	Trust Board Meeting In Public	**Date:** 06 July 2023
Report Title	Summary Report from the Trust Executive Committee Meeting held on 08 March 2023	**Agenda Item Number:** 19
Chair	Joe Harrison, Chief Executive	
Report Author	Timi Achom, Corporate Governance Officer	

Key Messages to Note

1. **Matters approved by the Committee**

Business cases

a. AIDOC AI platform

Policies/Guidelines/Strategies

a. Central Alert System (CAS)
b. Identification and management of Post EUS/ERCP/Advanced Therapeutic Procedure-related complications
c. Lifetime Annual Leave Account Policy and Procedure v1.1
d. Uniform and Dress Code Policy
e. Mental Capacity and Deprivation of Liberty Safeguarding (DoLS) Policy

2. **Matters Recommended for Trust Board approval**

None

3. **Summary of matters considered at the meeting**

- Feedback on the CQC visit on 20 February 2023.
- Junior Doctor's 72-hour industrial action starting on 13 March 2023.
- Wearing a face mask would no longer be mandatory on the hospital site from 7 March 2023 following low COVID rates.
- International Women's Day on 8 March 2023. Activities around the Trust to recognise women in various fields and celebrate their contributions and achievements was ongoing.
- A review of the Corporate risk register.
- Mandatory blood transfusion training for specific staff.
- Ongoing incident reporting issues with the system – RADAR.
- Patient experience inpatient survey was underway.
- Dr. Andrew Cooney had been appointed Clinical Director for Musculoskeletal Medicine and would be stepping down from his position as Associate Medical Director (including work on QI).
- Reduction to the Trust’s vacancy rate and the ongoing work to address the increased staff turnover.

4. **Highlights of Board Assurance Framework Review**

N/A

5. **Risks/concerns (Current or Emerging) identified**

All appropriate risks considered.

Strategic Objectives Links	1. Keeping you safe in our hospital

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

Meeting Title	Trust Board Meeting In Public	**Date:** 06 July 2023
Report Title	Summary Report from the Trust Executive Committee Meeting held on 10 May 2023	**Agenda Item Number:** 19
Chair	Joe Harrison, Chief Executive	
Report Author	Timi Achom, Corporate Governance Officer	

Key Messages to Note

1. **Matters approved by the Committee**

Business cases

a. Additional 2 WTE (Whole Time Equivalent) permanent Trust SHO's for the ENT department

Policies/Guidelines/Strategies

a. Adult Sedation Guidelines March 2023
b. Teicoplanin IV Treatment Protocol for Prescribing, Administration and Monitoring for Adults
c. Chaplaincy Referral Guidelines
d. Data Subject Access & Individual Rights
e. DNACPR Adult
f. Electrolyte Replacement Guide
g. Fire Safety Policy
h. Fire Safety Procedure
i. Switching IV to Oral Antibiotics
j. Fuel Shortage and Continuity SOP
k. Gentamicin Once Daily – Treatment Protocol for Adult Prescribing, Administration and Monitoring
l. Paediatric Unit Escalation Guideline
m. Paediatric Unit Operational Policy
n. Splenectomy Guidelines – for the Prevention and Treatment of Infection in Patients with an Absent or Dysfunctional Spleen
o. TRiM maternity staff support following incidents
p. Trust Evacuation and Shelter Policy
q. Working at Heights Procedure
r. Working at Heights Policy

2. **Matters Recommended for Trust Board approval**

None

3. **Summary of matters considered at the meeting**

- All minutes from Gold Committee meetings would be subject to disclosure for the UK Covid-19 Enquiry.
- Feedback on how hospital coped following Junior Doctor's industrial strike.
- Concerns raised by the CQC around patient safety following unannounced visit to the Campbell Centre.
- Support around CQC preparedness.
- Review of risks and overdue incidents.
- Patient Experience: Concern over the number of complaints going to the CQC where complainants were not satisfied with the Trust's response.
- Ongoing work around QI (Quality Improvement).

- Discussion around M12 – March 2023 performance.
- Divisional updates with a focus around cancer.
- 2023/24 financial plan.
- The Insight PACS and Orthotics Service contract renewal was approved.
- Radiotherapy build was on track with a completion date of 05 April 2024.
- Pool of volunteers to increase to around 400.

4. Highlights of Board Assurance Framework Review

The Committee reviewed and noted the Board Assurance Framework.

5. Risks/concerns (Current or Emerging) identified

All appropriate risks were considered.

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

Meeting Title	Trust Board Meeting In Public	**Date:** 06 July 2023
Report Title	Summary Report from the Trust Executive Committee Meeting held on 14 June 2023	**Agenda Item Number:** 19
Chair	Joe Harrison, Chief Executive	
Report Author	Timi Achom, Corporate Governance Officer	

Key Messages to Note

1. **Matters approved by the Committee**

Business cases

a. Fire Doors Replacement, Staffing and Maximum Demand Increase (electricity available for site).

Policies/Guidelines/Strategies

a. Haematological Management of Major Haemorrhage in Adults Guideline
b. Insulin management guide for healthcare professionals Guideline

2. **Matters Recommended for Trust Board approval**

None

3. **Summary of matters considered at the meeting**

- Junior Doctors industrial action which commenced 14th June 2023.
- Fit testing and its booking process being reviewed after being taken over by Occupational Health.
- Assurances was provided around support for safeguarding by the senior team whilst recruitment was ongoing.
- The new Clinical Negligence Scheme for Trusts (CNST) guidance had been published and gaps were being reviewed.
- Concerns raised by the coroner around the preventing future deaths notice for sepsis care, poor quality investigations, lack of investigation and record disclosure was discussed.
- Ongoing significant amount of QI programmes and training was being undertaken by the QI team
- Some improvement in all performance areas i.e., Emergency Department, Outpatient Transformation, Elective Recovery, Inpatients, Human Resources and Patient Safety.
- Divisional cancer update.

4. **Highlights of Board Assurance Framework Review**
The Committee reviewed and noted the Board Assurance Framework.

5. **Risks/concerns (Current or Emerging) identified**

All appropriate risks were considered.

Strategic Objectives Links (Please delete the objectives that are not relevant to the report)	1. Keeping you safe in our hospital 2. Improving your experience of care 3. Ensuring you get the most effective treatment 4. Giving you access to timely care 5. Working with partners in MK to improve everyone's health and care

	6. Increasing access to clinical research and trials 7. Spending money well on the care you receive 8. Employ the best people to care for you 9. Expanding and improving your environment 10. Innovating and investing in the future of your hospital

Meeting Title	Trust Board	Date: July 2023
Report Title	**Quality and Clinical Risk Committee Meeting Summary Report – 12 March 2023**	Agenda Item Number: 19
Chair	Bev Messinger, Non-Executive Director	
Report Author	Timi Achom, Corporate Governance Officer	

Key Messages to Note

1. Matters approved by the Committee/Recommended for Trust Board approval

N/A

2. Items identified for escalation to Trust Board

a. Quality Improvement work as a presentation to the July 2023 Board Meeting in Public
b. 2023/24 Quality Priorities

3. Summary of matters considered at the meeting

a. The Committee noted the variation in requirements for the wearing of PPEs and face masks in the hospital as COVID infections continued to decline.

b. The Committee noted the arrangements in place to mitigate the impact of the non-consultant doctors' strike in the second week of March 2023, including the redeployment of consultants and specialty doctors and other clinical staff to care for inpatient and emergency patients.

c. The Committee noted and approved the 2023/24 quality priorities and the 2022/23 quality priorities.

d. The Committee received the Quarterly Trust-wide Serious Incidents Report and reviewed the overall incident reporting rates.

e. The Committee noted the ongoing Quality Improvement (QI) work which continued to provide support around medication and pressure ulcers, while developing an annual plan to improve support for clinical audit processes in the Trust.

f. The Committee also reviewed the following:

- Pressure Ulcers Quarterly update
- Infection Prevention and Control BAF
- Quarterly Mortality Report

4. Highlights of Board Assurance Framework Review

The Committee noted Board Assurance Framework which focused on clinical risks.

5. Risks/concerns (Current or Emerging) identified

N/A

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

Meeting Title	Trust Board	Date: July 2023
Report Title	**Quality and Clinical Risk Committee Meeting Summary Report – 05 June 2023**	**Agenda Item Number: 19**
Chair	Bev Messinger, Non-Executive Director	
Report Author	Timi Achom, Corporate Governance Officer	

Key Messages to Note

1. Matters approved by the Committee/Recommended for Trust Board approval

N/A

2. Items identified for escalation to Trust Board

a. Police interface as a presentation to the July 2023 Board Meeting in Public.
b. ENT Cancer pathway as a presentation to the July 2023 Board Meeting in Public.

3. Summary of matters considered at the meeting

a. The Committee received the Quarterly Highlight Report from the Medical Director and Director of Patient Care and Chief Nurse. They discussed the top issues and challenges relating to the Medical and Nursing Director's portfolios.

b. The Committee noted the challenges around the decision taken by the London Metropolitan Police Commissioner around reducing the amount of time officers spent responding to mental health and behavioural calls related to mental health.

c. The Committee received the draft Quality report and suggested recommendations and amendments to the report.

d. The Committee received the Annual Claims Report and acknowledged the vast majority of the "heavy lifting" in relation to claims done by NHS resolution and the shared decision making between the Trust and NHS resolution.

e. The Committee noted Quarterly Mortality Report and noted the increase in the Trust HSMR (Hospital Standards Mortality Rate).

f. The Committee also reviewed the following:

- Pressure Ulcers Quarterly update
- Falls Annual Report
- Bi-Annual Safe Staffing Report for Nursing, Midwifery, and Allied Health Professionals
- Antimicrobial Stewardship Annual Report

4. Highlights of Board Assurance Framework Review

The Committee noted Board Assurance Framework which focused on the grading of risks.

5. Risks/concerns (Current or Emerging) identified

N/A

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

Meeting Title	Trust Board in Public	Date: 06/07/2023
Report Title	**Charitable Funds Committee**	**Agenda Item Number: 19**
Chair	*Haider Husain, (Non-Executive Director)*	
Report Author	*Timi Achom, (Corporate Governance Officer)*	

Key Messages to Note
1. Matters approved by the Committee/Recommended for Trust Board approval - The Committee approved the revised Charity Reserve Policy.
2. Items identified for escalation to Trust Board - The Charity achieved £130k in donations in 2021/22 and had a year-to-date (YTD) donations income of £268k against a planned YTD income of £388k. Charitable donations were being impacted by inflationary pressures, and the Radiotherapy Appeal was being undertaken in a challenging environment. - The Committee was supportive of the continuing success of the Meaningful Activities Facilitator, and would support the role's alignment with Age UK MK. - The Committee expressed some concern that the staffing may not be ready to support the PET-CT scanner after it had been installed. The Committee hoped that JB would have successful discussions with the Commissioners and the private sector contract holders, so the Trust's staff could be adequately trained and upgraded to manage the PET-CT scanner.
3. Summary of matters considered at the meeting - The Committee noted the proposal regarding a charitable appeal in 2023 to support the new Radiotherapy build. - The Committee noted the Meaningful Activities Facilitator (MAF) Report and was supportive of its continuing success including the role's alignment with Age UK MK.
4. Highlights of Board Assurance Framework Review - The Committee highlighted the risk of the Radiotherapy Appeal not achieving its £500k target due to current inflationary pressures.
5. Risks/concerns (Current or Emerging) identified - None

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

Meeting Title	**Trust Board in Public**	**Date: 06/07/2023**
Report Title	**Charitable Funds Committee**	**Agenda Item Number: 19**
Chair	*Haider Husain, (Non-Executive Director)*	
Report Author	*Timi Achom, (Corporate Governance Officer)*	

Key Messages to Note
1. Matters approved by the Committee/Recommended for Trust Board approval - Extended funding for the Meaningful Activities Facilitator (MAF) role for financial year 2023/24.
2. Items identified for escalation to Trust Board - None
3. Summary of matters considered at the meeting - The Committee noted the Charity Finance Report and acknowledged an income of £300k and incurred expenditure of £474k at the end of March 31st, 2023. This was because the forecasted income plan for financial year 2022/23 was based on the expectation that charitable funds would receive £468k. Mitigating actions for 2023/24 financial year was in place. - The Committee noted the ongoing progress update around refocusing charity support on the creation of a Wellbeing Hub, which would be based on the Radiotherapy site due to OUH funding all the equipment to go into the Radiotherapy Centre. - The Committee received the Arts for Health Report.
4. Highlights of Board Assurance Framework Review - None
5. Risks/concerns (Current or Emerging) identified - None

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

Meeting Title	Trust Board	Date: 06 July 2023
Report Title	**Workforce and Development Assurance Committee Summary Report - 15 May 2023**	**Agenda Item Number: 19**
Chair	Bev Messinger, Non-Executive Director	
Report Author	*Timi Achom, Corporate Governance Officer*	

Key Messages to Note
1. Matters approved by the Committee/Recommended for Trust Board approval None
2. Items identified for escalation to Trust Board a. Freedom To Speak Up to be a standing agenda item at the Workforce and Development Assurance Committee. b. Improvements to the staff survey results. c. Update of FPPTs
3. Summary of matters considered at the meeting on 20 October 2022. a. The Committee noted the revised Workforce Strategy for 2023/24 which highlighted the changes from 2022/23 Objectives. b. The Committee was pleased with the feedback and 2022/23 results from the staff survey provider. Highlights had been shared at the last Trust Board. c. The Committee noted the 2022 Freedom To Speak Up (FTSU) Annual Review and agreed to the change to financial year reports from a calendar year report. d. The Committee received the WRES (Workforce Race Equality Standard) & WDES (Workforce Disability Equality Standard) Reports and acknowledged good progress around these.
4. Highlights of Board Assurance Framework Review Staffing levels risks – The Committee agreed to changing the likelihood rating from 3 (the event should occur at some time) to 2 (the event could occur) given that the headcount at the Trust at 4200, was at its highest.
5. Risks/concerns (Current or Emerging) identified Risk 447 (external payroll provider under-performance) – The payroll provider was changed in January 2023 from University Hospitals Birmingham (UHB) to East Lancashire Financial Services (ELFS) who alerted the Trust to several areas which required a different processing approach. This had resulted in an increase in the number of under and over payments. In mitigation, quarterly review meetings were being held and additional monitoring was in place.

Strategic Objectives Links	
(Please delete the objectives that are not relevant to the report)	*1. Keeping you safe in our hospital* *2. Improving your experience of care* *3. Ensuring you get the most effective treatment* *4. Giving you access to timely care* *5. Working with partners in MK to improve everyone's health and care* *6. Spending money well on the care you receive*

	7. *Employ the best people to care for you* 8. *Expanding and improving your environment* 9. *Innovating and investing in the future of your hospital*

Meeting title	Board of Directors	Date: 6 July 2023
Report title:	Use of Trust Seal	Agenda item:
Lead director Report author Sponsor(s)	Name: Kate Jarman Name: Julia Price	Title: Director of Corporate Affairs Title: Senior Corporate Governor Officer
FoI status:	Public	

Report summary	To inform the Board of the use of the Trust Seal.							
Purpose *(tick one box only)*	**Information**	x	**Approval**		**To note**	x	**Decision**	
Recommendation	That the Board of Directors note the use of the Trust Seal since May 2023							

Strategic objectives links	Objective 7 become well led and financially sustainable.
Board Assurance Framework links	**None**
CQC outcome/ regulation links	**None**
Identified risks and risk management actions	**None**
Resource implications	
Legal implications including equality and diversity assessment	None

Report history	None
Next steps	None
Appendices	

Use of Trust Seal

1. Purpose of the Report

In accordance with the Trust Constitution, this report informs the Board of entries in the Trust seal register which have occurred since the last full meeting of the Board.

2. Context

Since the last Trust Board, the Trust Seal has been executed as follows:

30 May 2023 – Novation of Payroll Contract to new host organisation for ELFS.

Trust Board Meeting in Public

Forward Agenda Planner

Standing Items

Standing Business Items	Standing Trust Board Meeting In Public Items
Apologies	Patient Story
Meeting Quorate	Nursing Workforce Update
Declaration of Interests	Performance Report
Minutes of the previous meeting	Finance Report
Action Tracker	Workforce Report
Escalation items for Board attention	Board Assurance Framework
AOB	Trust Seal
Forward Agenda Planner	Summary Reports from Board Committees
	Significant Risk Register Report
	Serious Incident Report
	Patient Experience Report
	Maternity Assurance Group Update

Additional Agenda Items

Month	Assurance Reports/Items
January	Objectives Update
	Antimicrobial Stewardship - Annual Report
	Declaration of Interests Report
	Green Plan Update
	Maternity Patient Survey 2022 interim report
	Infection Prevention and Control Annual Report
	Equality, Diversity & inclusion (ED&I) Update
March	
May	
July	Annual Claims Report
	Equality, Diversity & inclusion (ED&I) Update
	Falls Annual Report
	Pressure Ulcers Annual Report
	Green Plan Update

	Freedom to Speak Up Guardian Annual Report
September	Safeguarding Annual Report
	Research & Development Annual Report
	Emergency Preparedness, Resilience and Response Annual Report
	Annual Complaints Report
	Annual Patient Experience Report
	Green Plan Update (C/F from June 2023)
November	CNST Maternity Incentive Scheme and Board Assurance Framework Sign Off
	Update on quality priorities (electives, diagnostics, emergency care and outpatients)
	Freedom to Speak Up Guardian Report
	Accountability and support for theatre productivity
	Mortality Update